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ASF Health Standards Version 11

Standard 12: Critical Care

Core standard · applicability by facility type shown for each criterion

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01	10 November 2026	First issue of the paper standard. Adapted from the web version of Standard 12 in ASF Health Standards Version 11.	Prof. Giorgi Pkhakadze

APPROVAL



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Date: 10 November 2026

Complete on its own, without internet access. References are listed in section 11. The current revision is at france-asf.fr.

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1 Introduction

This document is Standard 12 of ASF Health Standards. It sets out how a facility cares for critically ill and deteriorating patients safely: continuous monitoring matched to acuity, safe nurse staffing, early recognition and rapid response to deterioration, sedation and delirium management, family communication, decisions about end-of-life care, and dignified care of the dying patient.

A standard is a set of numbered criteria. Each criterion says what must be in place (the criterion statement), how it is rated for each setting, what the assessor will check and what evidence the facility must show. The guidance in this document explains what each criterion means in practice, so that a reader who has only this paper can understand and meet it.

Purpose of this document. Standard 12 makes sure that critically ill patients are seen early, monitored continuously, cared for by enough skilled staff, and treated with dignity to the end of life.

Who should read it. Intensive care and critical care nurses, doctors (intensivists and anaesthetists), the critical care lead, the clinical governance lead, the chief executive, and the assessors who verify the facility. Each criterion names the positions responsible for it (section 8.2).

The standard is a tool to improve care, not a list of paperwork. Templates and forms named in this document are reference drafts. You may adapt them, replace them with your own, or upload your own documents, provided they meet the same criterion.

2 About ASF and this standard

Accréditation Sans Frontières (ASF) is a non-governmental, non-profit accreditation body. It was legally established in Paris in 2020. ASF develops health standards that are practical, affordable and open to all facilities, including those working with limited resources, in crisis, or in transition.

ASF believes accreditation should be accessible in every sense: geographically, so that facilities in remote areas can take part; financially, so that cost is not a barrier; and in language and format, so that staff can read and use the standard in their own working environment.

Each standard is an independent document. Standard 12 has been written so that it can be read and used on its own. It repeats the definitions, abbreviations and references it needs. A reader who has only this document can understand every criterion in it.

3 How to use this standard

If you deliver critical care, read section 4 to confirm which criteria apply to your facility type, then section 5 to find the rating for your setting. Read each criterion from 12.1 to 12.8, paying attention to the rating, the guidance and the evidence. Prepare the evidence named in each criterion, covering the period stated.

If you are an assessor, use the sample and the checks in each criterion. The pass rule and the immediate-fail rule decide each criterion. A criterion is met only when all its checks are passed and no immediate-fail event is found.

Reading a criterion. Each criterion has: the criterion statement; the three ratings (humanitarian, transition and fragile, standard); the rating rule; the guidance; what good looks like; common mistakes; why it matters; the sample; the checks, with method, evidence and pass condition; the immediate-fail event; the documents with who writes, approves and checks them; the positions responsible; and the references.

Document codes. Each document has a code made of a topic prefix, a type and a number, for example ENV-SOP-001 (environment, procedure, 001). The type is one of FRM (form, a record kept as evidence), REG (register), PLN (plan),

POL (policy), SOP (standard operating procedure) or GDL (guide). The codes identify documents only. The full list is in section 12.

4 Scope

Standard 12 covers continuous monitoring, nurse-to-patient ratios, rapid response and deterioration recognition, sedation and delirium management, family communication and presence, end-of-life and withdrawal of care, and care of the dying patient. The applicability is shown in section 4.

The standard applies in three settings. The rating for each criterion is given for each setting, and the facility uses the rating for its own setting: **humanitarian settings** (emergency or crisis, very limited resources), **transition and fragile settings** (a health system in change or under strain), and **standard settings** (full resources).

WHERE STANDARD 12 APPLIES

Standard 12 applies when the facility provides intensive or critical care, or cares for patients at high risk of deterioration. For each facility type the table shows whether critical care is a default service (expected) or an optional service (offered only if the facility provides it). The applicability of all 70 standards is in **Annex 1: Applicability of ASF Health Standards by facility type** (ASF-HS11-ANX01), published on france-asf.fr.

