

Primary Health Clinic Standards

The complete ASF accreditation standard for primary health clinic facilities. Every criterion is published in full — statement, classification, and the verification questions used by Monitors and supervisors. Free. No account required.

8 standards · 45 criteria · 33 non-negotiable · 12 core · 0 standard · Version 3.0



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How to read this page: Each standard groups related criteria. Each criterion has a classification — **Non-Negotiable** (all must be met; any single failure bars accreditation), **Core** ($\geq 85\%$ for accreditation, $\geq 70\%$ for certification), or **Standard** ($\geq 70\%$ for accreditation). The verification questions show what a Monitor checks. To test your facility against these criteria, use the free self-assessment tool.

STANDARD 1 · MANDATORY

Patient Registration & Continuity of Care

1.1 Every Patient Is Empaneled to a Specific, Named Clinician

Non-Negotiable

Every registered patient is formally empaneled — assigned to a specific, named clinician or care team responsible for their ongoing care — not simply added to a general patient list with no defined, accountable relationship.

1. Is every registered patient formally empaneled to a specific, named clinician or care team? — A real, specific assignment, not a general patient list with no defined accountability.
2. Is empanelment genuinely sensitive to patient and family preference, not assigned arbitrarily? — Genuine consideration of preference, not a mechanical assignment process alone.
3. Can a patient or staff member identify exactly who this patient's primary clinician is, without ambiguity? — A clear, unambiguous answer, not uncertainty about who is actually responsible.

1.2 A Patient's Own Medical History Is Actually Known and Used, Not Treated as a New Encounter Each Visit

Non-Negotiable

A patient's relevant medical history, prior visits, and ongoing issues are genuinely reviewed and actively used at each visit — not treated as a fresh encounter each time, with the clinician relying only on what the patient happens to mention that day.

1. Is a patient's relevant history genuinely reviewed before or during each visit, not relied on solely from what they mention that day? — Real, active review of the actual record, not passive reliance on patient recall alone.
2. Are ongoing issues from prior visits actively followed up, not lost between encounters? — Genuine, tracked follow-through, not issues that quietly drop between visits.
3. Can the clinician describe specific, relevant history for a patient without the patient having to repeat it? — Genuine, demonstrated knowledge, not dependence on the patient re-explaining their own history each time.

1.3 Continuity Is Actively Measured, Not Assumed

Core

The practice actively measures its own continuity of care — the proportion of a patient's visits that are genuinely with their own empaneled clinician or team — not assuming continuity is adequate without ever actually checking.

1. Does the practice actively calculate a real continuity measure, not assume continuity is adequate? — A genuine, calculated measure, not an unverified assumption.
2. Is this measure reviewed regularly, not calculated once and forgotten? — Genuine, ongoing review, not a one-time calculation.
3. When continuity is found to be low for a specific patient or pattern, is there a genuine response? — Real, active response to a low result, not a measure tracked without consequence.

1.4 Registration Captures What Actually Matters for Ongoing Care

Core

Patient registration captures genuinely relevant information for ongoing primary care — chronic conditions, family history, social context affecting health — not only administrative and billing information, treated as sufficient on its own.

1. Does registration genuinely capture chronic conditions, family history, and relevant social context, not only administrative details? — Real, clinically relevant information, not billing and contact details alone.
2. Is this information actively used to inform the patient's early care, not collected and left unused? — Genuine, early use of registration information, not documentation without follow-through.
3. Is registration information genuinely updated over time, not treated as fixed from the first visit? — Real, ongoing updates, not information that grows stale as the patient's circumstances change.

1.5 A Patient Can Reach Their Own Clinician or Care Team, Not Just Whoever Is Available

Non-Negotiable

A patient has a genuine, defined way to reach their own empaneled clinician or care team for an ongoing issue — not only the option of whoever happens to be available that day, with no real path back to the clinician who actually knows their history.

1. Does a patient have a genuine, defined way to reach their own empaneled clinician or team? — A real, specific pathway, not default routing to whoever is available.
2. Is this pathway genuinely known to patients, not just theoretically available? — Real, communicated awareness, not an option patients don't know exists.
3. When the patient's own clinician genuinely isn't available, is there a defined handoff that preserves relevant history? — A real, structured handoff, not a complete loss of continuity when the usual clinician is out.

