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ASF Health Standards Version 11

Standard 1: Assessment, Care Planning and Safety

Base standard · applies to all facility categories

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REVISION HISTORY

Revision	Date	Change	Approved by
02	10 November 2026	Added applicability by facility type (criterion level) and the cross-reference to Annex 1.	Prof. Giorgi Pkhakadze
01	1 November 2026	First issue of the paper standard. Adapted from the web version of Standard 1.	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 1 of ASF Health Standards. It sets out what a facility must do to assess every patient properly, plan their care, keep them safe, and make sure the staff who do this work are enough in number and skill. Standard 1 is the base standard. Every facility meets it.

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 1 defines the minimum that every facility must have in place before any other standard can be met. Patient assessment, care planning, safety measures and staffing are the base on which the other standards are built. If this base is weak, later standards cannot succeed.

Who should read it. Facility managers, nurse managers, clinicians, quality staff, HR staff who manage rotas and training records, 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 1 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, and does not need Standard 20 or any other standard. Standards refer to each other only where a criterion depends on another standard, and then the reference is stated in full.

3 How to use this standard

If you are a facility manager or staff member, read section 4 to confirm the standard applies to you, then section 5 to find the rating for your setting. Read each criterion from 1.1 to 1.7, 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 guidance; why it matters; the sample; the checks, with method, evidence and pass condition; the immediate-fail event; the documents; the positions responsible; and the references.

How to prepare. Start with the rating for your setting, then gather the evidence named in each criterion for the period it covers. For each criterion, check your own records against the checks, and fix any gap before the assessor arrives. The

guidance and the common mistakes sections are there to help you find gaps early.

Document codes. Each document has a code made of a topic prefix, a type and a number, for example CLN-FRM-001 (clinical care, form, 001). The type is one of FRM (form, a record kept as evidence), POL (policy), SOP (standard operating procedure) or GDL (guide). The codes are used only to identify documents. The full list is given in the criteria.

4 Scope

This is the base standard, so it applies to all facility categories. It covers the assessment of every patient on admission, the individual care plan, restraint and seclusion, nutrition and diet, pressure injury prevention, prevention of blood clots, and the staffing needed to deliver these.

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 1 APPLIES

Standard 1 is a core standard, so every facility type is assessed against it. A criterion is marked N/A for a facility type only when that facility has no activity the criterion covers, for example restraint and seclusion for a fitness centre. The applicability of all 70 standards is in **Annex 1: Applicability of ASF Health Standards by facility type** (ASF-HS11-ANX01), also published at https://france-asf.fr/asf-annex-1-applicability/. The online version of this standard is at https://france-asf.fr/standards/standard-1/.

Criterion	Applies to
1.1 Staffing Matches Patient Need	all nine facility types
1.2 Every Patient Gets a Structured Assessment	all nine facility types
1.3 There is an Actual Care Plan	all nine facility types
1.4 Restraint and Seclusion Use Is Governed and Minimised	Hospital, Ambulatory clinic, Long-term care, Home care N/A: Primary health clinic, Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
1.5 Nutrition and Therapeutic Diet Needs Are Actively Managed	Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care N/A: Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
1.6 Pressure Injury Risk Is Assessed and Actively Prevented	Hospital, Long-term care, Home care N/A: Ambulatory clinic, Primary health clinic, Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic
1.7 VTE Risk Is Assessed Before Every Admission and Procedure	Hospital, Ambulatory clinic, Long-term care N/A: Primary health clinic, 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
PHIG	Public Health Institute of Georgia
GMJ	Georgian Medical Journal, host of the GMJ Guidelines Library and the GMJ Academy
CG / NG	NICE clinical guideline and NICE guideline reference numbers
CLAS	Culturally and Linguistically Appropriate Services (standards)
CNO	Chief nursing officer
CQO	Chief quality and safety officer
ETAT	Emergency Triage Assessment and Treatment (WHO)
FRM	Form. A record that is filled in and kept as evidence
GDL	Guide. Reference guidance for staff
HR	Human resources
ICOPE	Integrated Care for Older People (WHO)

Abbreviation	Meaning
ISCO-08	International Standard Classification of Occupations, 2008 edition (International Labour Organization)
NICE	National Institute for Health and Care Excellence (UK)
POL	Policy. A written statement of what the facility will do and why
SOP	Standard operating procedure. A step-by-step description of how a task is done
VTE	Venous thromboembolism (deep vein thrombosis and pulmonary embolism)
WHO	World Health Organization

DOCUMENT CODE PREFIXES

Prefix	Topic
CLN	Clinical care documents
CON	Consent and patient rights documents
ID	Patient identification documents
STF	Staff documents
HH	Hand hygiene documents
PSF	Falls and patient safety documents
EMG	Emergency and fire safety documents
STD1-EL	Standard 1 e-learning course

7 Terms and definitions

Term	Definition
Acuity	How ill or dependent a patient is, which decides how much nursing and medical care they need.
Admission assessment	The structured assessment carried out when a patient is admitted (criterion 1.2).
Assessor	The ASF-trained person who verifies, against the evidence, whether a facility meets each criterion. Also called the surveyor.
Care plan	A written, individual plan for one patient, stating goals, actions, responsibilities and review dates.
Criterion	One numbered requirement in a standard, for example 1.2. Each criterion has its own rating, pass rule and immediate-fail rule.
Escalation	Passing a problem to the person who can act on it, and recording that it was passed and what happened.

