ACCRÉDITATION SANS FRONTIÈRES (ASF)
NON-GOVERNMENTAL, NON-PROFIT

ASF Health Standards Version 11

Standard 29: Hospital Emergency Department

Applies to hospital emergency departments

DOCUMENT NUMBER	ASF-HS11-S29
REVISION	01
DATE OF THIS REVISION	1 November 2026
STATUS	Approved for use.
OWNER	Accréditation Sans Frontières (ASF)
APPROVED BY	Approved.
APPLIES TO SURVEYS STARTING AFTER	Not applicable until approved
REVIEW	Every year, or earlier if the law, a cited guideline or the standard itself changes. Next scheduled review: 1 November 2027.
CONTROLLED COPY	The copy on france-asf.fr is the controlling copy. A printed copy is valid only for the version shown on its cover.

REVISION HISTORY

Revision	Date	Change	Approved by
01	1 November 2026	First version, from the Version 10 emergency standard, renumbered as Standard 29. Approved.	Prof. Giorgi Pkhakadze, MD, MPH, PhD

APPROVAL

Approved on 1 November 2026. Approved for use in surveys.

APPROVED BY

Prof. Giorgi Pkhakadze, MD, MPH, PhD
President, Accréditation Sans Frontières
Date: 1 November 2026

Complete on its own, without internet access. References are listed in section 12. The current version is at france-asf.fr.

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1 Introduction

This document is Standard 29 of ASF Health Standards. It sets out how a hospital emergency department triages every arrival, keeps its resuscitation area ready, names a senior clinician responsible at all times, records and hands over each decision to admit, transfer or discharge, and follows up patients who leave before assessment.

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 29 protects patients who come to the emergency department at any time, often when they are most unwell and without an appointment. A department that triages on arrival, keeps its resuscitation area ready and records its decisions gives each patient the first and most important care in the right order.

Who should read it. Hospital managers, the head of the emergency department, emergency physicians and nurses, triage staff, the secretary who keeps the registers, and the assessors who verify the department. 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 29 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 are a hospital manager or a member of the emergency department team, read section 4 to confirm that the standard applies to your department, then section 5 to find the rating for your setting. Read each criterion from 29.1 to 29.5, 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, and 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 ED-POL-001 (emergency department, policy, 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 13.

4 Scope

Standard 29 covers the hospital emergency department: triage on arrival, resuscitation readiness, senior clinician responsibility, decisions to admit, transfer or discharge with their handover, and patients who leave before assessment.

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 29 APPLIES

Standard 29 applies to hospital emergency departments that receive patients arriving at any time, including those who come without an appointment. It is not applicable to ambulatory clinics, aesthetic and procedure clinics, primary health clinics, long-term care, telemedicine, home care, fitness and wellness, or dental clinics. A criterion is marked N/A for a facility type that does not provide emergency care.

Criterion	Applies to
29.1 Every Arrival Is Triaged Before Waiting	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic
29.2 Resuscitation Area Is Always Ready	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic
29.3 A Senior Clinician Is Responsible at All Times	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic
29.4 Decisions to Admit, Transfer or Discharge Are Recorded and Handed Over	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic
29.5 Patients Who Leave Before Assessment Are Recorded and Followed Up	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental 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
ED	Emergency department
ETAT	Emergency Triage Assessment and Treatment (WHO)
ISCO	International Standard Classification of Occupations (ISCO-08), used to code each role
ISO	International Organization for Standardization
RCEM	Royal College of Emergency Medicine
WHO	World Health Organization

DOCUMENT CODE PREFIXES

Prefix	Topic
ED	Hospital emergency department

7 Terms and definitions

Term	Definition
Triage	The sorting of patients on arrival by urgency, so that the most urgent are seen first.
Recognised triage scale	A triage tool used in emergency care, named in the department's triage procedure.
Resuscitation area	The place in the emergency department where a patient in cardiac arrest or immediate threat to life is treated.
Senior clinician	The doctor or clinician responsible for the emergency department at a given time.
Disposition decision	The decision to admit, transfer or discharge a patient, recorded with its reason.
Left before assessment	A patient who leaves the department before being assessed or treated.

