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ASF Health Standards Version 11

Standard 30: Neonatal and Paediatric Hospital Care

Applies to hospitals with neonatal and paediatric inpatient care

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REVISION HISTORY

Revision	Date	Change	Approved by
01	1 November 2026	First version, from the Version 10 standard for neonatal and paediatric care, renumbered as Standard 30. 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 30 of ASF Health Standards. It sets out how a hospital with neonatal and paediatric inpatient care doses child medicines for weight and age, matches each newborn to a defined level of care, informs and involves families, protects children from harm, and transfers newborns and children safely to a higher level of care.

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 30 protects newborns and children in hospital, who depend entirely on the adults caring for them. Correct doses, the right level of care, informed families and safe transfers protect the child at each step.

Who should read it. Hospital managers, paediatricians, neonatologists, paediatric nurses, pharmacists, social workers, the secretary who keeps the registers, and the assessors who verify the unit. 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 30 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 neonatal or paediatric team, read section 4 to confirm that the standard applies to your unit, then section 5 to find the rating for your setting. Read each criterion from 30.1 to 30.5, 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 **NEO-POL-001** (neonatal, 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 30 covers hospitals with neonatal and paediatric inpatient care: weight-based dosing of child medicines, newborn care matched to a defined level of care, families informed and present in care, protection of children from harm, and safe transfers to a higher level of care.

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 30 APPLIES

Standard 30 applies to hospitals with neonatal and paediatric inpatient care, including newborn units and children's wards. 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 inpatient neonatal or paediatric care.

Criterion	Applies to
30.1 Medicines Are Dosed for the Child's Weight and Age	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic
30.2 Newborn Care Is Matched to a Defined Level of Care	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic
30.3 Families Are Informed and Present in Care	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic
30.4 Children Are Protected From Harm	Hospital N/A: Ambulatory clinic, Aesthetic and procedure clinic, Primary health clinic, Long-term care, Telemedicine, Home care, Fitness and wellness, Dental clinic
30.5 Newborns Are Transferred Safely to a Higher Level of Care	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
NICU	Neonatal intensive care unit
KMC	Kangaroo mother care
ISCO	International Standard Classification of Occupations (ISCO-08), used to code each role
ISO	International Organization for Standardization
NEO	Neonatal and paediatric hospital care
WHO	World Health Organization

DOCUMENT CODE PREFIXES

Prefix	Topic
NEO	Neonatal and paediatric hospital care

7 Terms and definitions

Term	Definition
Weight-based dosing	Dosing a medicine against the child’s recorded current weight and age, rather than an adult dose.
Level of care	The defined capability of a neonatal area, with the staffing and skills it requires.
Step-up	Moving a baby to a higher level of care when the pathway shows it is needed.
Kangaroo mother care	Skin-to-skin care of a small newborn with the mother or family member, supported by the unit.
Safeguarding lead	The named person who receives and tracks child protection concerns in the unit.
Acceptance	Confirmation from the receiving unit that it can take the child before the transfer begins.

8 Standard 30 at a glance: criteria, responsibilities, training

Standard 30: Neonatal and Paediatric Hospital Care is a standard of ASF Health Standards for hospitals with neonatal and paediatric inpatient care. It covers weight-based dosing, the level of care for newborns, families informed and present in care, protection from harm, and safe transfers to a higher level of care.

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
30.1	Medicines Are Dosed for the Child's Weight and Age	Must	Must	Must
30.2	Newborn Care Is Matched to a Defined Level of Care	Minimum	Must	Must
30.3	Families Are Informed and Present in Care	Minimum	Medium	Must
30.4	Children Are Protected From Harm	Minimum	Must	Must
30.5	Newborns Are Transferred Safely to a Higher Level of Care	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
30.1	Medicines Are Dosed for the Child's Weight and Age	**Paediatrician** (ISCO 2212) · **Pharmacist** (ISCO 2262)
30.2	Newborn Care Is Matched to a Defined Level of Care	**Neonatologist** (ISCO 2212) · **Paediatric nurse** (ISCO 2221)
30.3	Families Are Informed and Present in Care	**Paediatric nurse** (ISCO 2221) · **Social worker** (ISCO 2635)
30.4	Children Are Protected From Harm	**Social worker** (ISCO 2635) · **Paediatrician** (ISCO 2212)
30.5	Newborns Are Transferred Safely to a Higher Level of Care	**Neonatologist** (ISCO 2212) · **Paediatrician** (ISCO 2212)

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 neonatal and paediatric service. A hospital with a different structure records its own reporting lines in its organogram.