Term	Definition
Evidence	The records, documents and observations that show a criterion is met.
Gap record	The record of a shift or service that runs below its calculated staffing level, with the action and the escalation.
Humanitarian setting	A facility working in emergency or crisis conditions with very limited resources.
Immediate fail	One event that means a criterion is not met, whatever else is in place.
Least restrictive option	The intervention that limits a person's freedom the least while still managing the risk.
Facility category	A type of facility to which a standard applies. Standard 1 applies to all facility categories.
Applies, adapted, not applicable	Tags shown for each criterion and each facility category. Applies: the criterion is required as written. Adapted: required with the change stated. Not applicable: the criterion does not apply and the reason is given.
Must, Medium, Minimum	The three ratings of a criterion. Must is required in every setting; Medium is required, adapted to what a transition setting can realistically do; Minimum is the lowest acceptable level in a humanitarian setting. See section 5.
Pass rule	The condition that shows a criterion is met, given as a number, a percentage or a yes/no test.
Pressure injury	Damage to skin and tissue caused by sustained pressure, most often over bony areas.
Prophylaxis	Medicine given to prevent a condition. In this standard, it means medicine given to prevent blood clots.
Restraint	Any method that restricts a person's movement or access to their body, used for safety or care.
Seclusion	Placing a person alone in a room or space they are not free to leave.
Sample	The set of records, shifts or patients that the assessor checks for a criterion. The sample is stated for each criterion.
Setting	The context in which a facility works: humanitarian, transition and fragile, or standard. Each criterion is rated for each setting.
Skill mix	The balance of qualifications and experience among the staff on a shift.
Standard setting	A facility with full resources. Every criterion is Must in standard settings.
Therapeutic diet	A diet prescribed to meet a clinical need, for example a diabetic or low-salt diet.
Transition and fragile setting	A facility in a health system that is changing or under strain, able to meet part of the standard at Medium level.
Triage	Rapid sorting of patients by how urgently they need care.
Verified micro-credential	A training credential that can be checked against the issuer's record, such as one held in the GMJ Academy micro-credential portfolio.

8 Standard 1 at a glance

Standard 1: Assessment, Care Planning and Safety is the base standard of ASF Health Standards. Every facility meets it. It covers how every patient is assessed on admission, how an individual care plan is written and kept current, how restraint and seclusion are governed, how nutrition and diet are managed, how pressure injuries and blood clots are prevented, and how staffing is calculated against patient need.

The standard has seven criteria. Each is shown below and explained on its own page in section 9. The criteria are read separately: a criterion can be printed and used alone, and each one states its own rating, evidence and pass rule.

8.1 CRITERIA IN THIS STANDARD

No.	Criterion
1.1	Staffing matches patient need
1.2	Every patient gets a structured assessment
1.3	There is an actual care plan
1.4	Restraint and seclusion use is governed and minimised
1.5	Nutrition and therapeutic diet needs are actively managed
1.6	Pressure injury risk is assessed and actively prevented
1.7	VTE risk is assessed before every admission and procedure

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.

No.	Criterion	Positions responsible or involved
1.1	Staffing matches patient need	Chief nursing officer (CNO) · Medical director · Head nurse / ward manager
1.2	Every patient gets a structured assessment	Registered nurse · Consultant physician (internal medicine) · Emergency physician · Medical officer on duty (night)
1.3	There is an actual care plan	Registered nurse · Nurse specialist · Advanced practice nurse / nurse practitioner · Head nurse / ward manager
1.4	Restraint and seclusion use is governed and minimised	Mental health nurse · Psychiatrist · Clinical lead (hospital)
1.5	Nutrition and therapeutic diet needs are actively managed	Dietitian / nutritionist · Dietary aide (patient meals)
1.6	Pressure injury risk is assessed and actively prevented	Stoma and wound care nurse · Registered nurse · Health care assistant / nursing aide · Geriatrician
1.7	VTE risk is assessed before every admission and procedure	Consultant physician (internal medicine) · Surgeon (general surgery) · Anaesthesiologist · Medical officer on duty (night)

Quality oversight. The quality chain keeps this standard under review: the chief quality and safety officer (CQO), the quality manager, the accreditation coordinator and the risk manager.

8.3 TRAINING FOR STANDARD 1

Training is shown by setting. "Essential" must be completed by the people named. The colours follow section 5.

Code	Course	Level by setting	Who must take it	Status
STD1-EL-01	Restraint and seclusion course	Humanitarian: Essential · Transition: Essential · Standard: Essential	Nurse; Doctor	In development
STD1-EL-02	Nutrition and therapeutic diet course	Humanitarian: Optional · Transition: Recommended · Standard: Essential	Nurse; Kitchen staff; Doctor; Manager	In development
STD1-EL-03	Pressure injury prevention course	Humanitarian: Optional · Transition: Recommended · Standard: Essential	Nurse; Doctor	In development
STD1-EL-04	VTE prevention course	Humanitarian: Essential · Transition: Essential · Standard: Essential	Doctor; Nurse	In development
STD1-EL-05	Structured clinical assessment course	Humanitarian: Essential · Transition: Essential · Standard: Essential	Nurse; Doctor	In development
STD1-EL-06	Staffing and skill-mix course	Humanitarian: Essential · Transition: Essential · Standard: Essential	Manager; HR; Nurse; Doctor	In development
—	Correct Patient Identification	Humanitarian: Essential · Transition: Essential · Standard: Essential	Nurse; Doctor	Code to be assigned
T-07	Patient Identification, Informed Consent and Patient Rights	Humanitarian: Essential · Transition: Essential · Standard: Essential	Nurse; Doctor	Status to be confirmed
H-07	Governance and Management	Humanitarian: Essential · Transition: Essential · Standard: Essential	Manager; HR	Status to be confirmed
H-04	Care and Treatment: Clinical Standards for Accreditation	Humanitarian: Essential · Transition: Essential · Standard: Essential	Doctor; Nurse; Manager	Status to be confirmed

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. Each role carries its ISCO-08 code (International Labour Organization, 2008), which is recorded in the staff register.