Criterion	Applies to
12.1 Continuous Physiological Monitoring Appropriate to Acuity	**default** in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic.
12.2 Nurse-to-Patient Ratio Matches Acuity	**default** in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic.
12.3 Rapid Response and Deterioration Recognition System	**default** in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic.
12.4 Sedation and Delirium Management Protocol	**default** in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic.
12.5 Family Communication and Presence Policy	**default** in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic.
12.6 End-of-Life and Withdrawal of Care Protocol	**default** in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic.
12.7 Deteriorating Patients Are Recognised Early	**default** in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic.
12.8 Dying Patients Are Cared for With Dignity	**default** in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic.

5 Ratings and colours

Rating	Colour	Meaning
Must		Required in every setting. Criteria that can directly affect a patient's life are always Must, and no setting lowers them.
Medium		Required, adapted to what a transition setting can realistically do.
Minimum		The lowest acceptable level in a humanitarian setting, where resources are very limited.

In standard settings every criterion is Must.

TRAINING LEVELS

Level	Colour	Meaning
Essential		Must be completed by the people named in the role table.
Recommended		Good practice. Not checked as a requirement.
Optional		May be used for development.

6 Abbreviations

Abbreviation	Meaning
ASF	Accréditation Sans Frontières (Accreditation Without Borders), a non-governmental, non-profit accreditation body
FRM	Form. A record that is filled in and kept as evidence
GDL	Guide. Reference guidance for staff
POL	Policy. A written statement of what the facility will do and why
REG	Register. A running record of entries, such as staffing, training or absence
SOP	Standard operating procedure. A step-by-step description of how a task is done
ICU	Intensive care unit
NEWS	National Early Warning Score

DOCUMENT CODE PREFIXES

Prefix	Topic
CRT	Critical care
HSP	Hospice and palliative care

7 Terms and definitions

Term	Definition
Acuity	How ill a patient is and how much nursing and medical care they need at a given time.
Delirium	A sudden change in attention and awareness, common in critically ill patients and often linked to sedation.
Early-warning score	A score built from vital signs that shows how sick a patient is becoming, with a set response at each level.
Rapid response	A call for a team to attend a deteriorating patient within a defined time, made directly by any member of staff.
Sedation target	The level of calm or drowsiness set for a patient, recorded and reviewed.
Withdrawal of life-sustaining treatment	A decision, made with the team and the family, to stop treatment that keeps a patient alive.
Immediate fail	One event that means a criterion is not met, whatever else is in place.
Setting	The context in which a facility works: humanitarian, transition and fragile, or standard.

8 Standard 12 at a glance

Standard 12: Critical Care is a service standard of ASF Health Standards. It applies when the facility provides intensive or critical care, or cares for patients at high risk of deterioration, and covers how those patients are monitored, staffed, escalated, sedated, supported and cared for to the end of life.

The standard has nine criteria. Each is shown below and explained on its own page in section 9.

8.1 CRITERIA AND RATINGS

No.	Criterion	Humanitarian	Transition	Standard
12.1	Continuous Physiological Monitoring Appropriate to Acuity	Must	Must	Must
12.2	Nurse-to-Patient Ratio Matches Acuity	Minimum	Must	Must
12.3	Rapid Response and Deterioration Recognition System	Minimum	Must	Must
12.4	Sedation and Delirium Management Protocol	Minimum	Medium	Must
12.5	Family Communication and Presence Policy	Minimum	Medium	Must
12.6	End-of-Life and Withdrawal of Care Protocol	Minimum	Medium	Must
12.7	Deteriorating Patients Are Recognised Early	Minimum	Must	Must
12.8	Dying Patients Are Cared for With Dignity	Minimum	Must	Must

8.2 RESPONSIBILITIES

Each criterion names the positions responsible for it. The facility sets its own reporting lines, and each position should have written terms of reference. ISCO-08 codes are shown for each role and are recorded in the staff register.

No.	Criterion	Positions responsible or involved
12.1	Continuous Physiological Monitoring Appropriate to Acuity	Manager (ISCO 1342) · Nurse (ISCO 2221)
12.2	Nurse-to-Patient Ratio Matches Acuity	Secretary (ISCO 3344) · Manager (ISCO 1342)
12.3	Rapid Response and Deterioration Recognition System	Manager (ISCO 1342)
12.4	Sedation and Delirium Management Protocol	Manager (ISCO 1342) · Nurse (ISCO 2221)
12.5	Family Communication and Presence Policy	Manager (ISCO 1342) · Nurse (ISCO 2221)
12.6	End-of-Life and Withdrawal of Care Protocol	Manager (ISCO 1342) · Nurse (ISCO 2221)
12.7	Deteriorating Patients Are Recognised Early	Manager (ISCO 1342)

No.	Criterion	Positions responsible or involved
12.8	Dying Patients Are Cared for With Dignity	Manager (ISCO 1342)

8.3 TRAINING FOR STANDARD 12

Training is shown by course. Essential training must be completed by the people named. Recommended training is good practice. The colours follow section 5.