STANDARD 2 • MANDATORY

Preventive Care & Screening

2.1 Preventive Care Is Systematically Tracked, Not Relied on From Memory

Non-Negotiable

The practice uses a systematic tracking process to identify which evidence-graded preventive services each patient is due for, based on age, sex, and risk factors — not relying on a clinician remembering to consider this during a visit already focused on the patient's presenting concern.

1. Does the practice use a systematic process to identify which preventive services each patient is due for? — A real, structured tracking system, not reliance on the clinician remembering during a busy visit.
2. Does this tracking genuinely account for the patient's actual age, sex, and risk factors, not a generic checklist? — Individualized, accurate tracking, not a one-size-fits-all list.
3. Is the tracking system actively used at or before each visit, not maintained separately from actual care? — Genuine, integrated use, not a system that exists without informing real encounters.

2.2 Preventive Care Delivery Doesn't Depend on the Patient Remembering to Ask

Non-Negotiable

The practice proactively offers grade A and B preventive services when a patient is due — flagged, discussed, and offered as a matter of standard practice — not delivered only when a patient happens to specifically ask about a particular screening or vaccination.

1. Are grade A and B preventive services proactively offered when a patient is due, not only when specifically requested? — Genuine, proactive offering, not passive availability dependent on patient initiative.
2. Does proactive offering happen consistently regardless of the patient's apparent health literacy or assertiveness? — Equal, consistent proactive practice, not dependent on how informed or confident a specific patient seems.
3. Is there real evidence that proactive offering actually results in higher completion, not just occurs without measurable effect? — Genuine, measurable impact, not an assumption that offering alone is sufficient.

2.3 Screening Completion Rates Are Actively Measured and Acted On

Core

The practice actively measures its own completion rates for key preventive screenings across its patient panel, with a genuine response when rates fall short — not a general sense that screening happens without ever actually checking the real numbers.

1. Does the practice actively measure its own completion rates for key preventive screenings across its panel? — Real, calculated completion data, not a general assumption of adequacy.
2. Is there a genuine response when completion rates for a specific screening fall short? — Real, active improvement effort, not a rate tracked without consequence.
3. Is completion measured for the full eligible panel, not just patients who happen to attend preventive-focused visits? — Genuine, full-panel measurement, not a skewed sample of already-engaged patients.

2.4 Shared Decision-Making Happens for Screening With Genuine Tradeoffs

Non-Negotiable

For preventive services carrying genuine, documented tradeoffs between benefit and harm — such as lung cancer screening — the practice conducts real shared decision-making with the patient, not presenting the service as an automatic, default recommendation identical to lower-tradeoff screenings.

1. Does the practice conduct genuine shared decision-making for screenings with real, documented tradeoffs? — A real, substantive conversation, not the service presented as an automatic default.
2. Does this conversation genuinely convey both potential benefits and potential harms, not benefits alone? — Balanced, honest information, not a one-sided presentation favoring screening.
3. Can a patient who underwent such screening explain back the genuine tradeoffs they were told about? — Tests genuine understanding, not just that a conversation technically occurred.

2.5 Immunization Status Is Actively Tracked and Gaps Are Closed

Non-Negotiable

Every patient's immunization status is actively tracked against the current recommended schedule, with any identified gap actively addressed — not assumed current because no concern was raised, or left to the patient to remember and request.

1. Is immunization status actively tracked against the current recommended schedule for every patient? — Real, active tracking, not an assumption of currency without verification.

2. Is an identified gap actively addressed, not just noted and left for the patient to raise? — Genuine, active follow-through, not passive documentation of a known gap.
3. Is tracking checked at any visit, not only during a visit specifically scheduled for immunization? — An active check at any opportunity, not limited to a narrow visit type.

STANDARD 3 · MANDATORY

Chronic Disease Management

3.1 Chronic Conditions Are Tracked in a Registry, Not Managed Only at the Point of Visit

Non-Negotiable

Every patient with a chronic condition — diabetes, hypertension, and other ongoing conditions — is entered into an active disease registry that tracks their status between visits, not managed only reactively during whatever visit happens to occur.

