

Primary Health Clinic Standards — Full Guide

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 45 criteria.

8 standards · 45 criteria · Version 3.0

ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 6

Standard 6 — Clinical Environment & Safety

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 6.1 — Test Results Are Tracked to Actual Action, Not Just Confirmed Receipt
- 6.2 — History-Taking and Examination Follow a Structured Approach, Not Time-Pressured Shortcuts
- 6.3 — Medication Safety Follows Defined Processes for Prescribing and Monitoring
- 6.4 — Point-of-Care Testing Is Genuinely Reliable, Verified Against a Recognised Standard
- 6.5 — The Clinical Environment Itself Supports Safe Care, Not Just Administrative Compliance

6.1 Test Results Are Tracked to Actual Action, Not Just Confirmed Receipt

NON-NEGOTIABLE

Every diagnostic test result is tracked not just to confirmed receipt by the clinician, but to actual, documented action taken in response — not assumed adequately handled simply because someone acknowledged seeing it.

In plain terms: Every test result is tracked not just to 'the doctor saw it' but to 'the doctor did something about it' — the action is documented.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

A result that was received, reviewed, and filed is a result that changed nothing. The abnormal thyroid function that was seen and forgotten, the raised creatinine that was noted and not repeated, the positive faecal occult blood that was reviewed and not referred — each is a review without action. Tracking to action means: for every abnormal result, what was done? Repeated? Referred? Treatment changed? Patient informed? The action is recorded against the result. An audit checks that abnormal results have actions. This closes the last gap in results management.

WHAT GOOD LOOKS LIKE

- Every result is tracked to genuine, documented action, not just receipt.
- A real process identifies results received but never acted upon.
- Patients genuinely learn and understand their actual results.

COMMON FAILURE MODES

- Tracking confirms receipt but not whether any real action followed.
- No process identifies results that were seen but never acted on.
- Patients learn a test was done but not what it actually showed.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with results tracking to review but not to action.

BEFORE

Results were reviewed by the clinician and marked 'seen.' The Coordinator sampled 50 abnormal results marked 'seen': 14 had no documented action — no repeat, no referral, no patient contact. Two were significantly abnormal (a raised calcium, a positive coeliac screen) and had been sitting for months.

ACTION	The results workflow was changed: 'seen' is not a terminal state; the clinician must select an action (normal — inform patient; abnormal — repeat / refer / treat / discuss with patient / no action with reason). The action generates a task tracked to completion. A monthly audit of 30 abnormal results checks that each has a completed action.
AFTER	The Monitor reviewed three monthly audits: 98% of abnormal results with completed actions; the two historical cases had been actioned. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Sample 30 abnormal results from three months ago. For each, what was done?
2. Change the workflow: 'seen' must be followed by an action.
3. Make the action a tracked task.
4. Audit 30 abnormals a month.

The most common mistake: Treating 'reviewed' as the end — the result was reviewed and the patient was not helped.

SELF-ASSESSMENT QUESTIONS

1. Is every test result tracked to actual, documented action, not only confirmed receipt by the clinician? — *Genuine tracking of real action taken, not just acknowledgement of having seen the result.*

Evidence: Test result action tracking record

2. Is there a specific process for identifying a result that was received but never actually acted upon? — *A real, active identification process, not an assumption that receipt implies action.*

Evidence: Unactioned result identification process

3. Does the patient learn the actual result and its meaning, not just that a test was performed? — *Genuine, meaningful communication of the actual finding, not a passive assumption the patient will ask.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Action tracking is strong for abnormal results but less consistent for results confirming normal findings.** — Even a normal result needs genuine closure — the patient needs to know it was actually reviewed, not just filed.
- **Results are acted on but the action taken isn't consistently documented in a way that's genuinely traceable later.** — An undocumented action is difficult to distinguish from no action at all during a later review.
- **Patients are told results are available but not always given a genuine explanation of what they mean.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current test result tracking for genuine action tracking versus receipt confirmation alone.
Week 2	Establish a process for identifying results received but never actioned.
Week 3	Build a consistent practice for communicating actual result meaning to patients.
Ongoing	Audit a sample of results to confirm genuine action, not just documented receipt.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Action tracking review	Reviews whether test results are tracked to genuine, documented action, not only receipt.
DOCUMENT	Unactioned result identification review	Reviews the process for identifying results that were received but never acted upon.
ASK	Patient communication interview	Asks a patient whether they received and understood the actual meaning of a specific test result.

SUPERVISOR TIPS

- **Ask to trace a specific abnormal result from receipt through to the actual action taken.** — A real, traceable example reveals

whether tracking captures genuine action, not just acknowledgement.

- **Ask a patient to explain what a recent test result actually showed.** — This tests genuine communication and understanding, not just that results technically reached them.

EVIDENCE BASE

[26] Research on test result communication found that while automated notification systems statistically improved confirmed acknowledgement of test results, there was no corresponding improvement in documented actions taken in response, establishing that tracking to genuine action, not receipt alone, is necessary for real patient safety.

ASF training courses on GMJ Academy →

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

History-Taking and Examination Follow a 6.2 Structured Approach, Not Time-Pressured Shortcuts

NON-NEGOTIABLE

History-taking and physical examination genuinely follow a structured, complete approach appropriate to the presenting concern — not abbreviated under time pressure in ways that consistently drive real diagnostic error.

In plain terms: History and examination follow a structured approach appropriate to the problem — not shortened to fit a ten-minute slot.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A ten-minute consultation is a reality, not an excuse. Within it, the history for chest pain should still cover character, radiation, associated symptoms, and risk factors; the examination should still include the relevant system. Structured approaches — templates, checklists,

presentation-specific prompts — make sure the essentials are covered under time pressure. The failure mode is the 'shortcut': the abdominal pain examined without touching the abdomen, the depression assessed without asking about suicide, the child's rash diagnosed from across the room. Structure is how quality survives speed.

WHAT GOOD LOOKS LIKE

- History-taking is genuinely structured and complete, not abbreviated under pressure.
- Examination genuinely matches what the presenting concern actually warrants.
- A specific support process helps maintain thoroughness during high-volume periods.

COMMON FAILURE MODES

- History-taking is consistently abbreviated under time pressure.
- Examination is a token, minimal check regardless of the actual concern.
- No support exists to help maintain thoroughness when volume is high.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre with ten-minute appointments and free-text consultation notes.

BEFORE

Notes were brief and variable. The Coordinator audited 40 consultations for common presentations: abdominal pain examined in 60%; chest pain with cardiac risk factors documented in 35%; depression with suicide risk asked in 20%. Clinicians said 'there isn't time.'

ACTION

Presentation-specific consultation templates were introduced for the 15 most common presentations, each with the essential history items and examination steps as prompts. Templates take no longer to complete than free text and ensure coverage. A monthly audit of 20 consultations checks template completion. Appointment length was reviewed; complex presentations get double slots.

AFTER

The Monitor reviewed two monthly audits: essential history and examination documented in 90%+ across presentations. Observed a consultation using a template without loss of rapport. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Audit 30 consultations for your five commonest presentations: are the essentials documented?
2. Build a template per common presentation with prompts.
3. Audit monthly.
4. Double-book complex presentations.

The most common mistake: Blaming the ten-minute slot — structure fits in ten minutes; shortcuts do not save time, they defer it.

SELF-ASSESSMENT QUESTIONS

1. Does history-taking genuinely follow a structured, complete approach, not abbreviated under time pressure? — *Real, structured completeness, not a shortcut taken to save time.*

Evidence: N/A — tested directly

2. Does physical examination genuinely match what the presenting concern actually warrants, not a token, minimal check? — *Genuine, appropriate examination depth, not a cursory check regardless of the actual concern.*

Evidence: N/A — tested directly

3. Is there a specific process supporting complete data gathering even during high-volume, time-pressured periods? — *A real, defined support process, not an assumption that thoroughness will hold up under pressure without help.*

Evidence: Structured data-gathering support documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Structured history-taking is strong for new patient visits but less consistent for brief follow-up encounters.** — Diagnostic error risk doesn't diminish just because a visit is framed as a quick follow-up.

- **Examination depth is genuinely appropriate most of the time but noticeably reduced during the busiest periods.** — The real value of thorough examination doesn't diminish when the clinic happens to be busy.
- **A structured template exists but isn't consistently used across all clinicians in the practice.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current history-taking and examination practice for consistency, particularly under time pressure.
Week 2	Establish or reinforce a structured approach appropriate to common presenting concerns.
Week 3	Build specific support for maintaining thoroughness during high-volume periods.
Ongoing	Audit consultation quality periodically, including during genuinely busy periods.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	History-taking observation	Observes an actual consultation for genuine, structured, complete history-taking.
OBSERVE	Examination adequacy observation	Observes whether physical examination genuinely matches the presenting concern, not a minimal token check.
DOCUMENT	Time-pressure support review	Reviews what specific support exists for maintaining thoroughness during high-volume periods.

SUPERVISOR TIPS

- **Observe a consultation during a genuinely busy period specifically.** — This is where structured thoroughness is most likely to erode under real pressure.
- **Ask a clinician how they maintain thoroughness when the schedule is significantly overbooked.** — A specific, thoughtful

answer reveals genuine practice, not an assumption it holds up automatically.