8 Standard 29 at a glance: criteria, responsibilities, training

Standard 29: Hospital Emergency Department is a standard of ASF Health Standards for the hospital emergency department. It applies to emergency departments that receive patients arriving at any time, including those who come without an appointment. It covers triage on arrival, resuscitation readiness, senior clinician responsibility, decisions to admit, transfer or discharge, and patients who leave before assessment.

The standard has 5 criteria. Each is shown below and explained on its own page in section 9. Each criterion states its own rating for each setting, its evidence and its pass rule.

8.1 CRITERIA AND RATINGS

No.	Criterion	Humanitarian	Transition	Standard
29.1	Every Arrival Is Triaged Before Waiting	Must	Must	Must
29.2	Resuscitation Area Is Always Ready	Must	Must	Must
29.3	A Senior Clinician Is Responsible at All Times	Minimum	Must	Must
29.4	Decisions to Admit, Transfer or Discharge Are Recorded and Handed Over	Minimum	Medium	Must
29.5	Patients Who Leave Before Assessment Are Recorded and Followed Up	Minimum	Medium	Must

8.2 RESPONSIBILITIES

Each criterion names the positions responsible for it. Each position should have written terms of reference.

No.	Criterion	Positions responsible or involved
29.1	Every Arrival Is Triaged Before Waiting	Triage nurse (ISCO 2221) · Head of emergency department (ISCO 1342)
29.2	Resuscitation Area Is Always Ready	Head of emergency department (ISCO 1342) · Emergency nurse (ISCO 2221)
29.3	A Senior Clinician Is Responsible at All Times	Emergency physician (ISCO 2212) · Head of emergency department (ISCO 1342)
29.4	Decisions to Admit, Transfer or Discharge Are Recorded and Handed Over	Emergency physician (ISCO 2212) · Emergency nurse (ISCO 2221)
29.5	Patients Who Leave Before Assessment Are Recorded and Followed Up	Triage nurse (ISCO 2221) · Patient services manager (ISCO 1342)

Reporting lines. The reporting line and supervision of each role are taken from the ASF terms of reference for that role, published on france-asf.fr. For this standard the manager is the head of the emergency department. A hospital with a different structure records its own reporting lines in its organogram.

Role	Reports to	Supervises
Head of emergency department	Medical director	Triage nurses, emergency nurses.
Emergency physician	Head of department (per specialty)	No direct reports.
Emergency nurse	Head of department (per specialty)	No direct reports.
Triage nurse	Head of emergency department	No direct reports.
Patient services manager	Chief operating officer (COO)	Admissions officer, receptionist, appointments clerk, medical records manager, bed manager.

8.3 E-LEARNING

The e-learning courses for this standard, who must take each one, who is recommended to take it, and the criteria it supports, are listed in section 11.

8.4 RELATED COURSES IN THE GMJ ACADEMY

No related GMJ Academy courses are listed for this standard.

29.1 Every Arrival Is Triaged Before Waiting

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

Applies to: 1 of 9 facility types: Hospital. **Not applicable to:** Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic. Each setting shows its rating above.

> **Criterion.** Every patient arriving at the emergency department is triaged on arrival by a trained clinician, using a recognised triage scale. The triage category decides the maximum time to clinical assessment.

Rating rule. Must in every setting. Triage on arrival protects life, so it is never adapted to resources.

GUIDANCE

Triage is the first clinical decision for every person who comes to the emergency department. A trained clinician assesses each arrival on a recognised triage scale, and the category decides how soon the patient must be seen.

Triage happens on arrival, before the patient waits. A patient who arrives by ambulance or walks in is triaged in the same way, and the triage record is completed at the time of the assessment, not later.