1.1 Staffing Matches Patient Need

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

Applies to: all nine facility types. Each setting shows its rating above.

> **Criterion.** Staffing levels and skill mix are documented against patient volume and acuity — a calculation grounded in actual demand, not a fixed roster set once and never revisited.

Rating rule. Must in every setting: a calculated staffing level for each shift, with any gap escalated.

GUIDANCE

Staffing is a calculation, not a habit. For each area and each shift, the facility works out how many staff, with which skills, are needed for the patients who are present. The calculation takes into account the number of patients, how dependent they are (acuity), and the care they need. It is reviewed when patient numbers or acuity change, and the calculation for the last four weeks is kept as evidence.

The rota is then compared with the calculation for each shift. If a shift runs below the calculated level, the gap is recorded on the gap record with the action taken and the person who was told. A recorded and escalated gap is a managed risk; an unrecorded gap is a safety failure. Staffing decisions are reviewed by the manager, and the skill mix (the balance of qualifications and experience on the shift) is considered as well as the number of staff.

WHAT GOOD LOOKS LIKE

- A written staffing calculation for each area and shift, showing the patients present, their acuity and the staff needed.
- A rota that matches the calculation, or a gap record for every shift that does not.
- A named manager who reviews the calculation when patient numbers or acuity change, and records the review.
- Staff with the skills the area needs, shown in the skill-mix section of the calculation.

COMMON MISTAKES

- Using the same roster for every week regardless of how many patients are admitted.
- Recording a gap without recording who was told or what was done.
- Counting staff on the rota who are on leave, sick or not trained for the area.
- Calculating once at opening and never reviewing it.

> **Why it matters.** Too few nurses for the number of patients, or too few with the right skills, leads to missed care and avoidable harm. Staffing should be calculated from real demand, not from habit.

WHAT THE ASSESSOR CHECKS

Sample. Take 5 shifts at random from the last month across the inpatient areas. For each shift, check the calculation, the rota and the gap record.

1 Staffing is calculated from patient volume and acuity.

Method. Check the calculation for each area for the last 4 weeks.

Evidence to show. Staffing calculation record (CLN-FRM-001)

Pass when. Every area has a calculation for each shift in the period.

2 Shifts run at or above the calculated level.

Method. Compare the rota with the calculation for each of the 5 shifts.

Evidence to show. Rota and calculation.

Pass when. At least 90% of the sampled shifts meet the calculated level.

3 Gaps are escalated.

Method. Check the gap record for each shift below the level.

Evidence to show. Gap record (CLN-FRM-001)

Pass when. Every gap has an action and an escalation recorded.

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

Immediate fail. A shift runs below the calculated level with no escalation recorded. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Type
CLN-FRM-001	Staffing calculation record	Form (record)

Related documents in the criterion record: CLN-POL-001, ID-FRM-001, ID-SOP-001, STD1-EL-06, STF-FRM-001, STF-SOP-001

POSITIONS RESPONSIBLE

Chief nursing officer (CNO) · Medical director · Head nurse / ward manager

REFERENCES FOR THIS CRITERION

- International Labour Organization (2014). HealthWISE: Work Improvement in Health Services – Action Manual. Geneva: ILO. https://news.gmj.ge/guideline/healthwise-work-improvement-in-health-services-action-manual/

1.2 Every Patient Gets a Structured Assessment

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

Applies to: all nine facility types. Each setting shows its rating above.

> **Criterion.** A structured clinical assessment happens on admission — an evaluation using a defined process, not a chart entry completed to satisfy documentation requirements — performed by a qualified individual, drawing in other relevant disciplines where the patient's presentation calls for it, and documented as required by organisational policy.

Rating rule. Must in every setting: a structured assessment on admission, with any gap recorded. In humanitarian settings this may be a triage-based assessment.

GUIDANCE

A structured assessment is a defined process: the same headings and the same steps for every admission, carried out by a qualified clinician and recorded on the admission assessment record (CLN-FRM-002). A chart entry written only to satisfy paperwork does not meet this criterion. The assessment covers the reason for admission, the current condition, the risks and the needs of the patient.

Where the patient's presentation needs another discipline (for example pharmacy, nutrition, mental health or physiotherapy), that input is requested and recorded. Emergency admissions are assessed as soon as clinical safety allows, with a senior check. In humanitarian settings a triage-based assessment is accepted, provided that a defined triage process (such as ETAT) is used and recorded.

WHAT GOOD LOOKS LIKE

- A defined admission assessment form (CLN-FRM-002) with the same headings for every admission.
- Evidence that the assessment is done by a qualified clinician, and that a senior person checks emergency admissions.
- Input from other disciplines recorded where the patient needed it.
- For humanitarian settings, a triage record that shows the triage category and the reason for it.

COMMON MISTAKES

- Completing the form after the patient has left the ward.
- Leaving sections blank without a reason.
- Using a copied assessment from a previous patient.
- Treating an emergency admission as routine and skipping the senior check.

> **Why it matters.** A patient who is admitted without a structured assessment may have a problem missed until it is serious. A defined assessment on admission gives every patient the same thorough start.

WHAT THE ASSESSOR CHECKS

Sample. Take 20 admissions from the last month, including 5 emergency admissions. Check each admission assessment for the defined process and the senior check.

1 Every patient has a structured assessment on admission.

Method. Check the admission assessment record for each of the 20 admissions.

Evidence to show. Admission assessment record (CLN-FRM-002)

Pass when. At least 90% of admissions have a complete structured assessment within the set time.

2 The assessment is done by a qualified clinician.

Method. Check the name and role of the assessor on each record.

Evidence to show. Admission assessment record.