EVIDENCE BASE

[27] A study of confirmed diagnostic errors in primary care found that patient-practitioner encounter breakdowns were primarily related to problems with history-taking, in 56.3 percent of cases, examination, in 47.4 percent of cases, and ordering diagnostic tests for further work-up, in 57.4 percent of cases.

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

6.3 Medication Safety Follows Defined Processes for Prescribing and Monitoring

NON-NEGOTIABLE

Prescribing, dispensing, and ongoing monitoring of medications follow specific, defined safety processes — genuine allergy and interaction checking, clear instructions, monitoring where clinically required — not left to individual clinician memory and informal practice alone.

In plain terms: Prescribing, dispensing, and monitoring follow written safety processes — allergy and interaction checks every time, high-risk drugs monitored, repeat prescriptions reviewed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Primary care prescribes more medicines than any other setting, and its errors are quieter: the repeat prescription continued for years without review, the interaction between two drugs from two prescribers, the allergy recorded in one place and missed in another, the methotrexate without blood monitoring. Safety processes are specific: an allergy and interaction check at every prescription (electronic where possible); a

monitoring schedule for high-risk drugs (warfarin, lithium, methotrexate, DMARDs) with a register and overdue alerts; repeat prescriptions reviewed at least annually and reauthorised, not auto-renewed. The processes must be written, followed, and audited.

WHAT GOOD LOOKS LIKE

- A defined, systematic process genuinely checks allergies and interactions at prescribing.
- Patients receive clear instructions with verified understanding.
- Required monitoring is genuinely scheduled and tracked, not left to chance.

COMMON FAILURE MODES

- Allergy and interaction checking relies on individual clinician memory alone.
- Instructions are given without verifying genuine patient understanding.
- Monitoring for medications that require it isn't reliably scheduled or tracked.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with an EHR but no prescribing safety processes.

BEFORE

The EHR's interaction checker was switched off ('too many alerts'). Allergies were free text. Repeat prescriptions auto-renewed. No high-risk drug register. The Coordinator found a patient on methotrexate with no blood test for 18 months, and a patient prescribed a penicillin despite a recorded allergy in a free-text field.

ACTION

Allergies were structured and coded. The interaction checker was switched on with major interactions only. A high-risk drug register was built with monitoring schedules and overdue alerts; repeat prescriptions for these drugs are blocked if monitoring is overdue. All repeat prescriptions require annual clinician review with a documented reauthorisation. Pharmacy performs a monthly repeat prescription audit.

AFTER

The Monitor reviewed the register (no patient overdue), 30 prescriptions with documented

checks, the annual review records, and the pharmacy audit. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Is your interaction checker on? Are allergies coded or free text?
2. Build a high-risk drug register with monitoring schedules.
3. Block repeats for patients with overdue monitoring.
4. Require annual review of every repeat prescription.

The most common mistake: Switching off the interaction checker because it alerts too often — tune it to major interactions, do not silence it.

SELF-ASSESSMENT QUESTIONS

1. Does prescribing follow a defined process for genuine allergy and interaction checking, not reliance on memory alone? — *A real, systematic check, not individual clinician memory as the only safeguard.*
Evidence: Prescribing safety check documentation

2. Do patients receive clear, understandable instructions for new or changed medications, verified as understood? — *Genuine, verified understanding, not instructions given without confirmation.*
Evidence: N/A — tested directly

3. Is monitoring genuinely scheduled and tracked for medications that clinically require it, not left to chance? — *Real, scheduled, tracked monitoring, not an assumption it will happen without a defined process.*
Evidence: Medication monitoring schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **Interaction checking is systematic for new prescriptions but not rechecked when an additional medication is later added.** — Interaction risk applies at the point combinations actually occur, not only at each medication's original prescribing.
- **Instructions are given clearly but understanding isn't actively verified, particularly for complex regimens.** — Complex regimens carry genuinely higher risk of misunderstanding and benefit from active verification.
- **Monitoring is scheduled but follow-through when a patient misses a monitoring appointment is inconsistent.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current prescribing practice for systematic allergy and interaction checking.
Week 2	Establish patient instruction verification, particularly for complex medication regimens.
Week 3	Build a defined monitoring schedule with follow-up for missed monitoring.
Ongoing	Audit prescribing safety checks and monitoring completion periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Prescribing safety review	Reviews the defined process for allergy and interaction checking at prescribing.
OBSERVE	Patient instruction observation	Observes whether patients receive clear instructions with verified understanding.
DOCUMENT	Monitoring schedule review	Reviews whether required medication monitoring is genuinely scheduled and tracked.

SUPERVISOR TIPS

- **Ask how the practice checks for interactions when a second medication is added to an existing regimen.** — This reveals whether checking is genuinely systematic, not limited to initial prescribing alone.
- **Ask a patient to explain back the instructions for a recently prescribed medication.** — A specific, confident answer reveals genuine understanding, not assumed comprehension.

EVIDENCE BASE

[28] Preventable adverse drug events are estimated to affect approximately 2 percent of adult outpatients, with primary care clinicians, when systematically surveyed, identifying specific, addressable process gaps in prescribing, quality assurance, and patient education as the primary drivers of preventable medication error.

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6.4 Point-of-Care Testing Is Genuinely Reliable, Verified Against a Recognised Standard

NON-NEGOTIABLE

Point-of-care diagnostic testing performed at the clinic is verified as genuinely accurate against a recognised quality standard — regular calibration, quality control checks — not simply assumed reliable because the device is in use and produces a result.

In plain terms: Rapid tests done at the clinic — glucose, urine, strep, pregnancy, HbA1c — are checked for accuracy against a recognised quality standard with records, not assumed reliable.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

This is the PHC equivalent of ambulatory 3.6. Primary care runs more point-of-care tests than any other setting and relies on them for immediate decisions: the glucose that determines the insulin dose, the strep that determines the antibiotic, the HbA1c that determines the medication change. Quality control — control samples run at defined intervals, results recorded, failed controls stopping use — is what makes a rapid test trustworthy. Without it, the practice is treating on numbers it has never verified.

WHAT GOOD LOOKS LIKE

- Point-of-care testing is genuinely verified as accurate against a recognised standard.
- Calibration and quality control checks are

COMMON FAILURE MODES

- Testing is assumed reliable simply because the device produces a result.
- Calibration and quality control checks are skipped or undocumented.

regularly performed and documented.

- A specific, defined response exists for a failed quality control check.

- No specific process exists for a failed quality control check.

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre running glucose, HbA1c, urine dipstick, and INR at the point of care.

BEFORE

No QC on any device. The INR meter — used to adjust warfarin doses — had never been checked against a laboratory INR. When the Coordinator compared it: the meter read 0.4 low. Patients had been under-anticoagulated for an unknown period.

ACTION

A QC programme was set up per device: control samples daily for glucose and INR, per lot for strips and kits, weekly for HbA1c; results logged; any failure stops use until resolved; quarterly split-sample comparison with the laboratory for INR and HbA1c. The INR meter was replaced. Strips are stored per manufacturer. One nurse owns the QC log.

AFTER

The Monitor reviewed six weeks of QC logs for all devices, the laboratory comparison results (INR within 0.2), and the storage arrangements. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every point-of-care test you run.
2. Run a control sample on each device today.
3. For INR and HbA1c, send a split sample to the lab and compare.
4. Start a QC log per device.

The most common mistake: Adjusting warfarin doses on a POC INR meter that has never been checked against the laboratory.

SELF-ASSESSMENT QUESTIONS

1. Is point-of-care testing genuinely verified as accurate against a recognised quality standard, not assumed reliable? — *Real, verified accuracy, not an assumption based on the device simply producing a result.*

Evidence: Quality control verification record

2. Are regular calibration and quality control checks genuinely performed and documented? — *Real, scheduled, documented checks, not skipped or assumed unnecessary.*

Evidence: Calibration and QC schedule documentation

3. Is there a specific process for what happens if a quality control check fails? — *A real, defined response, not testing continuing regardless of a failed check.*

Evidence: QC failure response protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Quality control checks happen but documentation is inconsistent, making genuine verification difficult to confirm.** — Undocumented checks are difficult to distinguish from checks that didn't genuinely happen.
- **Checks are performed on a schedule but staff aren't fully confident in interpreting a genuinely failed result.** — A quality control system's real value depends on staff correctly recognising and responding to failure.
- **Verification happens for the most frequently used tests but not consistently across all point-of-care devices.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current point-of-care testing for genuine verification versus assumed reliability.
Week 2	Establish a regular, documented calibration and quality control schedule.
Week 3	Train staff on recognising and responding to a failed quality control check.

When	What
Ongoing	Audit calibration and quality control documentation periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Verification record review	Reviews evidence that point-of-care testing is genuinely verified against a recognised standard.
DOCUMENT	Calibration schedule review	Reviews records of regular, documented calibration and quality control checks.
ASK	QC failure response interview	Asks staff what specifically happens if a quality control check fails.

SUPERVISOR TIPS

- **Ask to see the actual calibration and quality control log for a specific point-of-care device.** — A real, specific record is the evidence of genuine verification, not assumed reliability.
- **Ask staff what they would do if a quality control check came back outside acceptable range.** — A specific, confident answer reveals genuine understanding, not assumed competence.

EVIDENCE BASE

[29] The World Health Organization has specifically called for point-of-care diagnostic methods designed to function reliably in settings with limited access to laboratory services, establishing genuine, verified accuracy — not mere availability of a testing device — as essential to the real clinical value of point-of-care testing.