Course	Essential for	Recommended for	Criteria	Status
Continuous Monitoring in Critical Care (CRT-01)	Manager, Nurse	None	12.1	In development
Nurse-to-Patient Ratios by Acuity in Critical Care (CRT-02)	Manager, Nurse	None	12.2	In development
Emergency Medical Equipment & AED Readiness (MED-02)	Manager, Nurse	None	12.3	In development
Sedation and Delirium Management in Critical Care (CRT-03)	Manager, Nurse	None	12.4	In development
Patient Identification, Informed Consent and Patient Rights (T-07)	Manager, Nurse	None	12.5	In development
Healthcare Ethics for ASF Accreditation (A-07)	Manager, Nurse	None	12.6	In development
Safety & Emergency Preparedness (H-05)	Manager, Nurse	None	12.7	In development
End-of-Life & Palliative Care (LTC-06)	Manager, Nurse	None	12.8	In development

Evidence of training may be a verified micro-credential in the GMJ Academy micro-credential portfolio, or a training certificate kept in the staff file.

12.1 Continuous Physiological Monitoring Appropriate to Acuity

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Must	**Must**	**Must**

Applies to: default in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Every critical care patient is continuously monitored with equipment and alarm parameters individually set to their clinical condition, with alarms responded to, not silenced or ignored due to alarm fatigue.

Rating rule. Must in every setting: every critically ill patient is monitored continuously at a level matched to their condition, with alarms set for that patient and answered.

GUIDANCE

Every critically ill patient is monitored continuously, with equipment and alarm limits set for that patient's condition, not one default for the whole unit. Alarms are answered when they sound. An alarm that is switched off or silenced without a recorded reason is a serious risk, because the next change may be missed.

Alarm fatigue is a real hazard: too many alarms that are not acted on teach staff to ignore them. The answer is correctly set limits and a clear response, not switching alarms off.

WHAT GOOD LOOKS LIKE

- Alarm limits are reviewed at every change in the patient's condition, and the bedside team can state the current limits.

COMMON MISTAKES

- A ventilated patient with alarms switched off and no monitoring record for the shift.
- Alarm limits left at default settings for every patient, whatever their condition.

> **Why it matters.** A critically ill patient can deteriorate in minutes. Continuous monitoring, with alarms set to the patient's acuity, shows the change while there is still time to act.

WHAT THE ASSESSOR CHECKS

Sample. Review monitoring records and alarm settings for 15 critical care patients across two shifts.

1 Each patient is monitored continuously at the level set for their condition.

Method. Check each record for continuous monitoring entries across the sampled shifts.

Evidence to show. Critical care monitoring and alarm settings (CRT-SOP-001).

Pass when. Every sampled patient has continuous monitoring recorded.

2 **Alarm limits are set for each patient and recorded.**

Method. Check each patient for the alarm limits recorded and the date set.

Evidence to show. Monitoring and alarm record (CRT-FRM-001).

Pass when. Every patient has individual alarm limits recorded.

3 **Alarms are responded to and any alarm off is recorded with a reason.**

Method. Check the alarm log for response times and any alarm switched off.

Evidence to show. Monitoring and alarm record (CRT-FRM-001).

Pass when. Every alarm is responded to and every alarm off has a reason.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A ventilated patient with alarms switched off and no monitoring record for a shift. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CRT-SOP-001	Critical care monitoring and alarm settings	Manager	Chief executive	Chief executive
CRT-FRM-001	Monitoring and alarm record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Critical care monitoring and alarm settings	— Must
Nurse (ISCO 2221)	Completes the Monitoring record	— Must

REFERENCES FOR THIS CRITERION

- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

12.2 Nurse-to-Patient Ratio Matches Acuity

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: default in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A defined nurse-to-patient ratio appropriate to critical care acuity is maintained at all times, including nights and weekends, with a documented escalation process when staffing falls below the required ratio — not an aspirational standard that quietly erodes under pressure.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: nurse-to-patient ratios match the acuity of patients at all times, including nights and weekends, with a documented escalation when staffing falls short.