> **Good practice.** Every arrival is triaged by a trained clinician, the category and time are recorded, and the maximum time to assessment is set for each category and met.

> **Partial because.** Triage happens for most arrivals, but some patients wait without triage, or the category and time are not recorded consistently.

WHAT GOOD LOOKS LIKE

- A triage procedure (**ED-SOP-001**) that names the scale in use and who may triage.
- A triage record (**ED-FRM-003**) completed for each attendance, with category and time.
- Triage completed before the patient is asked to wait, in every shift, including nights and weekends.
- Regular review of triage times against the maximum time for each category.

COMMON MISTAKES

- Triage done only on busy shifts, or by staff who have not been trained in the scale.
- Triage recorded on paper and not filed, so the time cannot be checked.
- A patient who looks well is not triaged, or is triaged without a recorded category.
- Maximum times for each category are not set, so the triage category has no effect.

> **Why it matters.** In the emergency department, the patient who looks well may be the one who is most ill. Triage on arrival, by a trained person with a recognised tool, puts the sickest first.

WHAT THE ASSESSOR CHECKS

Sample. Review arrival and triage records for 30 emergency department attendances across three shifts, including night and weekend.

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1 Every arrival is triaged before waiting.

Method. Check the arrival and triage records for each attendance in the sample.

Evidence to show. Triage record and log (**ED-FRM-003**).

Pass when. Triage category and time of triage are recorded for every attendance in the sample.

2 Triage is carried out by a trained clinician on a recognised scale.

Method. Check the training record of each clinician who triaged in the sample, and the scale named in the procedure.

Evidence to show. Emergency triage; training records (**ED-SOP-001**).

Pass when. Every clinician who triaged is trained in the named scale.

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

Immediate fail. A patient with chest pain waits three hours in the waiting room without triage. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
ED-SOP-001	Emergency triage	Head of emergency department (ISCO 1342)	Chief executive (ISCO 1120)	Head of emergency department (ISCO 1342)
ED-FRM-003	Triage record and log	Head of emergency department (ISCO 1342)	Chief executive (ISCO 1120)	Secretary (ISCO 3344)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Triage nurse (ISCO 2221)	Carries out triage on arrival	Safety & Emergency Preparedness (H-05) Essential
Head of emergency department (ISCO 1342)	Accountable for the triage procedure and its review	Safety & Emergency Preparedness (H-05) Essential

REFERENCES FOR THIS CRITERION

- WHO (2021). Emergency Triage Assessment and Treatment (ETAT): Manual for Participants. Child-specific (ETAT). https://news.gmj.ge/guideline/emergency-triage-assessment-and-treatment-etat-manual-for-participants/
- WHO (2020). Paediatric emergency triage, assessment and treatment: care of critically-ill children. Paediatric emergency triage and resuscitation; child-specific. https://news.gmj.ge/guideline/paediatric-emergency-triage-assessment-and-treatment-care-of-critically-ill-children/

29.2 Resuscitation Area Is Always Ready

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

Applies to: 1 of 9 facility types: Hospital. **Not applicable to:** Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic. Each setting shows its rating above.

> **Criterion.** A resuscitation area is available at all times. Its equipment and drugs are checked on a documented schedule, and staff on every shift are trained in immediate life support.

Rating rule. Must in every setting. A resuscitation area that is not ready when a patient arrives in cardiac arrest cannot be made ready in time.

GUIDANCE

The resuscitation area is the place where a patient in cardiac arrest or immediate threat to life is treated. It is available at all times, and its equipment and drugs are present, in date and complete.

Readiness is shown by a documented check on a set schedule. Each check is recorded in the readiness register against the list of equipment and drugs, and any missing or out-of-date item is replaced before the next shift.

> **Good practice.** The resuscitation area is checked against its list at a set schedule, every item is in date, and every shift has staff trained in immediate life support.