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

The Clinical Environment Itself Supports

6.5 Safe Care, Not Just Administrative Compliance

CORE

The physical clinical environment — equipment maintenance, infection control supplies, adequate space for examination and privacy — genuinely supports safe patient care, not simply meets a documentation checklist while real, everyday practice tells a different story.

In plain terms: The clinical environment actually supports safe care — equipment works and is maintained, infection control supplies are there, rooms are private and big enough — not just compliant on paper.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

A consulting room where the examination couch is broken, the sink has no soap, the door does not close, and the sharps bin is overflowing is a room where safe care is harder than it should be. This criterion is about the physical reality: equipment is present, working, and maintained; infection control supplies (hand rub, soap, gloves, cleaning products) are stocked at every point of use; rooms allow examination in privacy with adequate space; the environment is clean. It is checked by walking around, not by reading a policy.

WHAT GOOD LOOKS LIKE

- Equipment condition genuinely reflects real, current function, not just documentation.
- Infection control supplies are genuinely available where actually needed.
- Examination space genuinely supports privacy and dignity in daily practice.

COMMON FAILURE MODES

- Equipment maintenance is documented but real condition doesn't match.
- Supplies are stocked somewhere but not genuinely available at the point of use.
- Examination space technically exists but doesn't genuinely support privacy in practice.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre in a building that had not been reviewed for clinical suitability in years.

BEFORE

The Coordinator walked the rooms: one couch would not adjust; two rooms had no hand rub; one sink had no soap; one room's door had no lock and opened onto the waiting area; the sharps bin in the treatment room was full; the blood pressure cuff in room 3 was leaking. None of this was on any list.

ACTION

A monthly environment walk-round was introduced with a 20-item checklist per room: equipment function, supplies, privacy, cleanliness, safety. Findings go to the practice manager with a fix-by date. The broken couch was replaced; hand rub and soap stocked at every sink; a lock fitted; the cuff replaced. A quarterly equipment maintenance check was added.

AFTER

The Monitor walked all rooms: all checklist items met. Reviewed three monthly walk-round records with findings and fixes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk every clinical room today with a 20-item checklist.
2. Fix the worst three things this week.
3. Make the walk-round monthly.
4. Add equipment maintenance to a quarterly schedule.

The most common mistake: Having an infection control policy and no soap at the sink.

SELF-ASSESSMENT QUESTIONS

1. Does equipment maintenance genuinely reflect real, current condition, not just a completed checklist? — *Real, verified equipment*

condition, not documentation completed without genuine follow-through.

Evidence: Equipment maintenance record

2. Are infection control supplies genuinely, consistently available at the point of use, not just stocked somewhere in the building? —

Real, practical availability where actually needed, not theoretical stock elsewhere.

Evidence: N/A — tested directly

3. Does examination space genuinely support patient privacy and dignity, not just meet a minimal documented standard? — *Real,*

practical privacy in daily use, not a standard met only on paper.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Equipment is generally well-maintained but a specific item has been overdue for service without genuine follow-through.** — Every piece of equipment deserves the same genuine maintenance discipline, not just most of them.
- **Supplies are usually available but occasionally run short during high-volume periods.** — Genuine availability needs to hold up specifically when demand is highest, not only under typical conditions.
- **Privacy is generally respected but the physical space creates specific, recurring compromises during busy periods.**

IMPLEMENTATION PLAN

When	What
Week 1	Physically assess the clinical environment for genuine, real-world safety support, not documentation alone.
Week 2	Address any gap between documented equipment maintenance and actual current condition.
Week 3	Confirm infection control supplies are genuinely available at every actual point of use.
Ongoing	Periodically reassess the physical environment against genuine, practical safety and privacy standards.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Equipment condition observation	Physically checks equipment for genuine, current functional condition, not just documented maintenance.
OBSERVE	Supply availability observation	Checks infection control supplies for genuine availability at the actual point of use.
OBSERVE	Privacy observation	Assesses whether examination space genuinely supports patient privacy and dignity in real practice.

SUPERVISOR TIPS

- **Physically check equipment condition directly, not just review maintenance documentation.** — Direct observation reveals genuine condition, not assumed adequacy from paperwork.
- **Observe the examination space during a busy period specifically.** — This is where genuine privacy and safety support are most likely to be tested.

EVIDENCE BASE

[30] World Health Organization data indicate that as many as 4 in 10 patients are harmed in primary and ambulatory care settings, with up to 80 percent of this harm considered avoidable, establishing the genuine, everyday clinical environment, not documentation alone, as a real determinant of patient safety.

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

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

← **Primary Health Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 5 — Referral & Care Coordination**



Standard 7 — Governance & Staffing →

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ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 7

Standard 7 — Governance & Staffing

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

**7.1 — A Defined Coverage Plan
Exists for When the Solo Doctor
Is Unavailable**

**7.2 — Physician Wellbeing Is
Actively Monitored and
Supported, Not Left to
Individual Resilience Alone**

**7.3 — A Genuine Quality
Improvement Process Exists,
Even at Small Scale**

**7.4 — Staff, However Few,
Receive Real, Documented
Training for Their Actual Role**

**7.5 — Incident Reporting Leads
to Genuine Learning, Not Just
Documentation**

7.1 A Defined Coverage Plan Exists for When the Solo Doctor Is Unavailable

NON-NEGOTIABLE

A genuine, defined coverage arrangement exists for when the practice's own doctor is unavailable — illness, leave, emergency — with a real, named alternative for patients needing care in that gap, not an assumption that patients will simply wait or seek care elsewhere on their own.

In plain terms: When the practice's doctor is away — sick, on leave, at a funeral — there is a written arrangement for who covers, and patients know how to reach care.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A solo practice with no cover is a practice that closes when the doctor is ill. Patients with acute needs go to the emergency department; patients with chronic needs run out of medication; results go unreviewed; referrals stall. A coverage plan names who covers (a neighbouring practice, a locum agency, a colleague), what they cover (acute visits, prescriptions, results), how patients are told (a recorded message, a notice, a text), and how the covering clinician accesses the records. It is written before it is needed and tested annually.

WHAT GOOD LOOKS LIKE

- A genuine, defined coverage arrangement exists and is real, not theoretical.
- A specific, named alternative provider is identified for coverage gaps.
- Patients are genuinely, proactively aware of the coverage plan.

COMMON FAILURE MODES

- No defined coverage arrangement exists beyond an assumption patients will manage.
- No specific alternative is identified; patients are vaguely told to seek care elsewhere.
- Patients only learn about coverage gaps when they actually encounter one.

WORKED EXAMPLE

IN PRACTICE

A single-doctor health centre with two nurses and 2,500 patients.

BEFORE

When the doctor was hospitalised for a week, the practice closed. Patients arrived to a locked door. Prescriptions ran out. Abnormal results sat unreviewed. The nurses had no authority to act and no one to call.

ACTION	A reciprocal coverage agreement was signed with a neighbouring practice: each covers the other's acute visits, prescriptions, and result review during absence. Records access was arranged. A written absence protocol names who activates cover, what message goes on the phone and door, and how the nurses escalate. The arrangement was tested with a one-day planned absence.
AFTER	The Monitor reviewed the signed agreement, the absence protocol, the records access arrangement, and the test-day record. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: what happened last time the doctor was unexpectedly away?
2. Find a neighbouring practice and propose reciprocal cover.
3. Write a one-page absence protocol: who activates, what message, how to escalate.
4. Test it with a planned absence.

The most common mistake: Assuming a solo doctor will never be unavailable — everyone is unavailable eventually.

SELF-ASSESSMENT QUESTIONS

1. Does a genuine, defined coverage arrangement exist for when the doctor is unavailable? — *A real, specific arrangement, not an assumption that patients will manage without care.*
Evidence: Coverage arrangement documentation
2. Is there a real, named alternative provider or facility patients can be directed to during a coverage gap? — *A specific, real alternative, not a vague suggestion to seek care elsewhere.*
Evidence: Named alternative provider documentation
3. Are patients genuinely informed of the coverage plan, not left to discover it only when they need it? — *Real, proactive patient awareness, not information they only encounter during an actual gap.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A coverage plan exists for planned absences but not genuinely for sudden, unplanned unavailability.** — A genuine emergency doesn't announce itself in advance, and the plan needs to cover this reality too.
- **An alternative provider is named but the relationship hasn't been recently reconfirmed as still active.** — A coverage relationship needs to remain genuinely active, not just historically established.
- **The plan exists but patient awareness relies on them happening to ask, not proactive communication.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current coverage arrangements for genuine readiness, including sudden, unplanned absence.
Week 2	Establish or reconfirm a specific, named alternative provider relationship.
Week 3	Build proactive patient communication about the coverage plan.
Ongoing	Periodically reconfirm the coverage relationship remains genuinely active.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Coverage plan review	Reviews the actual, defined coverage arrangement for when the doctor is unavailable.
DOCUMENT	Alternative provider review	Reviews the specific, named alternative provider or facility patients would be directed to.
ASK	Patient awareness interview	Asks a patient whether they know what to do if the practice's doctor were unavailable.

SUPERVISOR TIPS

- **Ask what specifically would happen if the doctor became suddenly, unexpectedly unavailable today.** — A specific, confident answer reveals a genuine plan, not an assumption it would work out.