GUIDANCE

A defined nurse-to-patient ratio, matched to the acuity of the patients on the unit, is met on every shift, including nights and weekends. When staffing falls below the ratio, the shortfall is escalated and recorded with the action taken, rather than accepted silently.

A nurse caring for too many critically ill patients cannot watch them all at once. A ratio that holds only on the day shift gives false assurance. A daily staffing register shows whether the ratio was met.

WHAT GOOD LOOKS LIKE

- The ratio for each shift is shown on the unit board, so that staff and managers can see at a glance whether it is met.

COMMON MISTAKES

- One nurse for four ventilated patients on a night shift, with no record of the shortfall.
- A ratio written into policy that is not used when the unit is busy.

> **Why it matters.** A critical care nurse cannot safely look after too many patients at once. A ratio matched to acuity keeps each patient within reach of skilled care.

WHAT THE ASSESSOR CHECKS

Sample. Review staffing records for 10 shifts, including two nights and one weekend.

1 The ratio is met on each sampled shift, including nights and weekends.

Method. Check each shift against the ratio for the acuity on the shift.

Evidence to show. Daily staffing ratio register (CRT-REG-001).

Pass when. Every sampled shift meets the defined ratio.

2 **Staffing below the ratio is escalated and recorded with the action taken.**

Method. Check each shift below the ratio for an escalation record and the action taken.

Evidence to show. Daily staffing ratio register (CRT-REG-001).

Pass when. Every shift below the ratio has an escalation recorded.

3 **The ratio is reviewed against the acuity mix every month.**

Method. Check the monthly review record against the acuity figures for the period.

Evidence to show. Daily staffing ratio register (CRT-REG-001).

Pass when. Every month records the acuity mix and any change to the ratio.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A night shift with one nurse for four ventilated patients and no staffing record. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CRT-REG-001	Daily staffing ratio register	Secretary	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Secretary (ISCO 3344)	Keeps the Daily staffing ratio register	— Must
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

12.3 Rapid Response and Deterioration Recognition System

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: default in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A structured early-warning scoring system is used to detect patient deterioration, with a defined rapid response mechanism that staff can activate directly, without needing to escalate through multiple layers before help arrives.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: deterioration is detected with a structured early-warning score, and a rapid response can be called directly by any member of staff.

GUIDANCE

Deterioration is detected with a structured early-warning score recorded at a set frequency. A trigger score brings a rapid response within a defined time. Any member of staff can call the response directly, without waiting for several layers of approval.

Most patients who deteriorate on a ward or in a unit show warning signs for hours before a crisis. A score that is recorded, acted on and reviewed gives the team time to intervene.

WHAT GOOD LOOKS LIKE

- Staff can call a rapid response from the bedside without waiting for a senior decision, and every response is recorded.

COMMON MISTAKES

- A trigger score reached and no one called for more than an hour.
- The scoring tool is used, but the trigger levels are not written into the policy.

> **Why it matters.** Patients in intensive care often show early warning signs hours before they arrest. A structured scoring system, with a rapid response route, catches them in time.

WHAT THE ASSESSOR CHECKS

Sample. Review early warning scoring and rapid response records for 15 patients who reached a trigger score.

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1 A trigger score brings a rapid response within the defined time.

Method. Check each trigger for the time to response.

Evidence to show. Rapid response and escalation (CRT-SOP-002).

Pass when. Every trigger has a response within the defined time.

2 **Each rapid response is recorded with the reason, the time and the outcome.**

Method. Check each response record for the reason, the time and the outcome.

Evidence to show. Rapid response and escalation (CRT-SOP-002).

Pass when. Every response has a reason, a time and an outcome recorded.

3 **Nurses are trained to recognise the score and to call the response team directly.**

Method. Check the training record for each nurse on the unit and the call route used.

Evidence to show. Rapid response and escalation (CRT-SOP-002).

Pass when. Every nurse on the unit has completed the training and can name the call route.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A trigger score reached and no one called for 90 minutes. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CRT-SOP-002	Rapid response and escalation	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Rapid response and escalation	— Must
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- (National Institute for Health and Care Excellence (NICE), 2020 (surveillance decision)) https://www.nice.org.uk/guidance/cg50/evidence/2020-surveillance-of-acutely-ill-adults-in-hospital-recognising-and-responding-to-deterioration-nice-guideline-cg50-7027893037
- (NHS England (developer: Royal College of Physicians), 2017 (NEWS2 version)) https://www.england.nhs.uk/nationalearlywarningscore/

12.4 Sedation and Delirium Management Protocol

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: default in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A written protocol governs sedation level targets and delirium screening for critical care patients, with sedation minimised to the clinically necessary level and delirium actively screened for on a defined schedule, not assumed absent without active checking.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: sedation is set to a written target and kept to the clinical need, and delirium is screened for on a defined schedule.