1. Is every patient with a chronic condition entered into an active registry tracking their status? — A real, maintained registry, not management limited to whatever happens to come up during a visit.
2. Does the registry track status between visits, not only reflect data from the most recent encounter? — Genuine, ongoing tracking, not a static snapshot from the last visit alone.
3. Is the registry actively used to inform care, not maintained as a record separate from actual practice? — Real, integrated use, not documentation disconnected from real clinical decisions.

3.2 Control Targets Are Specific and Actively Measured, Not Assumed From General Improvement

Non-Negotiable

Chronic disease control is measured against specific, evidence-based targets — HbA1c below 7.0 percent for diabetes, blood pressure below 130/80 mmHg for hypertension — with the actual result documented, not a general sense that a patient seems to be doing better without a specific, measured number.

1. Is chronic disease control measured against specific, evidence-based numeric targets, not general impression? — A specific, documented number against a defined target, not a general sense of improvement.
2. Is the actual result documented for each patient, not assumed from overall trend? — A real, specific documented result, not an inference from general direction of change.
3. Is the practice's own aggregate control rate calculated, not just individual results recorded without a genuine summary view? — A real, calculated practice-level rate, not only scattered individual data points.

3.3 Patients Overdue for Chronic Disease Follow-Up Are Proactively Identified and Contacted

Non-Negotiable

The practice proactively identifies patients with a chronic condition who are overdue for testing or follow-up — particularly those with poor control — and actively reaches out to them, not waiting passively for the patient to schedule their own next visit.

1. Does the practice proactively identify patients with a chronic condition who are overdue for testing or follow-up? — Real, active identification, not passive awareness that some patients may be overdue.
2. Is there a specific, active outreach process for these patients, not just identification without follow-through? — Genuine outreach, not identification that doesn't lead to real contact.
3. Are patients with poor control specifically prioritized in this outreach, not treated the same as those with good control? — Genuine prioritization of the highest-risk patients, not undifferentiated outreach.

3.4 Team-Based Care Coordinates Chronic Disease Management

Core

Chronic disease management genuinely involves the full care team — nurses, pharmacists, or other appropriate team members, not the physician alone — with real, coordinated roles, not the physician bearing the entire ongoing management burden without support.

1. Does chronic disease management genuinely involve the full care team, not the physician alone? — Real, coordinated team involvement, not physician-only management.
2. Do team members have specific, defined roles in chronic disease management, not undefined or overlapping responsibility? — Clear, specific role definition, not ambiguous shared responsibility that no one actually owns.
3. Is there real evidence that team-based involvement is genuinely improving control rates, not just present without measurable effect? — Genuine, measurable impact, not team involvement without demonstrated benefit.

3.5 Medication Adjustment Follows a Defined Process When Targets Aren't Met

Non-Negotiable

When a patient's chronic disease control falls short of the defined target, medication or treatment adjustment follows a specific, defined process within a reasonable timeframe — not left unchanged indefinitely simply because the patient hasn't raised a concern.

1. Does treatment adjustment follow a specific, defined process when a patient's control falls short of target? — A real, defined process, not indefinite continuation of unchanged treatment.
2. Does adjustment happen within a reasonable, defined timeframe, not delayed indefinitely? — A specific, genuine timeframe, not an open-ended delay.
3. Is there defined follow-up after a treatment adjustment to confirm it's actually working? — Real, scheduled follow-up, not an adjustment made without checking whether it succeeded.

STANDARD 4 · MANDATORY

Acute & Same-Day Care

4.1 Red Flag Symptoms Are Actively Screened at Intake, Not Only by the Clinician Later

Non-Negotiable

Staff performing patient intake and registration — not only the treating clinician — are trained to recognise defined red flag symptoms and immediately escalate, with a specific process for taking the patient back for urgent assessment right away, not left waiting in a normal queue.

1. Are staff performing intake and registration specifically trained to recognise defined red flag symptoms? — Genuine, specific training for intake staff, not a responsibility left only to the clinician.
2. Is there a specific, immediate escalation process when a red flag is recognised at intake? — A real, immediate process, not a patient left in the normal queue despite a recognised red flag.
3. Is there a specific, ready space for a patient identified with a potential emergency at intake? — A real, dedicated, ready space, not an improvised response when a red flag is identified.