> **Partial because.** The area is available, but checks are irregular, the register is incomplete, or some staff on a shift have not been trained in immediate life support.

WHAT GOOD LOOKS LIKE

- A readiness policy (**ED-POL-002**) that sets the check schedule and who carries it out.
- A readiness register (**ED-REG-001**) with each check dated and signed.
- Equipment and drugs listed, checked against that list, and replaced when out of date.
- Immediate life support training for staff on every shift.

COMMON MISTAKES

- A check recorded as done with no items listed.
- Drugs past their expiry date left in place because no one checked them.
- Checks done only before inspections, not on the set schedule.
- Training recorded for some staff, but not for those on night shifts.

> **Why it matters.** A resuscitation area that is not ready when a patient arrives in cardiac arrest costs minutes that cannot be recovered. Equipment and drugs checked on a schedule are ready when needed.

WHAT THE ASSESSOR CHECKS

Sample. Review resuscitation area checks and drill records for the last 3 months and 10 staff training records.

1 Equipment and drugs are in date and complete at each check.

Method. Check the latest check record against the list of equipment and drugs.

Evidence to show. Resuscitation area readiness register (**ED-REG-001**).

Pass when. No item is out of date or missing at the last check.

2 Staff on every shift are trained in immediate life support.

Method. Check the training records of the 10 staff in the sample against the shift rota.

Evidence to show. Training records.

Pass when. Every shift in the sample has at least one trained staff member.

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

Immediate fail. A cardiac arrest with the resuscitation drugs out of date. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
ED-REG-001	Resuscitation area readiness register	Secretary (ISCO 3344)	Chief executive (ISCO 1120)	Head of emergency department (ISCO 1342)
ED-POL-002	Resuscitation area readiness	Chief executive (ISCO 1120)	Governing body members	Chief executive (ISCO 1120)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Head of emergency department (ISCO 1342)	Accountable for the readiness of the resuscitation area	Emergency Medical Equipment & AED Readiness (MED-02) Essential
Emergency nurse (ISCO 2221)	Carries out the checks and keeps the register	Emergency Medical Equipment & AED Readiness (MED-02) Essential

REFERENCES FOR THIS CRITERION

No external reference is cited for this criterion. Its requirements are set out in the criterion, the checks and the evidence listed.

29.3 A Senior Clinician Is Responsible at All Times

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

Applies to: 1 of 9 facility types: Hospital. **Not applicable to:** Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic. Each setting shows its rating above.

> **Criterion.** A named senior clinician is responsible for the department at all times. Escalation to specialist services follows a defined pathway with a stated response time.

Rating rule. Minimum in humanitarian settings. Must in transition and standard settings: a named senior clinician is responsible for the department at all times.

GUIDANCE

The department must always have a named senior clinician who is responsible for decisions and for the staff on duty. The duty rota shows who it is for each period, including nights and weekends.

When a specialist service is needed, the call follows the escalation pathway in the policy, with the stated response time. Each call is recorded on the senior clinician on duty record with the time of request and the time of review.

> **Good practice.** A named senior clinician is on the rota for every period, and every specialist call is recorded against the pathway and the response time.

> **Partial because.** A senior clinician is named for most periods, but some nights or weekends have no named person, or some specialist calls are not recorded.

WHAT GOOD LOOKS LIKE

- A policy (**ED-POL-001**) that names the responsible clinician and the escalation pathway.
- A duty rota that names the senior clinician for every period.
- A senior clinician on duty record (**ED-FRM-001**) for each specialist call.
- A stated response time for specialist review, checked against the record.

COMMON MISTAKES

- A rota that names a senior clinician for day shifts only.
- Specialist calls made by telephone with no record of the time.
- An escalation pathway that exists on paper but staff do not know.
- The response time is not stated, so nobody can tell if it was met.

> **Why it matters.** When something goes wrong in the department, someone senior must be in charge and reachable. Without a named senior clinician, decisions are delayed or made by nobody.