GUIDANCE

A written protocol sets a sedation target for each patient, keeps sedation to the clinical need, and requires delirium to be screened for at a defined interval. Sedation is reviewed daily, with a lightening of sedation where clinically safe.

Deep sedation keeps a patient still but can cause delirium and prolong ventilation. A protocol that sets the target and checks it daily protects the patient.

WHAT GOOD LOOKS LIKE

- Sedation is reviewed daily with the team, and the reason for any decision not to lighten sedation is recorded.

COMMON MISTAKES

- A patient held on deep sedation for several days with no daily review.
- Delirium assumed to be absent because the patient is quiet.

> **Why it matters.** Deep sedation keeps a patient still but can cause delirium, and sedation left running too long prolongs ventilation. A protocol that sets the target and screens for delirium keeps the patient awake enough and safe.

WHAT THE ASSESSOR CHECKS

Sample. Review sedation and delirium records for 15 patients who received sedation for more than 24 hours.

1 A written protocol sets the sedation level target for each patient.

Method. Check each record for the sedation target and the date set.

Evidence to show. Sedation and delirium management protocol (CRT-POL-001).

Pass when. Every sampled patient has a sedation target recorded.

2 Delirium is screened at the set interval.

Method. Check each record for delirium screening entries at the interval.

Evidence to show. Sedation and delirium screening chart (CRT-FRM-002).

Pass when. Every sampled patient is screened at the set interval.

3 **Sedation is reviewed daily and minimised to the clinical need.**

Method. Check the daily review entries and the level against the target.

Evidence to show. Sedation and delirium screening chart (CRT-FRM-002).

Pass when. Every sampled patient has a daily sedation review.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A patient held on deep sedation with no daily sedation review. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CRT-FRM-002	Sedation and delirium screening chart	Manager	Chief executive	Manager
CRT-POL-001	Sedation and delirium management protocol	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Sedation and delirium management protocol	— Medium
Nurse (ISCO 2221)	Completes the Sedation and delirium screening chart	— Medium

REFERENCES FOR THIS CRITERION

- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/

12.5 Family Communication and Presence Policy

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: default in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A structured process ensures family receives regular, understandable updates on the patient's condition, with a clear, applied family presence policy — not family access or communication left to vary by which staff member happens to be on shift.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: families receive regular, understandable updates, and a clear family presence policy is applied.

GUIDANCE

A structured process gives the family regular updates on the patient's condition, in plain language, with a chance to ask questions. The facility applies a clear family presence policy, and any restriction on visits is recorded with its reason and reviewed.

Families of critically ill patients are often frightened and cut off. Consistent, understandable updates reduce distress and help the team and the family work together.

WHAT GOOD LOOKS LIKE

- A named family contact is set on the first day, and updates are given at the same time each day.

COMMON MISTAKES

- A family denied information for days with no presence policy applied.
- Updates given verbally and never recorded.

> **Why it matters.** Families of patients in intensive care are often frightened and cut off. Regular, understandable updates and a clear policy on presence reduce distress and help the team work with them.

WHAT THE ASSESSOR CHECKS

Sample. Review family communication records for 15 critical care patients and the presence policy applied.

1 Family receive a regular update on the patient's condition.

Method. Check each record for family update entries at the set frequency.

Evidence to show. Family communication and presence (CRT-SOP-003).

Pass when. Every sampled family has regular updates recorded.

2 Updates are understandable and the family can ask questions.

Method. Check each update record for the explanation and the questions recorded.

Evidence to show. Family update record (CRT-FRM-003).

Pass when. Every update records an explanation and any questions.

3 **The family presence policy is applied and any restriction is recorded with a reason.**

Method. Check each restriction for the reason and the review.

Evidence to show. Family update record (CRT-FRM-003).