4.2 Same-Day Access Is Genuinely Available, Not Assumed Adequate Without Measurement

Non-Negotiable

The practice actively measures whether patients requesting a genuine same-day need can actually be seen that day, with a specific, tracked target — not an assumption that same-day access is adequate without ever checking real appointment availability against real demand.

1. Does the practice actively measure whether genuine same-day requests are actually accommodated that day? — Real, calculated measurement, not an assumption of adequacy.
2. Is there a specific, defined target for same-day access, not a vague sense that most patients get seen? — A specific, tracked target, not an undefined general impression.

3. When same-day access falls short of target, is there a genuine response, not a measure tracked without consequence? — Real, active response to a shortfall, not passive tracking alone.

4.3 Telephone or Remote Triage Follows a Structured, Validated Protocol

Non-Negotiable

Telephone or remote triage of patients requesting same-day care follows a structured, validated protocol — not the individual judgement of whoever happens to answer the phone, applied inconsistently from one call to the next.

1. Does telephone or remote triage follow a structured, validated protocol, not individual judgement alone? — A real, structured protocol, not inconsistent practice dependent on who answers the call.
2. Is the protocol consistently used across different staff members conducting triage? — Genuine, consistent application, not a protocol used by some staff but not others.
3. Does the protocol specifically prompt for red flag symptoms, not rely on the patient volunteering concerning details? — Active, structured questioning for red flags, not passive reliance on what the patient happens to mention.

4.4 Atypical Presentations Receive Genuine Consideration, Not Dismissed as Benign by Default

Non-Negotiable

When a patient's presentation is atypical or overlaps with a benign condition, the clinician genuinely considers serious alternative diagnoses before defaulting to a benign explanation — not treating overlap with common, self-limiting illness as sufficient reason to rule out something more serious.

1. Does the clinician genuinely consider serious alternative diagnoses for an atypical or overlapping presentation? — Real, active consideration, not immediate default to the more common, benign explanation.
2. Is there a specific process for documenting why a serious alternative was considered and ruled out? — A real, documented reasoning process, not an assumption reflected only in the final diagnosis.
3. Is there a defined safety-net process — return advice, follow-up — for a patient whose presentation remains uncertain? — A real, defined safety-net, not the patient sent away with no clear guidance if symptoms don't resolve as expected.

4.5 A Dedicated, Ready Emergency Response Exists for a Deteriorating Patient

Core

The practice maintains a specific, dedicated process and space for a patient who deteriorates or presents in genuine crisis while at the clinic — emergency equipment checked and ready, staff roles defined, a clear pathway to emergency services — not an improvised response assembled in the moment.

1. Is there a specific, dedicated space and process ready for a patient who deteriorates while at the clinic? — A real, ready process, not something assembled improvised in the moment.
2. Is emergency equipment genuinely checked and ready, not assumed functional without verification? — Real, verified readiness, not assumed equipment condition.
3. Are staff roles specifically defined for this scenario, with a clear pathway to emergency services? — Specific, practiced role clarity, not general awareness that an emergency plan exists somewhere.

STANDARD 5 • MANDATORY

Referral & Care Coordination

5.1 Every Referral Is Tracked to Actual Completion, Not Assumed to Have Happened

Non-Negotiable

Every specialist referral is actively tracked from the point it's sent through to a documented, completed appointment — not assumed to have happened simply because the referral was made, with no active follow-up to confirm the patient was actually seen.

1. Is every referral actively tracked from the point it's sent through to a documented, completed appointment? — Real, active tracking to actual completion, not assumed follow-through.
2. Is there a specific process for identifying a referral that hasn't resulted in a completed appointment within an expected timeframe? — A real, active identification process, not passive hope the referral was completed.
3. When an incomplete referral is identified, is there a genuine follow-up action, not just awareness the gap exists? — Real, active follow-up, not a gap noted without resolution.

5.2 Specialist Findings Return to the Referring Clinician Within a Defined Timeframe

Non-Negotiable

Specialist consultation notes and findings are returned to the referring clinician within a specific, defined timeframe, actively confirmed as received — not left to arrive whenever they happen to, or lost entirely in an unreviewed pile of incoming correspondence.