Role	Reports to	Supervises
Paediatrician	**Chief of department**	No direct reports.
Neonatologist	**Head of department (per specialty)**	No direct reports.

Role	Reports to	Supervises
Paediatric nurse	Head of department (per specialty)	No direct reports.
Social worker	Patient services manager	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.

30.1 Medicines Are Dosed for the Child's Weight and Age

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 medicine prescribed for a child is dosed against a recorded current weight, with a paediatric dosing check before the first dose. Adult dosing is not used by default.

Rating rule. Must in every setting. A wrong dose in a child can cause serious harm, so the dosing check is never adapted to resources.

GUIDANCE

Children are not small adults. The dose of most medicines depends on the child's weight and age, so the prescriber records the current weight before the first dose. A weight from a previous visit is not used for a new prescription without re-weighing.

Before the first dose, a paediatric dosing check confirms the dose against the weight and age, the route, and the frequency. Infants under 1 year are checked with particular care. Adult dosing tables are not used for a child unless the paediatric check has been completed and recorded.

> **Good practice.** Every child medicine is prescribed against a recorded current weight, the paediatric dosing check is recorded before the first dose, and no child is dosed from the adult table.

> **Partial because.** Weights are recorded for most children, but some doses are checked from memory, or the paediatric check is not recorded for some prescriptions.

WHAT GOOD LOOKS LIKE

- A paediatric medicine dosing procedure (**NEO-SOP-002**) that requires a current weight and a recorded dosing check before the first dose.
- A current weight recorded on the chart for every child at admission and at each new prescription.
- A dosing check recorded before the first dose, including for infants under 1 year.
- Regular review of prescribing records against the weight and age.

COMMON MISTAKES

- A weight copied forward from an earlier admission and not re-measured.
- An adult dosing table used for a child because no paediatric table is available on the ward.
- A dose rounded up to the nearest adult tablet without a check against the weight.
- The dosing check is done verbally and never written down.

> **Why it matters.** Children are not small adults. A medicine dose for a child depends on their weight and age, and a wrong dose can cause serious harm. The weight must be current and recorded.

WHAT THE ASSESSOR CHECKS

Sample. Review prescribing and dose records for 30 child medicines, including any given to infants under 1 year.

1 **Every child medicine is dosed against a recorded current weight.**

Method. Check each prescription in the sample for a recorded weight and the date it was taken.

Evidence to show. Paediatric medicine dosing; prescribing records (**NEO-SOP-002**).

Pass when. Every sampled prescription has a current recorded weight.

2 **A paediatric dosing check is recorded before the first dose.**

Method. Check each sampled first dose for the dosing check and its time.

Evidence to show. Paediatric medicine dosing (**NEO-SOP-002**).

Pass when. Every first dose has a dosing check recorded before it was given.

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

Immediate fail. A child medicine dosed from the adult table with no weight recorded. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
NEO-SOP-002	Paediatric medicine dosing	Manager (ISCO 1342)	Chief executive (ISCO 1120)	Manager (ISCO 1342)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Paediatrician (ISCO 2212)	Prescribes against the recorded weight and completes the dosing check	Clinical Standards for Accreditation (H-04) Essential
Pharmacist (ISCO 2262)	Checks the dose against the weight and age before dispensing	Clinical Standards for Accreditation (H-04) Essential

REFERENCES FOR THIS CRITERION

- World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705

30.2 Newborn Care Is Matched to a Defined Level of Care

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.** Each neonatal area is assigned a defined level of care. Staffing is set for that level, and a documented pathway moves a baby to a higher level of care when needed.

Rating rule. Minimum in humanitarian settings. Must in transition and standard settings: a defined level of care is set for each neonatal area.