Pass when. Every assessment names a qualified clinician.

3 Other disciplines are involved where the presentation requires it.

Method. Check the records where the presentation called for another discipline.

Evidence to show. Admission assessment record.

Pass when. Every case that required another discipline has their input recorded.

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

Immediate fail. A patient is admitted with no structured assessment. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Type
CLN-FRM-002	Admission assessment record	Form (record)

Related documents in the criterion record: CLN-SOP-001, HH-FRM-001, HH-POL-001, HH-SOP-001, STD1-EL-05

POSITIONS RESPONSIBLE

Registered nurse · Consultant physician (internal medicine) · Emergency physician · Medical officer on duty (night)

REFERENCES FOR THIS CRITERION

- World Health Organization (2017). Hospital Safety Index: Guide for Evaluators, second edition. Geneva: WHO. https://news.gmj.ge/guideline/hospital-safety-index-guide-for-evaluators-2nd-ed/
- World Health Organization. Emergency Triage Assessment and Treatment (ETAT): Manual for Participants. Geneva: WHO. https://news.gmj.ge/guideline/emergency-triage-assessment-and-treatment-etat-manual-for-participants/
- National Institute for Health and Care Excellence (2019). Acutely ill adults in hospital: recognising and responding to deterioration (CG50). London: NICE. https://news.gmj.ge/guideline/acutely-ill-adults-in-hospital-recognising-and-responding-to-deterioration/

1.3 There is an Actual Care Plan

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

Applies to: all nine facility types. Each setting shows its rating above.

> **Criterion.** A documented, individualised care plan guides treatment — built from the patient's specific assessment, not a generic template applied regardless of their particular situation — states the goals or desired results of treatment, and involves the patient, and family when appropriate, in setting it.

Rating rule. Minimum in humanitarian settings: a short care plan with the priority needs, drawn from the assessment.

GUIDANCE

A care plan is written for each patient from that patient's own assessment. It states what the treatment is trying to achieve (the goals), what each team member will do, and when the plan will be reviewed. A plan copied from a template without changes does not meet this criterion, even if it is complete on paper.

The patient is involved in setting the goals. The family is involved when the patient wishes it or when the patient cannot take part in the decision, and the reason is recorded. The plan is updated when the patient's condition changes, and each update is dated and signed. In humanitarian settings a short plan with the priority needs is acceptable, as stated in the setting rule above.

WHAT GOOD LOOKS LIKE

- An individual care plan (CLN-FRM-003) built from the assessment for each patient, dated on the first day of care.
- Goals stated in terms the patient can understand, with a review date.
- A record of the patient's own view, and the family's role where the patient wants it.
- Updates dated and signed whenever the condition changes.

COMMON MISTAKES

- A template care plan that is not changed for the patient.
- Goals such as 'stable' or 'comfortable' with no way to measure them.
- A plan that exists only in the file and is not used by the ward team.
- No plan at all for patients who stay more than one day.

> **Why it matters.** A care plan that is generic does not fit the patient, and it guides nobody. An individual plan, built from the assessment and updated as the patient changes, is what makes treatment work.

WHAT THE ASSESSOR CHECKS

Sample. Take 20 inpatients who have stayed more than 24 hours. Check each individual care plan for the assessment link, the goals and the patient involvement.

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1 Each patient has an individual care plan.

Method. Check the care plan record for each of the 20 patients.

Evidence to show. Individual care plan (CLN-FRM-003)

Pass when. Every patient has a care plan by day 1.

2 **The plan states goals and is built from the patient's own assessment.**

Method. Check each plan for goals and the link to the assessment.

Evidence to show. Individual care plan.

Pass when. At least 90% of plans have goals and a link to the assessment.

3 **The patient, and family where appropriate, take part.**

Method. Check for the patient's view in each plan.

Evidence to show. Individual care plan.

Pass when. At least 90% of plans record the patient's involvement.

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

Immediate fail. A patient has no individual care plan after the first day of care. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Type
CLN-FRM-003	Individual care plan	Form (record)

Related documents in the criterion record: CLN-SOP-002, CON-FRM-001, CON-SOP-001

POSITIONS RESPONSIBLE

Registered nurse · Nurse specialist · Advanced practice nurse / nurse practitioner · Head nurse / ward manager

REFERENCES FOR THIS CRITERION

- World Health Organization (2020). Medication safety in transitions of care. Geneva: WHO. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/

1.4 Restraint and Seclusion Use Is Governed and Minimised

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

Applies to: 4 of 9 facility types: Hospital, Ambulatory clinic, Long-term care, Home care. **Not applicable to:** Primary health clinic, Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Physical or chemical restraint and seclusion are used only under a defined protocol, as a last resort, time-limited, monitored, and documented — never as a routine or convenience practice.

Rating rule. Must in every setting: restraint or seclusion only on a clinical order, with a time limit and a review.

GUIDANCE

Restraint and seclusion are the most restrictive interventions a facility can use. They are a last resort. They may be used only under the written protocol (CLN-POL-002), on a clinical order, for the shortest time needed to manage an immediate risk. Before use, less restrictive options (such as talking, reassurance, a change of environment or closer observation) are tried and recorded.

Each use is monitored and the person is released as soon as the risk has passed. Every use is recorded on the restraint and seclusion record (CLN-FRM-004). For older people, the WHO guidance is that physical restraints should be avoided. Staff who may use these measures are trained in the protocol (course STD1-EL-01).

WHAT GOOD LOOKS LIKE

- A written restraint and seclusion protocol (CLN-POL-002) approved by the clinical lead.
- A clinical order for each use, with a stated time limit.
- A record of the less restrictive options tried first (CLN-FRM-004).
- Monitoring entries during use and a record of release.