1. Are specialist findings returned to the referring clinician within a specific, defined timeframe? — A real, specific timeframe, not an open-ended expectation of eventual return.
2. Is receipt of specialist findings actively confirmed, not assumed if nothing seems to go wrong? — Genuine, active confirmation, not passive assumption of receipt.
3. Is there a specific process for following up when specialist findings don't arrive within the expected timeframe? — A real, active follow-up process, not findings simply waited for indefinitely.

5.3 Responsibility for Follow-Up Is Explicitly Assigned, Not Left Ambiguous

Non-Negotiable

At every stage of the referral process, one specific person or role is explicitly responsible for the next step — not left as shared or assumed responsibility that, in practice, no one specifically owns.

1. Is one specific person or role explicitly responsible for each stage of the referral process? — Real, specific, named responsibility, not shared or assumed ownership.
2. Can any staff member correctly identify who is responsible for a specific stage, without hesitation? — Genuine, confident, consistent knowledge, not uncertainty about who owns a given step.
3. When responsibility changes — staff turnover, role changes — is the assignment genuinely updated, not left stale? — Real, maintained assignment, not an outdated structure that no longer reflects who actually does the work.

5.4 A Genuinely Urgent Referral Is Tracked With Greater Urgency Than a Routine One

Non-Negotiable

A referral for a genuinely urgent clinical concern is tracked and followed up with meaningfully greater urgency than a routine referral — not placed into the same tracking process and timeframe as any other referral, regardless of the underlying concern's real clinical significance.

1. Is a genuinely urgent referral tracked with meaningfully greater urgency than a routine one? — A real, differentiated process, not identical tracking regardless of clinical significance.
2. Is urgency specifically communicated to the receiving specialist, not left for them to infer? — Explicit, clear urgency communication, not an assumption the specialist will recognise it independently.
3. Is there a specific, shorter timeframe for identifying an incomplete urgent referral, distinct from routine referrals? — A genuinely shorter, specific timeframe, not the same interval applied to every referral.

5.5 The Patient Is Actively Supported Through the Referral Process, Not Left to Navigate It Alone

Core

The patient receives genuine, active support navigating the referral process — clear information about what to expect, help scheduling where needed, someone to contact with questions — not handed a referral and left entirely responsible for making it happen themselves.

1. Does the patient receive genuine, active support navigating the referral process, not just a referral handed over? — Real, active support, not the patient left entirely responsible for making the referral happen.
2. Is there a specific person the patient can contact with questions or difficulties during the referral process? — A real, known contact, not an assumption the patient will figure out who to ask.
3. Is there genuine follow-up with the patient if an initial specialist contact attempt doesn't result in scheduling? — Real, active follow-up at exactly the most common failure point, not the process ending after one attempt.

STANDARD 6 · MANDATORY

Clinical Environment & Safety

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.

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.
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.
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.

6.2 History-Taking and Examination Follow a 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.

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.
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.
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.

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.

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.

2. Do patients receive clear, understandable instructions for new or changed medications, verified as understood? — Genuine, verified understanding, not instructions given without confirmation.
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.

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.

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

6.5 The Clinical Environment Itself Supports 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.

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.
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.
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.

STANDARD 7 • MANDATORY

Governance & Staffing

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.

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.
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.
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.

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.

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.
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.
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.

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.

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.
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.
3. Is there real evidence the improvement effort has produced a genuine, measurable change? — Actual, measurable outcome, not activity without demonstrated real effect.

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.

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

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.

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.
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.
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.

STANDARD 8

Health & Migration

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.

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

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.

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

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.

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

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.

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.
2. Does handover to another provider specifically include migration- and displacement-related context? — Specific inclusion of this context, not a generic clinical handover.
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.

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.

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

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.

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

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.

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.
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.
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.

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.

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.
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.

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.

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.

- 1.** Can staff name the specific legal status categories this practice actually serves? — Specific, named categories, not a general sense that "migrants" are served.
- 2.** Does the practice avoid applying a single, uniform assumption about access rights across all statuses? — Genuine differentiation, not treating all categories identically.
- 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.

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.

- 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.
- 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.
- 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.