Pass when. Every restriction has a reason and a review recorded.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A family denied information for days with no presence policy applied. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CRT-SOP-003	Family communication and presence	Manager	Chief executive	Chief executive
CRT-FRM-003	Family update record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Family communication and presence	— Medium
Nurse (ISCO 2221)	Completes the Family update record	— Medium

REFERENCES FOR THIS CRITERION

- (Society of Critical Care Medicine (SCCM), 2025 (published Crit Care Med 2025;53(2))) https://sccm.org/clinical-resources/guidelines/guidelines/guidelines-on-family-centered-care-for-adult-icus-2024

12.6 End-of-Life and Withdrawal of Care Protocol

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Medium**	**Must**

Applies to: default in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** A written protocol governs end-of-life decision-making and withdrawal of life-sustaining treatment in critical care, including family involvement, ethics consultation access, and palliative support — not decisions that vary with the individual clinician's approach.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings: decisions to withdraw life-sustaining treatment follow a written protocol, with family involvement and access to ethics consultation.

GUIDANCE

A written protocol governs decisions to withdraw or limit life-sustaining treatment. Each decision involves the treating clinicians, the patient where possible, the family, and access to an ethics consultation, and is documented when it is made.

These are among the hardest decisions in medicine. A clear protocol makes them careful, consistent and open, and protects both the patient and the staff.

WHAT GOOD LOOKS LIKE

- The protocol names the route to an ethics consultation and a spiritual or cultural support contact for the family.

COMMON MISTAKES

- Life support withdrawn with no documented decision and no family discussion.
- A decision made by one clinician without the team or the family.

> **Why it matters.** Decisions to stop life-sustaining treatment are among the hardest in medicine. A written protocol, with the patient or family and the team, makes the decision careful and respectful.

WHAT THE ASSESSOR CHECKS

Sample. Review end-of-life and withdrawal decision records for 10 patients in the last 12 months.

1 A written protocol governs each decision to withdraw life-sustaining treatment.

Method. Check the protocol for the decision steps and the approvals.

Evidence to show. End-of-life decisions and withdrawal of life-sustaining treatment (CRT-POL-002).

Pass when. The protocol covers every decision step.

2 Each decision is documented with the clinicians and the family involved.

Method. Check each decision record for the clinicians and the family involvement.

Evidence to show. Withdrawal of treatment decision record (CRT-FRM-004).

Pass when. Every decision names the clinicians and the family involved.

3 The ethics consultation and a family meeting are offered before a withdrawal decision is final.

Method. Check each decision for the record of the ethics offer and the family meeting.

Evidence to show. Withdrawal of treatment decision record (CRT-FRM-004).

Pass when. Every decision records that an ethics consultation was offered and that the family meeting took place.

Pass. The criterion is met when every check above is passed.

Immediate fail. . Life support withdrawn with no documented decision and no family discussion. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CRT-FRM-004	Withdrawal of treatment decision record	Manager	Chief executive	Manager
CRT-POL-002	End-of-life decisions and withdrawal of life-sustaining treatment	Chief executive	Governing body members	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the End-of-life decisions and withdrawal of life-sustaining treatment	— Medium
Nurse (ISCO 2221)	Completes the Withdrawal of treatment decision record	— Medium

REFERENCES FOR THIS CRITERION

- WHO (2021). Quality health services and palliative care: practical approaches and resources to support policy, strategy and practice. Used for: Quality palliative care services, including end-of-life and dying-patient care. Palliative-specific. https://news.gmj.ge/guideline/quality-health-services-and-palliative-care-practical-approaches-and-resources-to-support-policy-strategy-and-practice/
- WHO (2019). Integrating palliative care and symptom relief into primary health care. Used for: Palliative and end-of-life care in primary care settings. Palliative-specific, not intensive care. https://news.gmj.ge/guideline/integrating-palliative-care-and-symptom-relief-into-primary-health-care/

12.7 Deteriorating Patients Are Recognised Early

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: default in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Vital signs are recorded for every inpatient at a set frequency, and the frequency rises when the patient worsens. A recognised early warning score triggers a defined response at each level.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: vital signs are recorded at a frequency that rises as the patient worsens, and a recognised early-warning score triggers a defined response.

GUIDANCE

Vital signs are recorded for every inpatient at a set frequency. The frequency rises when the patient worsens, and a recognised early-warning score triggers a defined response at each level. A score that is recorded but leads to no response protects no one.

Patients who deteriorate on a ward often show abnormal vital signs for hours before a crisis. Early recognition, at the level set by the score, is the most effective way to prevent it.

WHAT GOOD LOOKS LIKE

- Early-warning scores are displayed at the bedside, with the response for each level and the person to call written beside them.

COMMON MISTAKES

- A deteriorating inpatient with vital signs recorded twice a day and no early-warning score.
- Scores recorded, but no escalation when they rise.