COMMON MISTAKES

- Using restraint for staff convenience or to manage a noisy ward.
- Orders that are verbal and never written up.
- Continuing use after the time limit without a new review.
- No record of when the person was released.

> **Why it matters.** Restraint and seclusion can cause injury, distress and death, and they are often used for the convenience of staff. A protocol that treats them as a last resort, time-limited and monitored, protects the patient.

WHAT THE ASSESSOR CHECKS

Sample. Review all restraint and seclusion records for the last 3 months, and the monthly review for each.

1 Each use follows the protocol and is ordered for a time limit.

Method. Check each record for the order and the time limit.

Evidence to show. Restraint and seclusion record (CLN-FRM-004)

Pass when. Every use has an order and a time limit.

2 A less restrictive option is recorded as tried first.

Method. Check each record for the less restrictive options.

Evidence to show. Restraint and seclusion record.

Pass when. Every use has the options recorded.

3 Each use is monitored and released when the risk passes.

Method. Check the monitoring checks and the release time.

Evidence to show. Restraint and seclusion record.

Pass when. Every use has monitoring checks and a release time.

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

Immediate fail. Restraint or seclusion is used with no order, or continues past its time limit. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Type
CLN-FRM-004	Restraint and seclusion record	Form (record)

Related documents in the criterion record: CLN-POL-002, PSF-FRM-001, PSF-FRM-002, PSF-SOP-001, STD1-EL-01

POSITIONS RESPONSIBLE

Mental health nurse · Psychiatrist · Clinical lead (hospital)

REFERENCES FOR THIS CRITERION

- World Health Organization (2021). Step Safely: strategies for preventing and managing falls across the life-course. Geneva: WHO. https://news.gmj.ge/guideline/step-safely-strategies-for-preventing-and-managing-falls-across-the-life-course/
- National Institute for Health and Care Excellence (2025). Falls: assessment and prevention in older people and in people 50 and over at higher risk. London: NICE. https://news.gmj.ge/guideline/falls-assessment-and-prevention-in-older-people-and-in-people-50-and-over-at-higher-risk/
- World Health Organization (2024). Long-term care for older people: package for universal health coverage. Geneva: WHO. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/

1.5 Nutrition and Therapeutic Diet Needs Are Actively Managed

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

Applies to: 5 of 9 facility types: Hospital, Ambulatory clinic, Primary health clinic, Long-term care, Home care. **Not applicable to:** Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Patients are screened for nutritional risk, therapeutic diets are correctly identified and delivered, and food handling meets basic safety standards — nutrition treated as part of clinical care, not a hospitality afterthought.

Rating rule. Minimum in humanitarian settings: nutrition screening on admission and food safety checks on the food served.

GUIDANCE

Each patient is screened for nutritional risk on admission using the nutrition risk screen (CLN-FRM-005). A patient at risk is assessed in more detail and a nutrition plan is written into the care plan. Therapeutic diets must match the medical order, and the diet order and tray record shows what was prescribed and what was served.

Food safety is part of nutrition care. Food temperatures are recorded on the sample days, and the records are kept with the screening records. For older people in long-term care, the WHO guidance on nutrition care applies.

WHAT GOOD LOOKS LIKE

- A nutrition risk screen (CLN-FRM-005) completed for every patient on admission.
- A diet order that matches the medical order, and a tray record for the sample days.
- Food temperature records for the sample days, kept with the screening records.
- A nutrition plan in the care plan for each patient at risk.

COMMON MISTAKES

- Screening only patients who ask for food.
- Serving a therapeutic diet that does not match the order.
- Recording food temperatures after the food has been served rather than before.
- Leaving the screening result out of the care plan.

> **Why it matters.** Poor nutrition slows healing and raises the risk of complications. Screening patients for nutritional risk, and delivering the right diet, is a simple step that changes outcomes.

WHAT THE ASSESSOR CHECKS

Sample. Take 20 inpatients from the last month. Check the nutrition screen, the diet on the order and the food safety record for 5 days.

1 Each patient is screened for nutritional risk on admission.

Method. Check the nutrition screen for each of the 20 patients.

Evidence to show. Nutrition risk screen record (CLN-FRM-005)

Pass when. At least 90% of patients have a screen on admission.

2 Therapeutic diets are delivered as ordered.

Method. Compare the diet on the order with the tray for each patient on the sample days.

Evidence to show. Diet order and tray record.

Pass when. At least 90% of therapeutic diets match the order.

3 Food handling meets basic safety standards.

Method. Check the food temperature and hygiene record on the sample days.

Evidence to show. Food safety record.

Pass when. Every sampled delivery has its temperature recorded and in range.

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

Immediate fail. A patient at nutritional risk has no screen, or receives a diet different from the order. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Type
CLN-FRM-005	Nutrition risk screen record	Form (record)

Related documents in the criterion record: CLN-SOP-003, CON-FRM-002, CON-POL-002, STD1-EL-02

POSITIONS RESPONSIBLE

Dietitian / nutritionist · Dietary aide (patient meals)

REFERENCES FOR THIS CRITERION

- World Health Organization (2024). Long-term care for older people: package for universal health coverage. Geneva: WHO. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/

1.6 Pressure Injury Risk Is Assessed and Actively Prevented

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

Applies to: 3 of 9 facility types: Hospital, Long-term care, Home care. **Not applicable to:** Ambulatory clinic, Primary health clinic, Telemedicine, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Every patient is assessed for pressure injury risk on admission and periodically thereafter, with a specific, documented prevention plan for at-risk patients — repositioning schedules, appropriate surfaces — not addressed only after an injury has already developed.

Rating rule. Minimum in humanitarian settings: a risk assessment on admission and a repositioning plan for at-risk patients.