- **Ask a patient directly whether they know what to do if the doctor were unavailable.** — This tests genuine, proactive awareness, not an assumption patients would figure it out.

EVIDENCE BASE

[31] Continuity of care functions as genuine infrastructure protecting both patient outcomes and the rural primary care workforce itself, establishing defined coverage arrangements, distinct from unplanned care gaps, as essential to sustaining this infrastructure specifically in solo and small rural practice.

ASF training courses on GMJ Academy →

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

7.2 **Physician Wellbeing Is Actively Monitored and Supported, Not Left to Individual Resilience Alone**

NON-NEGOTIABLE

The physician's own wellbeing and burnout risk is genuinely, actively monitored and supported — real access to support, genuine attention to sustainable workload — not treated as a private matter left entirely to individual resilience with no structural attention at all.

In plain terms: The doctor's own wellbeing and burnout risk are monitored and supported — real access to help, real time off, real workload limits — not left to 'they'll cope.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A burned-out doctor makes more errors, retires earlier, and — in the worst cases — harms themselves. Primary care burnout is epidemic and structural: workload, isolation, administrative load, the impossibility of doing everything. A practice that treats physician wellbeing as a personal matter loses its doctor eventually. Monitoring means a regular

check-in — a validated burnout measure annually, a conversation with a peer or mentor, workload data reviewed; support means protected time, access to confidential counselling, administrative help, and a culture where saying 'I am struggling' is safe. In a solo practice, this may mean an external peer group.

WHAT GOOD LOOKS LIKE

- Physician wellbeing receives genuine, active attention, not treated as purely private.
- Real, accessible support exists if burnout risk is identified.
- Workload is genuinely, periodically reviewed for sustainability.

COMMON FAILURE MODES

- Wellbeing is treated as an entirely private matter with no structural attention.
- No genuine, accessible support exists beyond a theoretical resource.
- Workload sustainability is assumed, never genuinely reviewed.

WORKED EXAMPLE

IN PRACTICE

A single-doctor health centre where the doctor worked 60-hour weeks and had not taken leave in two years.

BEFORE

Nobody asked how the doctor was. He had not taken leave because there was no cover. He was making documentation errors and had become short with patients. Two complaints in three months. He did not recognise it as burnout; the practice manager did but did not know how to raise it.

ACTION	With the coverage arrangement (7.1) in place, four weeks of leave were scheduled. A validated burnout measure (Maslach or a brief equivalent) is completed annually and reviewed with a trusted peer from the reciprocal practice. A monthly peer group of four local solo doctors was joined. Administrative tasks were delegated to the practice manager. A confidential counselling service was identified. Workload data — consultations per day, hours worked — is reviewed quarterly.
AFTER	The Monitor reviewed the burnout measure results (improved over two years), leave records, peer group attendance, and delegated task list. Interviewed the practice manager who described the check-in process. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. When did the doctor last take two consecutive weeks off?
2. Complete a validated burnout measure this month.
3. Find or form a peer group.
4. Delegate three administrative tasks this month.

The most common mistake: Treating the doctor's wellbeing as the doctor's own business — a burned-out doctor is the practice's biggest risk.

SELF-ASSESSMENT QUESTIONS

1. Is physician wellbeing genuinely, actively monitored, not treated as a purely private matter? — *Real, active attention, not an assumption that wellbeing is solely the individual's own concern.*

Evidence: N/A — tested directly

2. Does the physician have genuine, real access to support if burnout risk is identified? — *Actual, accessible support, not a theoretical resource that's difficult to genuinely use.*

Evidence: Support access documentation

3. Is workload genuinely, periodically reviewed for sustainability, not assumed manageable indefinitely? — *Real, periodic review, not an assumption the current pace is sustainable without ever checking.*

Evidence: Workload review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Attention to wellbeing happens informally but isn't structured into any genuine, regular process.** — Informal attention is less reliable than a genuine, structured practice that doesn't depend on someone happening to notice.
- **Support resources exist but are genuinely difficult to access given the demands of solo practice.** — A resource that's difficult to actually use in practice provides limited real protective value.
- **Workload review happens but doesn't lead to genuine adjustment even when sustainability concerns are identified.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current attention to physician wellbeing for genuine structure versus informal assumption.
Week 2	Establish genuine, accessible support specifically feasible for solo practice demands.
Week 3	Build a periodic, structured workload sustainability review.
Ongoing	Act on genuine sustainability concerns identified through review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Wellbeing monitoring interview	Asks the physician directly whether their own wellbeing receives genuine, active attention.
DOCUMENT	Support access review	Reviews what genuine, accessible support exists if burnout risk is identified.
DOCUMENT	Workload review documentation	Reviews evidence of periodic, genuine workload sustainability review.

SUPERVISOR TIPS

- **Ask the physician directly about their own current workload sustainability and access to support.** — A genuine, honest answer reveals real practice, not an assumption everything is fine.
- **Ask what specifically changed the last time a wellbeing or workload concern was identified.** — A real, specific example reveals whether attention leads to genuine action, not just awareness.

EVIDENCE BASE

[32] Agency for Healthcare Research and Quality research found that more than one quarter of physicians in small- and medium-sized primary care practices experience moderate to severe burnout, with rural clinicians reporting the highest rates, and established that burnout measurably impairs attention, memory, and executive function with direct implications for patient safety.

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

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

7.3

**A Genuine Quality Improvement Process
Exists, Even at Small Scale**

CORE

The practice maintains a genuine, ongoing quality improvement process — even a small, single, well-chosen project — not the absence of any structured improvement effort simply because the practice is too small for a formal committee structure.

In plain terms: The practice has an ongoing quality improvement process — even one small, well-chosen project at a time — not the assumption that small practices are too small for QI.

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

WHY THIS MATTERS

'We're too small for quality improvement' is the most common excuse in primary care and the least valid. QI at small scale is one project: pick a measure (e.g. proportion of diabetics with an annual foot check), find the baseline (20%), make a change (nurse does foot checks at every diabetes visit), remeasure (75%), keep it going. That is the whole method. One project at a time, completed, documented, sustained, then the next. A practice that has done three such projects in two years has a QI process. A practice waiting until it is big enough will wait forever.

WHAT GOOD LOOKS LIKE

- A genuine, ongoing improvement effort exists, appropriately scaled to the practice.
- The effort addresses a real, specific gap identified in this practice.
- Real evidence shows a genuine, measurable resulting change.

COMMON FAILURE MODES

- No genuine improvement effort exists, treated as unnecessary given small practice size.
- Any improvement activity is generic, not genuinely relevant to this practice's real circumstances.
- No evidence connects improvement activity to any genuine, measurable change.

WORKED EXAMPLE

IN PRACTICE

A single-doctor health centre with no history of quality improvement.

BEFORE

The doctor believed QI was for large organisations. No measure had ever been tracked. No improvement project had been attempted. The practice was not getting better.

ACTION

One project was chosen: increase influenza vaccination in over-65s. Baseline measured (28%). Change: nurse recall list and phone calls in October. Remeasured in January (58%). Documented on one page. Second project: reduce missed specialist referrals, using the referral log (5.1). Third: hand hygiene. Each

	project is one page: measure, baseline, change, result.
AFTER	The Monitor reviewed three completed one-page QI projects with baseline and result data, and the plan for the fourth. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Choose one thing to improve. Just one.
2. Measure it now — that is your baseline.
3. Make one change.
4. Measure again in three months. Write it on one page.

The most common mistake: Waiting to be big enough for QI — one project on one page is QI.

SELF-ASSESSMENT QUESTIONS

1. Does the practice maintain a genuine, ongoing quality improvement effort, even at small scale? — *A real, specific improvement effort, not the absence of one justified by practice size.*
Evidence: Quality improvement project documentation
2. Is the improvement effort based on a real, identified gap specific to this practice, not a generic exercise? — *Genuine, specific relevance to this practice's actual circumstances, not a generic template.*
Evidence: N/A — tested directly
3. Is there real evidence the improvement effort has produced a genuine, measurable change? — *Actual, measurable outcome, not activity without demonstrated real effect.*
Evidence: Improvement outcome evidence

COMMON REASONS FOR A PARTIAL ANSWER

- **An improvement effort was started but hasn't been genuinely completed or evaluated.** — A genuine improvement cycle needs to reach evaluation to demonstrate real, meaningful effect.
- **The chosen focus is reasonable but wasn't specifically selected based on this practice's own real data or experience.** — Genuine relevance comes from grounding the effort in this practice's actual circumstances, not a generic priority.

- **A change was made but wasn't genuinely measured to confirm it produced real improvement.**

IMPLEMENTATION PLAN

When	What
Week 1	Identify a real, specific quality gap genuinely relevant to this practice.
Week 2	Design a small, appropriately scaled improvement effort addressing this gap.
Week 3	Implement the improvement and establish a way to genuinely measure its effect.
Ongoing	Evaluate the improvement effort and identify the next genuine priority.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Improvement project review	Reviews the practice's genuine, ongoing quality improvement effort, however small in scale.
ASK	Relevance interview	Asks the physician how the improvement effort relates to a real, identified gap in this specific practice.
DOCUMENT	Outcome evidence review	Reviews evidence of genuine, measurable change resulting from the improvement effort.