> **Why it matters.** Most deaths on a ward were preceded by hours of warning signs. A score that is recorded but leads to no response protects no one.

WHAT THE ASSESSOR CHECKS

Sample. Review vital sign frequency and deterioration response for 15 inpatients who deteriorated in the last 3 months.

1 The deterioration is recognised and acted on within the set time.

Method. Check each deterioration for the recognition and action time.

Evidence to show. Rapid response and escalation (CRT-SOP-002).

Pass when. Every deterioration is acted on within the set time.

2 Vital sign frequency rises when the early warning score rises.

Method. Check each patient record against the score and the frequency set for that score.

Evidence to show. Rapid response and escalation (CRT-SOP-002).

Pass when. Every rise in score is followed by a higher frequency of vital signs.

3 **The current score is recorded at each shift handover.**

Method. Check the handover records for the score recorded and any action noted.

Evidence to show. Rapid response and escalation (CRT-SOP-002).

Pass when. Every shift handover records the current score.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A deteriorating inpatient with vital signs recorded twice a day and no early warning score. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
CRT-SOP-002	Rapid response and escalation	Manager	Chief executive	Chief executive

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Maintains the Rapid response and escalation	— Must
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- (National Institute for Health and Care Excellence (NICE), 2020 (surveillance decision)) https://www.nice.org.uk/guidance/cg50/evidence/2020-surveillance-of-acutely-ill-adults-in-hospital-recognising-and-responding-to-deterioration-nice-guideline-cg50-7027893037
- (NHS England (developer: Royal College of Physicians), 2017 (NEWS2 version)) https://www.england.nhs.uk/nationalearlywarningscore/

12.8 Dying Patients Are Cared for With Dignity

HUMANITARIAN SETTINGS	TRANSITION AND FRAGILE SETTINGS	STANDARD SETTINGS
Minimum	**Must**	**Must**

Applies to: default in Hospital. **Not applicable to:** Ambulatory clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** The care of the dying patient follows a defined plan, including comfort measures, pain control, and the support of family present. The plan is reviewed with the patient and family.

Rating rule. Minimum in humanitarian settings. Must in transition and fragile settings. Must in standard settings: the dying patient has a written care plan covering comfort, pain control and the support of family, reviewed with them.

GUIDANCE

The care of a dying patient follows a written plan, prepared with the patient where possible and with the family. The plan covers comfort measures, pain control, the presence of family, and spiritual or cultural needs. It is reviewed with the patient and family as the condition changes.

A plan removes the need for staff to improvise at the most difficult time. It also gives the family a clear picture of what is being done and why.

WHAT GOOD LOOKS LIKE

- The family is offered a quiet space and a named contact at night, and the plan is reviewed with them.

COMMON MISTAKES

- A dying patient left in pain with no comfort plan.
- Family asked to leave while the patient is still conscious, with no reason recorded.

> **Why it matters.** The last days of life need a clear plan, comfort measures and a dignified environment. Without a plan, care becomes improvised and the patient suffers.

WHAT THE ASSESSOR CHECKS

Sample. Review care plans and records for 10 patients who died in critical care in the last 6 months.

1 A written dying care plan is in place before the decision that the patient is at the end of life is recorded.

Method. Check each record for the plan date against the date of the end-of-life decision.

Evidence to show. Dying care plan record (HSP-FRM-005).

Pass when. Every dying patient has a plan recorded before or on the day of the decision.

2 Pain and comfort are assessed and treated at the set interval.

Method. Check the record for pain and comfort scores and the treatment given.

Evidence to show. Dying care plan record (HSP-FRM-005).

Pass when. Every assessment is recorded at the set interval with the treatment given.

3 The plan is reviewed with the patient's family and the review is recorded.

Method. Check the review entries for the family present and the date.

Evidence to show. Care of the dying patient (HSP-SOP-003).

Pass when. Every plan records a review with the family and a date.

Pass. The criterion is met when every check above is passed.