GUIDANCE

Every patient is assessed for pressure injury risk on admission and again at set intervals (CLN-FRM-006). A patient at risk has a written prevention plan that includes repositioning, pressure-relieving equipment where needed, and nutrition and hydration support. The plan is part of the individual care plan (1.3).

Skin checks are recorded. Any change in the skin is reported and acted on the same shift. Staff are trained to recognise early signs of damage (course STD1-EL-03).

WHAT GOOD LOOKS LIKE

- A pressure injury risk assessment (CLN-FRM-006) on admission and at set intervals.
- A written prevention plan for each patient at risk, linked to the care plan.
- Skin check records with the date and the person who checked.
- Evidence that changes in the skin are reported and acted on the same shift.

COMMON MISTAKES

- Assessing the risk once on admission and never again.
- Writing a prevention plan but not carrying it out (for example, repositioning not recorded).
- Recording skin checks with no findings on patients who are plainly at risk.
- Delaying the report of a skin change to the next day.

> **Why it matters.** Pressure injuries develop in hours on a patient who cannot move, and they are among the most preventable harms in hospital. Assessing risk on admission and repeating it, with a plan, prevents them.

WHAT THE ASSESSOR CHECKS

Sample. Take 20 patients from the last month, including 5 at risk. Check the admission assessment, the repositioning record and the skin checks.

1 **Each patient is assessed for pressure injury risk on admission.**

Method. Check the risk assessment for each of the 20 patients.

Evidence to show. Pressure injury risk record (CLN-FRM-006)

Pass when. At least 90% of patients have a risk assessment on admission.

2 **Each at-risk patient has a written prevention plan.**

Method. Check each at-risk patient for the repositioning schedule and surface.

Evidence to show. Pressure injury prevention record.

Pass when. Every at-risk patient has a plan.

3 **Skin checks are done and changes are reported the same shift.**

Method. Check the skin check record for the at-risk patients.

Evidence to show. Skin check record.

Pass when. At least 90% of skin checks are recorded, and every change is reported.

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

Immediate fail. A pressure injury develops in an at-risk patient with no prevention plan in place. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Type
CLN-FRM-006	Pressure injury risk and prevention record	Form (record)

Related documents in the criterion record: CLN-SOP-004, EMG-FRM-001, EMG-FRM-002, EMG-SOP-001, STD1-EL-03

POSITIONS RESPONSIBLE

Stoma and wound care nurse · Registered nurse · Health care assistant / nursing aide · Geriatrician

REFERENCES FOR THIS CRITERION

- National Institute for Health and Care Excellence (2014). Pressure ulcers: prevention and management (CG179). London: NICE. https://news.gmj.ge/guideline/pressure-ulcers-prevention-and-management/

1.7 VTE Risk Is Assessed Before Every Admission and Procedure

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

Applies to: 3 of 9 facility types: Hospital, Ambulatory clinic, Long-term care. **Not applicable to:** Primary health clinic, Telemedicine, Home care, Fitness and wellness, Dental clinic, Aesthetic and procedure clinic. Each setting shows its rating above.

> **Criterion.** Every patient is assessed for venous thromboembolism risk at admission and before surgical procedures, with appropriate prophylaxis — pharmacological or mechanical — prescribed and administered for at-risk patients, not left as a general awareness that blood clots are a possible complication.

Rating rule. Must in every setting: VTE risk assessed on admission and before surgery, with prophylaxis for at-risk patients by the locally agreed protocol.

GUIDANCE

Every patient is assessed for the risk of venous thromboembolism (VTE: deep vein thrombosis or pulmonary embolism) on admission and before surgery (CLN-FRM-007). A patient at risk has prophylaxis (medicine given to prevent clots) prescribed under the locally agreed protocol (CLN-SOP-005). If prophylaxis is not prescribed, the reason is recorded.

Doses given are recorded on the medicine administration record. The NICE guideline (2019) is the reference for the risk assessment and for prophylaxis. Staff who prescribe or give prophylaxis are trained (course STD1-EL-04).

WHAT GOOD LOOKS LIKE

- A VTE risk assessment (CLN-FRM-007) on admission and before every operation.
- Prescribed prophylaxis for each at-risk patient, or a recorded reason why it was not prescribed.
- A medicine administration record showing the doses given.
- A locally agreed prophylaxis protocol (CLN-SOP-005) that staff know.

COMMON MISTAKES

- Assessing only surgical patients and missing medical patients at risk.
- Prescribing prophylaxis with no record of the doses given.
- Skipping the risk assessment before surgery because the patient is booked as a day case.
- Using a protocol copied from another hospital without adapting it.

> **Why it matters.** Blood clots in the legs that reach the lungs can kill a patient who looked well. Assessing every patient before admission and before surgery, and preventing clots in those at risk, is one of the most effective safety measures.

WHAT THE ASSESSOR CHECKS

Sample. Take 20 admissions from the last month, including 10 surgical patients. Check the clot risk assessment and the prophylaxis record.

1 Each patient is assessed for clot risk on admission and before surgery.

Method. Check the assessment for each patient and each surgical procedure in the sample.

Evidence to show. VTE risk assessment record (CLN-FRM-007)

Pass when. At least 90% of assessments are done on admission and before surgery.

2 At-risk patients have prophylaxis prescribed.

Method. Check the prescription for each at-risk patient.

Evidence to show. Prescription and VTE record.

Pass when. Every at-risk patient has prophylaxis prescribed, or a reason recorded.

3 Prophylaxis is given as prescribed.

Method. Check the medicine administration record for each at-risk patient.

Evidence to show. Medicine administration record.

Pass when. At least 90% of prescribed doses are recorded as given.