WHAT THE ASSESSOR CHECKS

Sample. Review the senior clinician duty rota for 30 days, and the escalation log for 10 specialist calls.

1 A named senior clinician is responsible for the department at each time.

Method. Check the rota for a named senior clinician in every period.

Evidence to show. Senior clinician responsibility and specialist escalation (**ED-POL-001**).

Pass when. No period in the sample has an unnamed senior clinician.

2 **Each specialist call follows the defined escalation pathway.**

Method. Check each call for the pathway step and the response time.

Evidence to show. Senior clinician on duty record (**ED-FRM-001**).

Pass when. Every call follows the pathway and has a recorded response.

3 **The stated response time for specialist review is met.**

Method. Check each call for the time from request to review against the stated time.

Evidence to show. Senior clinician on duty record (**ED-FRM-001**).

Pass when. Every call meets the stated response time.

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

Immediate fail. No senior clinician on duty overnight and a specialist call goes unanswered. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
ED-FRM-001	Senior clinician on duty record	Head of emergency department (ISCO 1342)	Chief executive (ISCO 1120)	Head of emergency department (ISCO 1342)
ED-POL-001	Senior clinician responsibility and specialist escalation	Chief executive (ISCO 1120)	Governing body members	Chief executive (ISCO 1120)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Emergency physician (ISCO 2212)	The senior clinician responsible for the department	Safety & Emergency Preparedness (H-05) Essential
Head of emergency department (ISCO 1342)	Maintains the responsibility and escalation policy	Safety & Emergency Preparedness (H-05) Essential

REFERENCES FOR THIS CRITERION

- Royal College of Emergency Medicine (2016, revised February 2016). The on call role of the Emergency Medicine Consultant.

29.4 Decisions to Admit, Transfer or Discharge Are Recorded and Handed Over

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

Applies to: 1 of 9 facility types: Hospital. **Not applicable to:** Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic. Each setting shows its rating above.

> **Criterion.** The decision to admit, transfer or discharge is recorded with its reasons. Handover to the receiving ward or facility is structured. Interfacility transfers are handled under the transfer requirements of this Version 11 set.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings.

GUIDANCE

Each time a patient leaves the department, the decision is recorded with its reasons on the disposition decision record. The record shows whether the patient is admitted, transferred or discharged.

The handover to the receiving ward, clinician or facility is structured, so the next team knows the diagnosis, the treatment given and what remains to be done.

> **Good practice.** Each disposition decision is recorded with its reason, and each handover is structured and recorded.

> **Partial because.** Most decisions are recorded, but the reason is missing for some, or handover is informal and not recorded.

WHAT GOOD LOOKS LIKE

- A disposition decision record (**ED-FRM-002**) for every attendance that ends in a decision.
- A structured handover that covers diagnosis, treatment, and what remains to be done.
- Medication list handed over with the patient on transfer or discharge.
- Regular audit of recorded reasons.

COMMON MISTAKES

- A discharge recorded with no reason.
- A verbal handover that is not recorded.
- A medication list missing from a transfer.
- The GP not informed of a discharge that needs follow-up.

> **Why it matters.** A decision to admit, transfer or discharge a patient should be recorded with its reasons. A handover that is not made clearly is where the next team misses the problem.

WHAT THE ASSESSOR CHECKS

Sample. Review admission, transfer and discharge decisions for 30 attendances, and handover records for 15 of them.

1 Each decision to admit, transfer or discharge is recorded with its reason.

Method. Check each attendance for the decision and the reason recorded.

Evidence to show. Disposition decision record (**ED-FRM-002**).

Pass when. Every sampled decision has a recorded reason.

2 Each handover is structured and recorded.

Method. Check the handover records for the 15 sampled attendances.

Evidence to show. Disposition decision record (**ED-FRM-002**).

Pass when. Every sampled handover is recorded with the required content.