Immediate fail. . A dying patient left in pain with no comfort plan and family not allowed to stay. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
HSP-SOP-003	Care of the dying patient	Manager	Chief executive	Chief executive
HSP-FRM-005	Dying care plan record	Manager	Chief executive	Manager

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Manager (ISCO 1342)	Checks the criterion at each review	— Must

REFERENCES FOR THIS CRITERION

- WHO (2021). Quality health services and palliative care: practical approaches and resources to support policy, strategy and practice. Used for: Quality palliative care services, including end-of-life and dying-patient care. Palliative-specific. https://news.gmj.ge/guideline/quality-health-services-and-palliative-care-practical-approaches-and-resources-to-support-policy-strategy-and-practice/
- WHO (2019). Integrating palliative care and symptom relief into primary health care. Used for: Palliative and end-of-life care in primary care settings. Palliative-specific, not intensive care. https://news.gmj.ge/guideline/integrating-palliative-care-and-symptom-relief-into-primary-health-care/

10 Questions and answers

Does Standard 12 apply to every facility?
No. It applies when the facility provides intensive or critical care, or cares for patients at high risk of deterioration. Section 4 shows, for each facility type, whether critical care is a default or an optional service, and where it does not apply.

Is there a minimum nurse-to-patient ratio?
Criterion 12.2 requires a defined ratio that matches the acuity of the patients, met on every shift. The facility sets the ratio. A shift that falls below it must be escalated and recorded.

Can alarms on a ventilated patient be switched off?
No. Under 12.1 monitoring is continuous and the alarms are set for the patient's condition. A ventilated patient with alarms switched off is an immediate fail.

What happens when a trigger score is reached?
Under 12.3 a rapid response is called within the defined time. Under 12.7 a patient who is deteriorating is recognised early and acted on.

Do I have to use the forms on this page?
No. They are reference drafts. Adapt them, write your own, or upload your own, provided the same criterion is met and the evidence can be shown.

The criterion text is the authority. These answers summarise it.

11 References

CITED FOR CRITERIA

1. World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 Used for: https://news.gmj.ge/guideline/global-patient-safety-action-plan-2021-2030-towards-eliminating-avoidable-harm-in-health-care/ (criterion 12.1, 12.4)
2. (National Institute for Health and Care Excellence (NICE), 2020 (surveillance decision)) https://www.nice.org.uk/guidance/cg50/evidence/2020-surveillance-of-acutely-ill-adults-in-hospital-recognising-and-responding-to-deterioration-nice-guideline-cg50-7027893037 (criterion 12.3, 12.7)
3. (NHS England (developer: Royal College of Physicians), 2017 (NEWS2 version)) https://www.england.nhs.uk/nationalearlywarningscore/ (criterion 12.3, 12.7)
4. (Society of Critical Care Medicine (SCCM), 2025 (published Crit Care Med 2025;53(2))) https://sccm.org/clinical-resources/guidelines/guidelines/guidelines-on-family-centered-care-for-adult-icus-2024 (criterion 12.5)
5. WHO (2021). Quality health services and palliative care: practical approaches and resources to support policy, strategy and practice. Used for: Quality palliative care services, including end-of-life and dying-patient care. Palliative-specific. https://news.gmj.ge/guideline/quality-health-services-and-palliative-care-practical-approaches-and-resources-to-support-policy-strategy-and-practice/ (criterion 12.6, 12.8)
6. WHO (2019). Integrating palliative care and symptom relief into primary health care. Used for: Palliative and end-of-life care in primary care settings. Palliative-specific, not intensive care. https://news.gmj.ge/guideline/integrating-palliative-care-and-symptom-relief-into-primary-health-care/ (criterion 12.6, 12.8)

INTERNATIONAL STANDARDS CITED

1. International Labour Organization (2008). International Standard Classification of Occupations, ISCO-08. Geneva: ILO.

12 Document register

Every document code used in Standard 12, with its type and the criteria that use it. The codes identify the documents; a facility may use its own document if it meets the same criterion.

Code	Document	Type	Criteria
CRT-FRM-001	Monitoring and alarm record	Form (record)	12.1
CRT-FRM-002	Sedation and delirium screening chart	Form (record)	12.4
CRT-FRM-003	Family update record	Form (record)	12.5
CRT-FRM-004	Withdrawal of treatment decision record	Form (record)	12.6
CRT-POL-001	Sedation and delirium management protocol	Policy	12.4
CRT-POL-002	End-of-life decisions and withdrawal of life-sustaining treatment	Policy	12.6
CRT-REG-001	Daily staffing ratio register	Register	12.2
CRT-SOP-001	Critical care monitoring and alarm settings	Procedure (SOP)	12.1
CRT-SOP-002	Rapid response and escalation	Procedure (SOP)	12.3, 12.7
CRT-SOP-003	Family communication and presence	Procedure (SOP)	12.5
HSP-FRM-005	Dying care plan record	Form (record)	12.8
HSP-SOP-003	Care of the dying patient	Procedure (SOP)	12.8