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

Immediate fail. An at-risk patient has no prophylaxis and no recorded reason. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Type
CLN-FRM-007	VTE risk assessment record	Form (record)

Related documents in the criterion record: CLN-SOP-005, CON-POL-001, STD1-EL-04

POSITIONS RESPONSIBLE

Consultant physician (internal medicine) · Surgeon (general surgery) · Anaesthesiologist · Medical officer on duty (night)

REFERENCES FOR THIS CRITERION

- National Institute for Health and Care Excellence (2019). Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism (NG89). London: NICE. https://news.gmj.ge/guideline/venous-thromboembolism-in-over-16s-reducing-the-risk-of-hospital-acquired-deep-vein-thrombosis-or-pulmonary-embolism/

10 Questions and answers

Do I need to meet all seven criteria?
Yes. Standard 1 is the base standard and every facility meets it. Each criterion has its own pass rule and immediate-fail rule, so each one must be met on its own.

What is an immediate fail?
An immediate fail is one event that means the criterion is not met, even if everything else passes. For example, a shift that runs below the calculated level with no escalation fails 1.1, and a patient admitted with no structured assessment fails 1.2. Each criterion lists its own immediate fail.

Which documents do I submit?
The forms listed under each criterion. Registers and records are Excel, one row per record. Policies and procedures are signed PDFs with version, date, owner and approver. Upload them through the facility portal before the survey, and make sure they cover the period stated in each criterion.

What is the staffing calculation record and what goes in it?
It is the Staffing calculation record (CLN-FRM-001). Record the calculation for each area and each shift, for the last 4 weeks, signed by the manager. Each shift below the calculated level needs a gap record with an escalation, and the gap record is part of the same evidence.

What counts as a structured assessment on admission?
A defined process carried out by a qualified person, not a chart entry made only to satisfy paperwork. Other disciplines take part where the patient needs them, and their input is recorded. The admission record is kept on the Admission assessment record (CLN-FRM-002).

What should an individual care plan contain?
It must be built from the patient's own assessment, state the goals, and record the patient's involvement. Every patient has a plan by day 1 of care. The form is the Individual care plan (CLN-FRM-003).

What are the rules for restraint and seclusion?
Use only under a defined protocol, as a last resort, for a set time, with monitoring and a release when the risk has passed. Each use needs an order and a time limit, and the less restrictive options tried first must be recorded. The record is kept on the Restraint and seclusion record (CLN-FRM-004).

How is nutrition checked?
Each patient is screened for nutritional risk on admission (Nutrition risk screen record, CLN-FRM-005). Therapeutic diets must match the order, and food temperatures are recorded on the sample days.

How do we prevent pressure injuries?
Every patient is assessed for pressure injury risk on admission and again periodically (Pressure injury risk record, CLN-FRM-006). Each at-risk patient has a written prevention plan, and skin checks are done with any change reported the same shift.

How is VTE risk handled?
Every patient is assessed for clot risk on admission and before surgery (VTE risk assessment record, CLN-FRM-007). At-risk patients have prophylaxis prescribed, or a reason recorded, and doses given are recorded.

What if we do not have the written protocol yet?
A criterion that asks for a defined protocol needs an approved protocol. A draft does not meet it. Complete and approve the protocol first, and then collect the records for the period.

What do the colours mean?
Red means Must: required in every setting. Criteria that can directly affect a patient's life are always Must, in

humanitarian, transition and standard settings, and no setting lowers them. Green means Medium: required, adapted to a transition setting. Yellow means Minimum: the lowest acceptable level in a humanitarian setting, where a facility cannot do everything. Each standard has at least one Must in humanitarian settings and at least one in transition settings. In standard settings, every criterion is Must. The same colours apply to training: red is essential, green recommended, yellow optional. Each course and role shows its level for each setting.

Do we have to use your forms and policies?
No. Everything here is a reference draft. Use it as a starting point, adapt it to your hospital, or upload your own. The assessor checks whether the standard is met and whether your documents show how.

What does essential or recommended training mean for my staff?
Essential training must be completed by the people named in the role table. Recommended training is good practice and is not checked as a requirement. Optional training may be used for development. The level depends on your setting: humanitarian settings have fewer essential courses than standard settings.

Do we have to use ISCO-08 codes?
Yes, for staff records. Each role carries its ISCO-08 code, and the national job title and licence are kept beside it. The Health Occupations Map explains how to choose a code.

Which training do staff need?
Each role lists its training in the staff table, marked must or recommended. Courses already on the GMJ Academy are linked. The staffing and skill-mix course is in development and will be announced when it is ready.

What will the surveyor do on the ground?
The sample and checks are set out for each criterion. The surveyor reads the records, checks what happens on the ward, and asks staff to explain their process. The sample size is given in each criterion, so you can prepare in advance.

Where can I get the full text?
The full text is on this page. A PDF download of Standard 1 is in development and will be added here.

Who can I ask about this standard?
Use the contact page: https://france-asf.fr/contact-en/ .