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

Immediate fail. A patient discharged with no reason recorded and no handover to the GP. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
ED-FRM-002	Disposition decision record	Head of emergency department (ISCO 1342)	Chief executive (ISCO 1120)	Secretary (ISCO 3344)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Emergency physician (ISCO 2212)	Decides and records admission, transfer or discharge	**Handover & Communication for ASF Accreditation (MT-04)** Essential
Emergency nurse (ISCO 2221)	Completes the disposition record and the handover	**Handover & Communication for ASF Accreditation (MT-04)** Essential

REFERENCES FOR THIS CRITERION

- WHO (2020). Medication safety in transitions of care. Medication safety in patient transfers and discharge; medication-specific. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/
- 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

29.5 Patients Who Leave Before Assessment Are Recorded and Followed Up

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

Applies to: 1 of 9 facility types: Hospital. **Not applicable to:** Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic. Each setting shows its rating above.

> **Criterion.** Patients who leave before they are assessed or treated are recorded, and the department makes reasonable attempts to follow them up. The rate and reasons are reviewed.

Rating rule. Minimum in humanitarian settings. Medium in transition and fragile settings. Must in standard settings.

GUIDANCE

Some patients leave before they are seen. Each departure is recorded in the register at the time it happens, with the time and the reason if given.

The department makes reasonable attempts to contact each recorded patient, and records the attempts. The rate of departures and the reasons are reviewed at a set interval, and the review leads to action where the rate is high.

> **Good practice.** Every departure before assessment is recorded, each recorded patient has follow-up attempts, and the rate and reasons are reviewed at a set interval.

> **Partial because.** Departures are recorded, but follow-up attempts are not recorded, or the rate and reasons are not reviewed.

WHAT GOOD LOOKS LIKE

- A procedure (**ED-SOP-003**) for departures before assessment and for follow-up.
- A register (**ED-REG-002**) kept for each shift.
- Follow-up attempts recorded with their dates.
- Review of the rate and the reasons at a set interval.

COMMON MISTAKES

- Departures are not recorded because the register is kept only on busy shifts.
- Follow-up calls not recorded, so it cannot be shown they were made.
- The rate is never reviewed.
- Reasons recorded, but nothing changes as a result.

> **Why it matters.** Patients who leave before they are seen may be seriously unwell, and the department must know who they are to follow them up. Recording and following up those patients is part of safe care.

WHAT THE ASSESSOR CHECKS

Sample. Review the register of patients who left before assessment for the last 6 months, and the follow-up records.

1 Each patient who leaves before assessment is recorded.

Method. Compare the department attendance log with the register for each shift.

Evidence to show. Left-before-assessment register (**ED-REG-002**).

Pass when. Every departure before assessment is recorded.

2 **The department makes reasonable attempts to follow up each recorded patient.**

Method. Check each record for the follow-up attempts and their dates.

Evidence to show. Patients who leave before assessment (**ED-SOP-003**).

Pass when. Every recorded patient has follow-up attempts recorded.

3 **The rate and the reasons are reviewed at a set interval.**

Method. Check the review entries for the rate and the reasons.

Evidence to show. Left-before-assessment register (**ED-REG-002**).

Pass when. The rate and reasons are reviewed at the set interval.

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

Immediate fail. Patients who walk out before being seen are not recorded and no one is told. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
ED-SOP-003	Patients who leave before assessment	Head of emergency department (ISCO 1342)	Chief executive (ISCO 1120)	Head of emergency department (ISCO 1342)
ED-REG-002	Left-before-assessment register	Secretary (ISCO 3344)	Chief executive (ISCO 1120)	Head of emergency department (ISCO 1342)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Triage nurse (ISCO 2221)	Records departures and attempts to follow up	Safety & Emergency Preparedness (H-05) Essential
Patient services manager (ISCO 1342)	Keeps the follow-up process under review	Safety & Emergency Preparedness (H-05) Essential

REFERENCES FOR THIS CRITERION

No external reference is cited for this criterion. Its requirements are set out in the criterion, the checks and the evidence listed.