SUPERVISOR TIPS

- **Ask what specific quality gap the current improvement effort is genuinely addressing.** — A specific, real answer reveals genuine relevance, not a generic exercise.
- **Ask for real evidence the improvement effort actually changed something measurable.** — A specific, real outcome reveals genuine effect, not activity alone.

EVIDENCE BASE

[33] Quality improvement initiatives adapted for solo and small primary care practices, including structured support models and micro-scale improvement projects, are established as genuinely effective and appropriate to practice size, distinct from an assumption that meaningful quality improvement requires large-scale infrastructure.

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

7.4 Staff, However Few, Receive Real, Documented Training for Their Actual Role

NON-NEGOTIABLE

Every staff member, however few the practice employs, receives genuine, documented training specific to their actual role — not informal, on-the-job learning alone with no structured content or verification of competency.

In plain terms: Every staff member — even if there are only two — has documented training for what they actually do: the receptionist for triage, the nurse for the tasks she performs.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

In a small practice, staff do many things: the receptionist triages, the nurse gives vaccinations and dresses wounds, the practice manager handles data protection. Each task requires training, and informal learning is not training. Documentation matters: what training, when, by whom, and when it is due for refresh. The evidence that a nurse is competent to give a vaccine is a training record, not 'she's been doing it for years.' The evidence that the receptionist knows red flags is a signed session record. Two staff, two training files, current.

WHAT GOOD LOOKS LIKE

- Every staff member receives genuine, documented, structured training.
- Competency is genuinely verified, not assumed from

COMMON FAILURE MODES

- Training relies entirely on informal, on-the-job learning with no structure.
- Competency is assumed from tenure, never actively verified.

- time in role.
- Training is genuinely refreshed periodically, not a one-time event.

- Training happens once and is never revisited.

WORKED EXAMPLE

IN PRACTICE

A single-doctor health centre with one nurse and one receptionist.

BEFORE	The nurse had learned on the job. No training records existed. The receptionist had never had any training beyond 'answer the phone.' When the Coordinator asked what the nurse was trained to do, the answer was 'everything she does.' Vaccination competency, wound care, BLS — none documented.
ACTION	A training needs list was written for each role from their actual duties. Each staff member now has a training file: BLS (both), vaccination competency (nurse), wound care (nurse), red flag triage (receptionist), data protection (both), infection control (both), safeguarding (both). Training was obtained from the regional health authority and online providers. Each item has a completion date and a refresh date.
AFTER	The Monitor reviewed both training files: complete for current duties with refresh dates. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every task each staff member does.
2. For each task, what training exists? Write the gaps.
3. Obtain training for the top three gaps this quarter.
4. Keep a file per person with dates.

The most common mistake: Accepting 'she's always done it' as competency — experience without training is habit.

SELF-ASSESSMENT QUESTIONS

1. Does every staff member receive genuine, documented training specific to their actual role? — *Real, structured training with documentation, not informal on-the-job learning alone.*

Evidence: Staff training record

2. Is competency genuinely verified, not simply assumed from time spent in the role? — *Real, active verification, not an assumption that tenure alone confirms competency.*

Evidence: Competency verification record

3. Is training genuinely refreshed periodically, not completed once and never revisited? — *Real, ongoing training, not a single initial session treated as sufficient indefinitely.*

Evidence: Ongoing training schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **Training is documented for clinical tasks but less structured for administrative or support roles.** — Every role, including administrative ones, carries real responsibilities that benefit from genuine, structured training.
- **Initial training is thorough but ongoing refresher training is inconsistent.** — Skills and knowledge benefit from genuine, periodic reinforcement, not a single strong initial session alone.
- **Training happens but competency verification relies on informal observation rather than a genuine, structured check.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current staff training for genuine structure versus informal on-the-job learning.
Week 2	Build structured, documented training for every staff role, including administrative.
Week 3	Establish genuine competency verification, not assumed from tenure.
Ongoing	Refresh training periodically for all staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Training record review	Reviews documented, structured training for every staff member, however few.
DOCUMENT	Competency verification review	Reviews evidence that competency is genuinely verified, not assumed from tenure.
DOCUMENT	Ongoing training review	Reviews whether training is genuinely refreshed periodically.

SUPERVISOR TIPS

- **Ask to see the actual, documented training record for a specific staff member.** — A specific, real record reveals genuine structure, not informal learning assumed sufficient.
- **Ask an administrative or support staff member about their own specific training.** — This reveals whether structured training genuinely extends beyond clinical roles.

EVIDENCE BASE

[34] Structured training and competency verification, distinct from informal on-the-job learning alone, is established practice for genuine patient safety regardless of practice size, with quality improvement support models specifically developed to extend structured training support to small and solo practices.

ASF training courses on GMJ Academy →

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

7.5 Incident Reporting Leads to Genuine Learning, Not Just Documentation

NON-NEGOTIABLE

When something goes wrong or nearly goes wrong, the practice genuinely reviews what happened and why, with real, documented change resulting where warranted — not

an incident logged and filed without any real reflection or resulting action.

In plain terms: When something goes wrong or nearly goes wrong, the practice looks at why and changes something — the review is documented and the change is real.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A small practice has incidents like any other: the wrong vaccine, the missed result, the medication error, the near-miss at reception. What distinguishes a learning practice is what happens next. Not blame, not a note in a file — a short structured review: what happened, why, what will change, who will make it happen. Documented on one page. Then the change is made and checked. Three such reviews a year is a learning system. A practice that records incidents and does nothing has a filing cabinet.

WHAT GOOD LOOKS LIKE

- Real incidents receive genuine review of what happened and why.
- Review genuinely results in documented change where warranted.
- Near-misses receive the same genuine attention as actual incidents.

COMMON FAILURE MODES

- Incidents are logged without genuine reflection on cause.
- Review happens but doesn't translate into any real, resulting change.
- Near-misses are dismissed because no actual harm occurred.

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre that recorded incidents in a book.

BEFORE

The incident book had 12 entries in two years, each a description with no analysis and no action. The same medication error (wrong strength

	dispensed) appeared three times. Nobody had asked why.
ACTION	A one-page incident review template was introduced: what happened, contributing factors, root cause, action, owner, date, follow-up check. The recurring dispensing error was reviewed: two strengths of the same drug were stored side by side. They were separated and labelled. The error has not recurred. Reviews are discussed at the monthly practice meeting. Near-misses are actively encouraged.
AFTER	The Monitor reviewed six completed incident reviews with actions implemented and checked; the incident log showed near-misses now reported. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your last five incidents. Was anything changed as a result?
2. Create a one-page review template: what, why, change, who, when.
3. Review the next incident with it.
4. Check that the change was made.

The most common mistake: Recording incidents without reviewing them — the same error repeats because nobody asked why.

SELF-ASSESSMENT QUESTIONS

1. When something goes wrong or nearly does, is there genuine review of what happened and why? — *Real, active reflection, not an incident simply logged and filed.*

Evidence: Incident review record

2. Does this review result in genuine, documented change where warranted, not review without action? — *Real, resulting change, not reflection that doesn't translate into any actual adjustment.*

Evidence: Resulting change documentation

3. Are near-misses genuinely reviewed with the same seriousness as actual incidents, not dismissed because no harm occurred? —
Genuine attention to near-misses, not only events that actually resulted in harm.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Review happens for significant incidents but not consistently for smaller, less dramatic ones.** — Smaller incidents can still reveal genuine, real patterns worth understanding.
- **Review is thorough but resulting changes aren't consistently tracked to confirm they were actually implemented.** — An identified change that isn't tracked to genuine implementation may not actually happen.
- **Near-misses are occasionally reviewed but not as a genuine, consistent practice.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current incident handling for genuine reflection versus documentation alone.
Week 2	Establish a genuine review process covering both actual incidents and near-misses.
Week 3	Build tracking to confirm identified changes are genuinely implemented.
Ongoing	Review incident and near-miss patterns periodically for genuine learning.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Incident review record review	Reviews evidence of genuine reflection on what happened and why for real incidents.
DOCUMENT	Resulting change review	Reviews whether genuine, documented change resulted from incident review where warranted.
ASK	Near-miss attention interview	Asks the physician how near-misses are genuinely reviewed, not just actual incidents.

SUPERVISOR TIPS

- **Ask for a real, specific example of an incident review and what actually changed as a result.** — A real, traceable example reveals genuine learning, not documentation alone.
- **Ask about a recent near-miss and how it was genuinely reviewed.** — This reveals whether near-misses receive real attention, not only events that caused actual harm.

EVIDENCE BASE

[35] Genuine review and resulting practice change following an incident, distinct from documentation alone, is established as essential to meaningful quality improvement and patient safety learning in primary care, regardless of practice size or formal committee structure.

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

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

← **Primary Health Clinic
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 6 — Clinical
Environment & Safety**

**Standard 8 — Health &
Migration →**

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ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 8

Standard 8 — Health & Migration

10 criteria · 6 non-negotiable · 4 core · Version 3.0

CRITERIA IN THIS STANDARD

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

**8.2 — Supporting Patient
Agency Through Genuine
Understanding of Care and the
Health System**

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

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

**8.5 — A Comprehensive Initial
Health Assessment Screens for
the Documented Triple Burden**

**8.6 — Evidence-Informed Care
for Refugee and Migrant
Populations**

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

**8.8 — Continuity Across
Relocation Is Actively
Supported, Not Assumed
Impossible**

**8.9 — Legal Status Diversity
Recognition**

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

8.1 People-Centred Care Adapted to Migration and Displacement Experience

NON-NEGOTIABLE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

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

COMMON FAILURE MODES

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

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

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

WORKED EXAMPLE

IN PRACTICE

A 7-room health centre in a city with a large refugee population.