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

11 References

CITED FOR CRITERIA

1. International Labour Organization (2014). HealthWISE: Work Improvement in Health Services – Action Manual. Geneva: ILO. https://news.gmj.ge/guideline/healthwise-work-improvement-in-health-services-action-manual/ (criterion 1.1)
2. World Health Organization (2017). Hospital Safety Index: Guide for Evaluators, second edition. Geneva: WHO. https://news.gmj.ge/guideline/hospital-safety-index-guide-for-evaluators-2nd-ed/ (criterion 1.2)
3. World Health Organization. Emergency Triage Assessment and Treatment (ETAT): Manual for Participants. Geneva: WHO. https://news.gmj.ge/guideline/emergency-triage-assessment-and-treatment-etat-manual-for-participants/ (criterion 1.2)
4. National Institute for Health and Care Excellence (2019). Acutely ill adults in hospital: recognising and responding to deterioration (CG50). London: NICE. https://news.gmj.ge/guideline/acutely-ill-adults-in-hospital-recognising-and-responding-to-deterioration/ (criterion 1.2)
5. World Health Organization (2020). Medication safety in transitions of care. Geneva: WHO. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/ (criterion 1.3)
6. World Health Organization (2021). Step Safely: strategies for preventing and managing falls across the life-course. Geneva: WHO. https://news.gmj.ge/guideline/step-safely-strategies-for-preventing-and-managing-falls-across-the-life-course/ (criterion 1.4)
7. National Institute for Health and Care Excellence (2025). Falls: assessment and prevention in older people and in people 50 and over at higher risk. London: NICE. https://news.gmj.ge/guideline/falls-assessment-and-prevention-in-older-people-and-in-people-50-and-over-at-higher-risk/ (criterion 1.4)
8. World Health Organization (2024). Long-term care for older people: package for universal health coverage. Geneva: WHO. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/ (criterion 1.4)
9. World Health Organization (2024). Long-term care for older people: package for universal health coverage. Geneva: WHO. https://news.gmj.ge/guideline/long-term-care-for-older-people-package-for-universal-health-coverage/ (criterion 1.5)
10. National Institute for Health and Care Excellence (2014). Pressure ulcers: prevention and management (CG179). London: NICE. https://news.gmj.ge/guideline/pressure-ulcers-prevention-and-management/ (criterion 1.6)
11. National Institute for Health and Care Excellence (2019). Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism (NG89). London: NICE. https://news.gmj.ge/guideline/venous-thromboembolism-in-over-16s-reducing-the-risk-of-hospital-acquired-deep-vein-thrombosis-or-pulmonary-embolism/ (criterion 1.7)

FURTHER READING FOR STANDARD 1

1. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). US Department of Health and Human Services, Office of Minority Health. https://news.gmj.ge/guideline/national-clas-standards-culturally-linguistically-appropriate-services/
2. Assessment of infection prevention and control practices for COVID-19 isolation areas in healthcare facilities. Pan American Health Organization. https://news.gmj.ge/guideline/assessment-of-infection-prevention-and-control-practices-for-covid-19-isolation-areas-in-healthcare-facilities/
3. Living systematic review of therapeutic options for post COVID-19 condition, 11 January 2023. Pan American Health Organization. https://news.gmj.ge/guideline/living-systematic-review-of-therapeutic-options-for-post-covid-

19-condition-11-january-2023/

4. Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care, 2nd ed. Geneva: WHO. https://news.gmj.ge/guideline/integrated-care-for-older-people-icope-guidance-for-person-centred-assessment-and-pathways-in-primary-care-2nd-ed/
5. World Health Organization QualityRights (2019). Ending seclusion and restraint. Geneva: WHO. https://news.gmj.ge/guideline/who-qualityrights-ending-seclusion-restraint-2019/
6. Tool for promoting culturally safe childbirth: basic manual. Pan American Health Organization. https://news.gmj.ge/guideline/tool-for-promoting-culturally-safe-childbirth-basic-manual/

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 1, 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
CLN-FRM-001	Staffing calculation record	Form (record)	1.1
CLN-FRM-002	Admission assessment record	Form (record)	1.2
CLN-FRM-003	Individual care plan	Form (record)	1.3
CLN-FRM-004	Restraint and seclusion record	Form (record)	1.4
CLN-FRM-005	Nutrition risk screen record	Form (record)	1.5
CLN-FRM-006	Pressure injury risk and prevention record	Form (record)	1.6
CLN-FRM-007	VTE risk assessment record	Form (record)	1.7
CLN-POL-001	Staffing levels and skill mix	Policy	1.1
CLN-POL-002	Restraint and seclusion	Policy	1.4
CLN-SOP-001	Structured clinical assessment on admission	Procedure (SOP)	1.2
CLN-SOP-002	Individualised care planning	Procedure (SOP)	1.3
CLN-SOP-003	Nutritional risk screening and therapeutic diets	Procedure (SOP)	1.5
CLN-SOP-004	Pressure injury risk assessment and prevention	Procedure (SOP)	1.6
CLN-SOP-005	Venous thromboembolism risk assessment and prophylaxis	Procedure (SOP)	1.7
CON-FRM-001	Consent record	Form (record)	1.3
CON-FRM-002	Reasonable adjustments record	Form (record)	1.5
CON-POL-001	Patient rights and responsibilities	Policy	1.7
CON-POL-002	Non-discrimination and equal access to care	Policy	1.5
CON-SOP-001	Informed consent before significant care	Procedure (SOP)	1.3
EMG-FRM-001	Fire equipment test log	Form (record)	1.6
EMG-FRM-002	Fire drill record	Form (record)	1.6
EMG-SOP-001	Fire safety and evacuation	Procedure (SOP)	1.6
HH-FRM-001	Hand hygiene observation audit tool	Form (record)	1.2
HH-POL-001	Hand hygiene policy	Policy	1.2
HH-SOP-001	Hand hygiene at the point of care	Procedure (SOP)	1.2

Code	Document	Type	Criteria
ID-FRM-001	Patient identification check log	Form (record)	1.1
ID-SOP-001	Patient identification and specimen labelling	Procedure (SOP)	1.1
PSF-FRM-001	Falls log	Form (record)	1.4
PSF-FRM-002	Falls risk assessment tool	Form (record)	1.4
PSF-SOP-001	Falls risk assessment and prevention	Procedure (SOP)	1.4
STF-FRM-001	Staff verification register	Form (record)	1.1
STF-SOP-001	Staff credential verification and recheck	Procedure (SOP)	1.1