10 Questions and answers

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

Who does Standard 29 apply to?
Hospital emergency departments that receive patients arriving at any time, including those who come without an appointment.

Do I need to meet every criterion in Standard 29?
Yes. Every criterion has its own pass rule and its own immediate-fail rule. A failure on any one criterion means that criterion is not met.

What is an immediate fail?
An immediate fail is one event or finding that means a criterion is not met, even if everything else in that criterion is in place. For example, a patient with chest pain waiting for hours without triage.

What do the colours mean for this standard?
Red (Must) is required. Green (Medium) is recommended in the transition setting. Yellow (Minimum) is the lowest acceptable level in humanitarian settings. In standard settings every criterion is Must.

Must every arrival be triaged before waiting?
Yes. Under 29.1 every arrival is triaged before waiting.

Who is responsible for the department at all times?
Under 29.3 a named senior clinician is responsible at all times, including overnight.

Do I have to use the documents on this page?
No. The policies, SOPs, forms and registers are drafts to help you. Adapt them to your department, write your own, or upload your own. What the assessor checks is that the criterion is met and that you can show how.

11 E-learning by standard

These are the GMJ Academy courses named in the criteria of this standard.

Course	Essential for	Recommended for	Criteria	GMJ Academy course page
Safety & Emergency Preparedness (H-05)	Manager; Nurse	None	29.1, 29.3, 29.5	GMJ Academy, course code H-05
Emergency Medical Equipment & AED Readiness (MED-02)	Manager; Nurse	None	29.2	GMJ Academy, course code MED-02
Handover & Communication for ASF Accreditation (MT-04)	Manager; Nurse	None	29.4	GMJ Academy, course code MT-04

12 References

CITED FOR CRITERIA

1. WHO (2021). Emergency Triage Assessment and Treatment (ETAT): Manual for Participants. Child-specific. https://news.gmj.ge/guideline/emergency-triage-assessment-and-treatment-etat-manual-for-participants/ (criterion 29.1)
2. WHO (2020). Paediatric emergency triage, assessment and treatment: care of critically-ill children. https://news.gmj.ge/guideline/paediatric-emergency-triage-assessment-and-treatment-care-of-critically-ill-children/ (criterion 29.1)
3. Royal College of Emergency Medicine (2016, revised February 2016). The on call role of the Emergency Medicine Consultant. (criterion 29.3)
4. WHO (2020). Medication safety in transitions of care. https://news.gmj.ge/guideline/medication-safety-in-transitions-of-care/ (criterion 29.4)
5. 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 (criterion 29.4)

13 Document register

Every document code used in Standard 29, 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	What it is for	Criteria
ED-SOP-001	Emergency triage	Procedure (SOP)	To set how every arrival is triaged on a recognised scale, by whom, and within what time.	29.1
ED-FRM-003	Triage record and log	Form (record)	To record the triage category and time of triage for each attendance.	29.1
ED-REG-001	Resuscitation area readiness register	Register	To record checks of resuscitation equipment and drugs against the list.	29.2
ED-POL-002	Resuscitation area readiness	Policy	To set the check schedule and who carries it out.	29.2
ED-POL-001	Senior clinician responsibility and specialist escalation	Policy	To name the senior clinician in charge at all times and set the specialist escalation pathway.	29.3
ED-FRM-001	Senior clinician on duty record	Form (record)	To record the named senior clinician for each period and each specialist call.	29.3
ED-FRM-002	Disposition decision record	Form (record)	To record each decision to admit, transfer or discharge, with its reason and handover.	29.4
ED-SOP-003	Patients who leave before assessment	Procedure (SOP)	To set how departures before assessment are recorded and followed up.	29.5
ED-REG-002	Left-before-assessment register	Register	To record each patient who leaves before assessment, and the reviews of rate and reasons.	29.5