BEFORE

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

ACTION

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

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

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

Evidence: Training record on migration-adapted care

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

Evidence: N/A — tested directly

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

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Adaptation happens for patients who disclose their history but isn't proactively considered otherwise.** — Not every patient will volunteer this history unprompted, even when it is clinically relevant.
- **Staff are aware of the principle but haven't received specific training on applying it.** — General awareness doesn't reliably translate into genuine practice adaptation without specific training.
- **Adaptation is strong for the first visit but isn't sustained as the patient continues in ongoing primary care.**

IMPLEMENTATION PLAN

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

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Ask staff to describe a specific example of adapting care for a patient's migration history.** — A real, specific example reveals genuine practice, not familiarity with the principle.
- **Ask about continuity of care support specifically for patients without stable documentation.** — This is where genuine adaptation is most tested.

EVIDENCE BASE

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

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

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

8.2 Supporting Patient Agency Through Genuine Understanding of Care and the Health System

NON-NEGOTIABLE

Patients are supported to genuinely understand both their own care and how to navigate the wider health system —

with understanding actively verified through methods like teach-back, in plain language, not assumed from silence, a nod, or general goodwill information about the system.

In plain terms: Refugee and migrant patients are helped to understand not just their own care but how the health system works — and you check that they actually understood.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A patient who does not know that the health centre has an outpatient department, that a referral means an appointment somewhere else, that a prescription must be filled at a pharmacy, or that emergency care is free regardless of status — that patient cannot navigate the system. Migrants often come from health systems with entirely different structures and assumptions. Explaining the system is as important as explaining the diagnosis. And explanation is not enough: teach-back, in the patient's language, is the only way to know it landed. The consequence of failure is missed follow-up, untreated conditions, and emergency presentations that could have been prevented.

WHAT GOOD LOOKS LIKE

- Teach-back genuinely verifies understanding of both the care plan and wider system navigation.
- Concrete, translated navigation guidance is provided, covering the system beyond this one clinic.
- Plain language is used consistently, especially when working through an interpreter.

COMMON FAILURE MODES

- Understanding is assumed from a nod or silence, with no active verification.
- Patients understand their specific care but not how the wider health system actually functions.
- Medical jargon is used routinely, straining both interpretation and comprehension.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre serving newly arrived migrants from several countries.

BEFORE	Migrant patients were given standard discharge information. A high proportion did not attend follow-up. When interviewed by a liaison worker, patients said they did not understand what a 'referral' was, did not know where the outpatient clinic was, and assumed all care cost money they could not pay. Some had returned to the emergency department for routine issues.
ACTION	A one-page 'How this health centre works' guide was produced in the six most common languages: what each department does, how referrals work, what is free, who to ask. It is given at registration and explained by the liaison worker or interpreter. Discharge includes a teach-back on the next step: 'Where will you go for your follow-up, and when?' Answers are recorded.
AFTER	The Monitor reviewed 15 migrant patient records with documented teach-back; follow-up attendance had risen from 40% to 72%. Interviewed two patients who described the system correctly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five migrant patients what a 'referral' means and where the outpatient clinic is.
2. Write a one-page system guide in your most common languages.
3. Give it at registration and explain it.
4. Add teach-back on the next step at discharge.

The most common mistake: Explaining the diagnosis carefully and assuming the patient knows how to get the follow-up you have arranged.

SELF-ASSESSMENT QUESTIONS

1. Is understanding actively checked using teach-back, for both the care plan and how the system works? — *Asking the patient to explain back in their own words, not just "do you understand?"*

Evidence: N/A — tested directly

2. Is practical guidance given on navigating the wider system, including registering elsewhere if they relocate? — *Real navigation guidance beyond this one clinic, not general encouragement.*

Evidence: Navigation guidance material

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

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Teach-back is used for major treatment decisions but not extended to system-navigation information.** — Understanding how to actually use the system matters as much as understanding the immediate care plan, especially for a first-contact patient.
- **System literacy support is given verbally but not reinforced with anything the patient can review later.** — Complex system information delivered once, verbally, under stress is easily forgotten.
- **Staff assume system literacy for patients registered for a while, missing gaps that may still exist.**

IMPLEMENTATION PLAN

When	What
Week 1	Observe current practice for both understanding-verification and system-navigation support.
Week 2	Train staff on teach-back technique and develop translated navigation guidance.
Week 3	Brief staff to proactively cover system literacy alongside the immediate clinical matter.
Ongoing	Spot-check patient understanding of both care and system navigation periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Teach-back practice observation	Observes a consultation, or a simulated scenario, to check whether teach-back genuinely verifies understanding of both care and system navigation.
DOCUMENT	Navigation material review	Reviews any materials or guidance provided on navigating the wider health system, in relevant languages.
ASK	Patient understanding check	Asks a recent refugee or migrant patient to explain back their care plan and how they would access care again, including elsewhere if needed.

SUPERVISOR TIPS

- **Observe an actual consultation if possible, watching specifically for teach-back covering both care and navigation.**
— This is a practice that is easy to describe in policy and easy to skip under time pressure.
- **Ask a patient directly what they understand about accessing care again, including if they relocate.** — This tests actual system literacy, not just satisfaction with the immediate visit.

EVIDENCE BASE

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

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

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

8.3 Language and Communication Aids — Interpreters and Cultural Mediators

NON-NEGOTIABLE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- Trained interpreters or cultural mediators are the default for language-discordant consultations.
- Staff confirm, without hesitation, that minors are never used to interpret.
- Family-member interpretation, when it happens, is reserved for genuinely low-risk situations only.

COMMON FAILURE MODES

- Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged.
- A minor has been used to interpret, even occasionally.
- Family members interpret for high-risk situations like informed consent or bad news.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre serving a refugee settlement of 30,000 people.

BEFORE

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

ACTION

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

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask how the last ten refugee consultations were interpreted.
Count how many used a child or a family member.
2. Write the rule today: no children; family only as a last resort and never for sensitive topics.
3. Recruit mediators from the main language groups — NGOs can help.
4. Contract a phone service for other languages.

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

the information is distorted.

SELF-ASSESSMENT QUESTIONS

1. Are trained interpreters or cultural mediators engaged for language-discordant consultations? — *Not ad hoc bilingual staff or family members as the default.*

Evidence: Interpreter engagement record

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

Evidence: N/A — tested directly

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

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Trained interpreters are used for major appointments but family members fill in for quick or informal interactions.** — Risk doesn't scale down proportionally with how brief or informal an interaction feels.
- **The no-minors rule is understood by the physician but not consistently reinforced with the limited support staff available.** — A critical safeguard needs to be embedded across the whole small team, not held only by the physician.
- **Interpreter access exists during clinic hours but reverts to family members for same-day or urgent visits.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent language-discordant consultations for interpreter engagement patterns.
Week 2	Establish reliable access to professional interpretation, including remote or telephone options where in-person isn't feasible.
Week 3	Brief all staff, however few, on the firm exclusion of children as interpreters, without exception.

When	What
Ongoing	Audit interpreter use records for consistency.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Ask staff directly whether a child has ever interpreted for a parent here.** — A direct question often surfaces what a general policy question won't.
- **Observe an actual encounter with a limited-proficiency patient if timing allows.** — Direct observation reveals whether professional interpretation is genuine practice, not just stated policy.

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

8.4 Collaborative Practice Across Health and Social Services

CORE

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

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

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

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- The practice actively, genuinely engages with relevant social support services.
- Handover to other providers specifically includes migration-related context.

COMMON FAILURE MODES

- Health care is treated in isolation from social support factors.
- Handover is generic, omitting migration-related context.
- Staff have no specific knowledge of relevant local services.

- Staff can name specific, current local services relevant to this population.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre in a region hosting refugees with no established links to social services.

BEFORE

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

ACTION

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

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the non-medical problems you see in refugee patients: housing, legal, food, education.
2. Find the organisations in your area that address each. Meet them.
3. Create a one-page directory for clinicians.
4. Track referrals and meet the organisations quarterly.

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

SELF-ASSESSMENT QUESTIONS

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

COMMON REASONS FOR A PARTIAL ANSWER

- **Engagement happens with legal services but not consistently with housing or employment support.** — Each of these factors can independently and significantly affect a patient's health.
- **Referral to specialist care includes clinical information but omits migration-related context that shaped the initial presentation.** — The receiving provider benefits from the same contextual understanding this practice relied on.
- **Staff know general categories of support exist but not specific, current local contacts.**

IMPLEMENTATION PLAN

When	What
Week 1	Map current engagement with relevant social support services.
Week 2	Establish or strengthen specific, current local service contacts.
Week 3	Build migration-related context into standard referral and handover documentation.
Ongoing	Refresh knowledge of local services periodically as availability changes.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

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

EVIDENCE BASE

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

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

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

8.5 A Comprehensive Initial Health Assessment Screens for the Documented Triple Burden

NON-NEGOTIABLE

Every newly registered refugee or migrant patient receives a comprehensive initial health assessment screening for the documented triple burden — infectious disease, non-communicable disease, and mental health — not a narrow,

single-issue check that misses the other two dimensions of this well-established pattern.

In plain terms: Every newly registered refugee or migrant patient gets a comprehensive first assessment that screens for the documented 'triple burden' — infectious disease, chronic conditions, and mental health — not just the presenting complaint.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Refugees and migrants arrive with three overlapping burdens: infectious diseases from their region of origin or transit (TB, hepatitis B and C, HIV, parasites); untreated chronic conditions (hypertension, diabetes, dental disease) from interrupted care; and mental health consequences of trauma, loss, and displacement (PTSD, depression, anxiety). A first assessment that addresses only the presenting complaint misses all three. A structured initial health assessment — following national or WHO refugee health guidance — screens systematically, so that the TB is found before it spreads, the hypertension before the stroke, and the PTSD before the crisis.

WHAT GOOD LOOKS LIKE

- Every newly registered patient receives a genuinely comprehensive initial assessment.
- The assessment covers all three triple-burden dimensions, not a narrow subset.
- Catch-up vaccination status is actively reviewed as part of the assessment.

COMMON FAILURE MODES

- Initial assessment is narrow, addressing only the immediate presenting concern.
- Only one or two triple-burden dimensions are covered, missing the others.
- Vaccination status is assumed current without active review.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre registering 40 refugee families a month.

BEFORE	New refugee patients were registered and seen when they presented with a problem. No initial assessment. Two cases of active TB were diagnosed late after repeated presentations for cough. Diabetes was found incidentally in several patients. Mental health was never screened.
ACTION	A refugee initial health assessment was adopted from national guidance: a 45-minute nurse-led appointment within four weeks of registration covering infectious disease screening by region of origin (TB, hepatitis, HIV with consent, parasites), chronic disease screening (BP, glucose, BMI, dental), mental health screening (PHQ-9, PTSD screen), vaccination status, and social needs. Results feed the problem list and trigger referrals. An interpreter is booked.
AFTER	The Monitor reviewed 30 completed initial assessments with findings and referrals: 4 latent TB, 6 hepatitis B, 8 diabetes/pre-diabetes, 11 mental health referrals. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find your national refugee initial health assessment guidance (or WHO's).
2. Create a nurse-led assessment appointment for every new refugee registration.
3. Book an interpreter for every one.
4. Feed findings into the problem list and referral log.

The most common mistake: Treating refugee patients as ordinary new registrations — the triple burden is invisible without systematic screening.

SELF-ASSESSMENT QUESTIONS

1. Does every newly registered refugee or migrant patient receive a comprehensive initial health assessment? — *A real, comprehensive assessment, not a narrow check limited to one presenting concern.*

Evidence: Initial health assessment record

2. Does this assessment genuinely cover all three dimensions of the triple burden — infectious disease, non-communicable disease, and mental health? — *Genuine coverage of all three, not one or two dimensions while the others go unaddressed.*

Evidence: N/A — tested directly

3. Does the assessment include catch-up vaccination review, not assumed current without checking? — *Real, active vaccination status review, not assumed adequacy.*

Evidence: Catch-up vaccination review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Infectious disease and vaccination screening are thorough but mental health screening is less consistently included.** — Mental health is a genuine, documented part of the triple burden, not a secondary consideration.
- **The assessment is comprehensive when time allows but abbreviated during busy periods.** — A newly arrived patient's genuine need for this assessment doesn't diminish because the clinic is busy that day.
- **Screening happens but isn't specifically adapted to the patient's actual country of origin and risk profile.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current initial assessment practice for genuine coverage of all three triple-burden dimensions.
Week 2	Build a structured, comprehensive initial assessment protocol including vaccination review.
Week 3	Train staff on country-of-origin-appropriate risk screening.
Ongoing	Audit initial assessment completeness for newly registered patients.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Initial assessment completeness review	Reviews initial health assessments for genuine coverage of all three triple-burden dimensions.

Method	What	Detail
DOCUMENT	Vaccination review check	Reviews whether catch-up vaccination status is actively assessed as part of initial screening.
ASK	Assessment practice interview	Asks staff how the initial assessment for a newly registered refugee or migrant patient genuinely covers all three dimensions.

SUPERVISOR TIPS

- **Ask to see a specific, real initial assessment and check for genuine coverage of all three dimensions.** — A real, specific example reveals whether this is genuine practice, not policy language.
- **Ask how the assessment is adapted for a patient's specific country of origin.** — A specific, informed answer reveals genuine, risk-appropriate practice, not a generic checklist.

EVIDENCE BASE

[40] Refugees are consistently described as facing a documented "triple burden" of infectious disease, non-communicable disease, and mental health issues, with integrated multi-disease screening at first primary care contact shown to achieve better uptake and feasibility than single-disease screening approaches, despite most health systems still lacking systematic implementation.

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

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

8.6 Evidence-Informed Care for Refugee and Migrant Populations

CORE

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain — not

applying general primary care guidelines uncritically to a population with documented, different health needs.

In plain terms: Staff use clinical guidelines specific to refugee and migrant health where they exist, know where evidence is thin, and adapt sensibly.

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

WHY THIS MATTERS

Refugee health has specific evidence: screening for TB, hepatitis B, and parasites by region of origin; vaccination catch-up schedules; recognition of conditions rare in the host country; management of trauma-related mental illness. Applying host-country guidelines without adaptation means missing conditions the host population does not have and over-testing for ones the refugee population does not. Where evidence exists — WHO, UNHCR, national refugee health guidelines — staff should use it. Where it does not, they should know that, and adapt with judgment rather than guess.

WHAT GOOD LOOKS LIKE

- Staff are aware of and use population-specific evidence-informed guidelines where they exist.
- Staff can describe specific, genuine differences in this population's health needs.
- Practice is genuinely adapted where population-specific evidence indicates it should be.

COMMON FAILURE MODES

- General population guidelines are applied uncritically with no population-specific awareness.
- Staff cannot describe any specific way this population's needs differ.
- Awareness exists but doesn't translate into any actual practice adaptation.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre that had started receiving refugees from a

region with high hepatitis B and TB prevalence.

BEFORE	Refugee patients were assessed using standard domestic protocols. Hepatitis B screening was not routine. Two cases of active TB were diagnosed late after multiple presentations. Clinicians were unaware of the WHO and national refugee health screening recommendations.
ACTION	The Coordinator obtained the national refugee health guideline and the WHO recommendations for the relevant region. A refugee health screening protocol was written: TB screening, hepatitis B and C, HIV with consent, parasitic infection screening, vaccination status, mental health screen. Clinicians received a one-hour briefing. The guideline was reviewed annually with an infectious diseases specialist.
AFTER	The Monitor reviewed the protocol with its sources, training records, and 20 refugee patient records showing protocol-based screening. Two hepatitis B cases identified and treated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find your national refugee health guideline, or the WHO/UNHCR one for your region.
2. Compare it to what you currently do for refugee patients.
3. Write a screening protocol based on the guideline.
4. Brief clinicians and review annually.

The most common mistake: Applying the domestic screening protocol to refugee patients from regions with a completely different disease burden.

SELF-ASSESSMENT QUESTIONS

1. Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist? — *Specific, current awareness, not general clinical knowledge assumed to be sufficient.*
Evidence: Guideline awareness record

2. Do staff recognise where this population's health needs genuinely differ from the general population? — *Genuine, specific recognition, not an assumption that general guidelines always apply equally.*

Evidence: N/A — tested directly

3. Is practice adapted where population-specific evidence indicates a different approach is warranted? — *Actual practice adaptation, not awareness without application.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

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

IMPLEMENTATION PLAN

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

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Guideline awareness review	Reviews whether staff have access to and awareness of population-specific evidence-informed guidelines.

Method	What	Detail
ASK	Population-difference interview	Asks staff to describe a specific way this population's health needs differ from the general population.
OBSERVE	Practice adaptation check	Checks whether practice genuinely reflects population-specific evidence where it exists.

SUPERVISOR TIPS

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

EVIDENCE BASE

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

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

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

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

NON-NEGOTIABLE

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

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

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

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- A structured reflective practice process genuinely exists and is used, not just assumed.
- Genuine, accessible psychological support exists and staff actually use it.
- Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.

COMMON FAILURE MODES

- No structured reflective practice process exists beyond an assumption of individual self-awareness.
- Psychological support exists only nominally, with no evidence staff actually access it.
- Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre where a third of patients are refugees.

BEFORE	No reflective practice existed. Staff complained about refugee patients in the break room; some described them as 'demanding.' A nurse who had heard multiple accounts of sexual violence had started avoiding female refugee patients. There was no supervision or support for staff exposed to trauma narratives.
ACTION	Monthly facilitated reflective practice sessions were introduced for clinical teams, led by a psychologist from a partner NGO, using real (anonymised) cases. An implicit bias workshop was run once for all staff. A peer support scheme was set up. Confidential counselling access was arranged through the NGO. Attendance was tracked.
AFTER	The Monitor reviewed session records (10 sessions, average 70% attendance), workshop records, and the counselling access agreement. Interviewed three staff who described the sessions as valuable and gave examples of changed practice. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

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

2. Does the practice provide genuine, accessible psychological support and a real space to discuss difficult cases? — *Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.*

Evidence: Psychological support access record

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

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Reflective practice happens informally but is not structured into any genuine, regular process.** — Individual good practice does not reliably generalise without a defined, shared process, even at small scale.
- **Support exists but is genuinely difficult to access given the demands of a very small practice.** — A benefit's existence does not guarantee genuine, comfortable access to it, particularly for a solo practitioner.
- **Support exists for acute incidents but not for the cumulative emotional weight of this work over time.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current training content and support access for genuine coverage of bias and staff wellbeing.
Week 2	Establish a structured reflective practice process feasible for the practice's actual size.
Week 3	Identify genuine, accessible psychological support options appropriate to solo or small practice.
Ongoing	Revisit reflective practice and wellbeing periodically, using real case examples where appropriate.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

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

EVIDENCE BASE

[42] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

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

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

8.8 Continuity Across Relocation Is Actively Supported, Not Assumed Impossible

CORE

When a refugee or migrant patient relocates, the practice actively supports genuine continuity of their care — a portable, patient-held summary, active handover where a

new provider is known — not treating relocation as an automatic, unavoidable end to any continuity at all.

In plain terms: When a refugee patient moves on, the practice helps them keep their care going — a portable record, a summary for the next clinician, a phone follow-up — rather than assuming it is impossible.

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

WHY THIS MATTERS

Refugees move: to another city, another region, another country. The practice that says 'we can't do anything once they leave' abandons the patient mid-treatment — the TB course half-done, the diabetes newly diagnosed, the mental health referral pending. Continuity support means: a portable health summary in the patient's hand (see hospital 9.8); a summary sent to the next practice if known; a phone number the patient can call from anywhere; and for high-priority conditions, a follow-up call. It cannot guarantee continuity, but it makes it possible.

WHAT GOOD LOOKS LIKE

- The practice actively supports continuity when a patient relocates.
- A genuine, portable, patient-held summary is provided.
- Active handover is genuinely attempted when a new provider becomes known.

COMMON FAILURE MODES

- Relocation is treated as an automatic, unavoidable end to continuity.
- No patient-held summary is provided; information stays only in this practice's records.
- No handover is attempted, even when a new provider is known.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre serving refugees who frequently relocate.

BEFORE

When patients moved, their records stayed. No summary was given. A patient on TB treatment relocated with no documentation; the next

	practice restarted from scratch and resistance developed. The practice considered relocation 'outside our control.'
ACTION	A relocation protocol was written: any patient indicating they may move receives a portable summary (diagnoses, medications, pending results, vaccinations, the practice's contact) in the local language and English; if the destination practice is known, a summary is sent with consent; the practice phone number is on the summary; for TB, pregnancy, or serious mental illness, a follow-up call is scheduled at two weeks. Community organisations are asked to help maintain contact.
AFTER	The Monitor reviewed 15 relocation records with summaries issued and, in 8, transfers to the destination practice. Two TB patients successfully continued treatment. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask what you gave the last refugee patient who moved away. If nothing, that is the gap.
2. Create a portable summary template.
3. Give it to any patient who may relocate.
4. Phone high-priority patients two weeks after they leave.

The most common mistake: Treating relocation as the end of responsibility — the patient's care is still the practice's until it is handed on.

SELF-ASSESSMENT QUESTIONS

1. Does the practice actively support continuity when a patient relocates, not treat relocation as an automatic end to continuity? — *Real, active support, not passive acceptance that continuity simply ends. Evidence: Relocation continuity support process*
2. Is a portable, patient-held summary genuinely provided, giving the patient something to carry forward? — *A real, usable summary the patient actually holds, not information that stays only in this practice's*

own records.

Evidence: Patient-held summary documentation

3. Where a new provider is known, is active handover genuinely attempted, not assumed impossible? — A real, attempted handover, not an assumption that contact with a future provider isn't achievable.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A summary is provided but isn't updated close to the point of relocation, so it quickly becomes outdated.** — A summary's real value depends on reflecting the patient's genuinely current status at the time they carry it forward.
- **Handover is attempted when the new provider is known well in advance but not for sudden, unplanned relocations.** — Sudden relocation doesn't reduce a patient's genuine need for continuity support.
- **Support exists in principle but staff aren't confident in how to actually provide a portable summary in practice.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine continuity support versus assumed end at relocation.
Week 2	Establish a standard, portable patient-held summary format.
Week 3	Train staff on attempting genuine handover when a new provider becomes known.
Ongoing	Confirm summaries are updated close to the actual point of relocation.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Relocation support process review	Reviews the practice's actual process for supporting continuity when a patient relocates.
DOCUMENT	Patient-held summary review	Reviews whether patients genuinely receive a portable, usable summary of their care.

Method	What	Detail
ASK	Handover attempt interview	Asks staff whether they've genuinely attempted handover to a new provider when one becomes known.

SUPERVISOR TIPS

- **Ask for a real, recent example of continuity support provided to a relocating patient.** — A real example reveals whether this is genuine practice, not an assumed impossibility.
- **Ask to see an actual patient-held summary and check how current it genuinely is.** — A specific, current document is the real evidence of genuine support, not a stale or theoretical one.

EVIDENCE BASE

[43] Continuity of care as genuine infrastructure, distinct from an assumption that relocation automatically ends the possibility of continuity, is established practice for protecting health outcomes in mobile and displaced populations specifically.

ASF training courses on GMJ Academy →

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

8.9 Legal Status Diversity Recognition

CORE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

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

COMMON FAILURE MODES

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

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre in a country with five legal categories for displaced people and different entitlements for each.

BEFORE

Registration staff did not know the categories. Patients were sometimes turned away because 'refugees are not covered' when in fact they were. Others were treated and the health centre could not claim reimbursement because the correct category was not recorded. The health centre

	had no written position on treating people outside any entitlement.
ACTION	The Coordinator obtained the legal entitlements for each category from the Ministry and UNHCR. A one-page reference was created for registration staff. A health centre policy stated: emergency care for everyone regardless of status; other care per entitlement; and a defined charity fund for those with no entitlement. Registration records the category (with the patient's consent) for reimbursement purposes only — it does not affect clinical care.
AFTER	The Monitor reviewed the entitlement reference, the policy, and 20 registration records with category correctly recorded. Interviewed two registration staff who correctly described entitlements for three categories. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

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

Evidence: N/A — tested directly

2. Does the practice avoid applying a single, uniform assumption about access rights across all statuses? — *Genuine differentiation,*

not treating all categories identically.

Evidence: Status-specific access policy documentation

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

Evidence: Status verification process

COMMON REASONS FOR A PARTIAL ANSWER

- **Staff can name the most common category served but not less frequent ones the practice still encounters.** — Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.
- **Differentiation exists in the physician's own understanding but isn't shared with the wider practice team.** — Every staff member interacting with patients benefits from the same genuine understanding.
- **A verification process exists but staff are inconsistently confident applying it.**

IMPLEMENTATION PLAN

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

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Status category awareness interview	Asks staff to name the specific legal status categories this practice actually serves.
DOCUMENT	Status-specific policy review	Reviews documentation for genuine differentiation across status categories, not a uniform assumption.

Method	What	Detail
DOCUMENT	Verification process review	Reviews the process for verifying status when it's genuinely unclear.

SUPERVISOR TIPS

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

EVIDENCE BASE

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

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

NON-NEGOTIABLE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

This is the PHC equivalent of ambulatory 25.8 and the same principle applies with equal force. An undocumented patient treated without a record is a patient without continuity, evidence, or protection. Care differentiated by status is discrimination. The practice policy must be explicit: identical clinical care, consent, documentation, and follow-up for everyone; immigration status not asked at registration; funding handled separately and never as a barrier. Staff must know this and act on it.

WHAT GOOD LOOKS LIKE

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

COMMON FAILURE MODES

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

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre in an area with many undocumented migrants.

BEFORE

Some undocumented patients were treated 'informally' without records. Reception sometimes asked for documents. A pregnant undocumented woman was turned away and delivered at home without antenatal care.

ACTION

A written policy: same care, same record, status not asked. Registration requires name, date of birth, and a contact — nothing else. Every patient gets a record. Funding questions are handled by the practice manager after care, with a charity

fund for those with no entitlement. Staff were briefed. A partnership with a migrant support organisation was established.

AFTER

The Monitor reviewed the policy, observed registration, reviewed 20 records of migrant patients with full documentation, and interviewed a receptionist who described the approach. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask reception what they do when a patient has no documents.
2. Write the one-sentence policy and post it.
3. Remove document questions from registration.
4. Handle funding after care, never before.

The most common mistake: Protecting undocumented patients by not recording their care — an unrecorded patient is unprotected.

SELF-ASSESSMENT QUESTIONS

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

Evidence: N/A — tested directly

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

Evidence: Staff training record

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

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The principle is understood by the physician but not consistently by administrative or reception staff.** — A patient's

first interaction is often with administrative staff, where the same principle needs to hold.

- **Care is consistent but documentation habits vary informally based on individual staff assumptions.** — Consistency needs to extend to documentation practice specifically, not only the clinical care itself.
- **The principle is followed but has never been specifically, formally trained.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for any differential treatment based on status.
Week 2	Establish specific staff training on this principle, covering all staff, not only clinical roles.
Week 3	Confirm documentation practice is genuinely consistent regardless of status.
Ongoing	Reinforce training periodically, particularly for new staff.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

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

EVIDENCE BASE

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

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← **Primary Health Clinic
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**Self-assess against these
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← **Standard 7 — Governance
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