GUIDANCE

Each neonatal area is assigned a level of care in the neonatal level of care policy (**NEO-POL-001**). The assigned level sets the minimum staffing, equipment and skills for every shift in that area.

When a baby needs a higher level of care, the step-up follows the documented pathway. The assessment record (**NEO-FRM-001**) shows the reason for the step-up, the decision and the time it was made. Staffing on each shift is checked against the level in the staffing register (**NEO-REG-001**).

> **Good practice.** Every neonatal area has an assigned level, every sampled shift is staffed for that level, and every step-up has a recorded pathway decision.

> **Partial because.** Levels are assigned, but some shifts are staffed below the level, or some step-ups have no recorded decision.

WHAT GOOD LOOKS LIKE

- A neonatal level of care policy (**NEO-POL-001**) that defines each level and the staffing it requires.
- A staffing register (**NEO-REG-001**) checked against the level on each shift.
- A level of care assessment record (**NEO-FRM-001**) completed for every step-up.
- A review of staffing against level at a set interval.

COMMON MISTAKES

- A unit that admits premature babies without a level of care being assigned.
- A shift recorded as adequately staffed without the staffing being compared with the level.
- A step-up made in an emergency with no decision record completed afterwards.
- The levels are on paper but unknown to the staff on the ward.

> **Why it matters.** A newborn needs the right level of care for their condition. A neonatal unit that is staffed for a lower level of care cannot keep a sick baby safe.

WHAT THE ASSESSOR CHECKS

Sample. Review the level of care assignment and staffing records for each neonatal area for the last 3 months.

1 Every neonatal area has a level of care assigned.

Method. Check each area for its assigned level.

Evidence to show. Neonatal level of care (**NEO-POL-001**).

Pass when. Every neonatal area has a level of care assigned.

2 Staffing meets the level of care on each sampled shift.

Method. Check each shift against the staffing needed for the level.

Evidence to show. Neonatal staffing against level of care register (**NEO-REG-001**).

Pass when. Every sampled shift meets the staffing for its level.

3 Every step-up to a higher level of care has a pathway decision recorded.

Method. Check each step-up for the pathway step and the decision record.

Evidence to show. Neonatal level of care assessment record (**NEO-FRM-001**).

Pass when. Every step-up has a pathway decision recorded.

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

Immediate fail. A premature baby admitted to a unit with no level of care defined and no staff to match it. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
NEO-POL-001	Neonatal level of care	Chief executive (ISCO 1120)	Governing body members	Chief executive (ISCO 1120)
NEO-REG-001	Neonatal staffing against level of care register	Secretary (ISCO 3344)	Chief executive (ISCO 1120)	Secretary (ISCO 3344)
NEO-FRM-001	Neonatal level of care assessment record	Manager (ISCO 1342)	Chief executive (ISCO 1120)	Manager (ISCO 1342)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Neonatologist (ISCO 2212)	Assigns and reviews the level of care for each neonatal area	Clinical Standards for Accreditation (H-04) Essential
Paediatric nurse (ISCO 2221)	Completes the level of care assessment record and the staffing check	Clinical Standards for Accreditation (H-04) Essential

REFERENCES FOR THIS CRITERION

- WHO (2020). Standards for improving the quality of care for small and sick newborns in health facilities. https://news.gmj.ge/guideline/standards-for-improving-the-quality-of-care-for-small-and-sick-newborns-in-health-facilities/

30.3 Families Are Informed and Present in Care

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.** Parents or guardians are informed about the child's condition and the plan. Consent is obtained from the appropriate person, taking account of the child's age and capacity. Family presence is supported.

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

GUIDANCE

Parents or guardians are told about the child's condition, the options and the plan in words they understand. Where an interpreter is needed, one is used. The information given is recorded in the notes.

Consent is obtained from the parent or guardian, and the child is involved in decisions as far as their age and capacity allow. Family presence is supported, including for kangaroo mother care where it is clinically appropriate.

> **Good practice.** Each child's family is informed and consent is recorded from the appropriate person, and family presence is supported and recorded.

> **Partial because.** Families are informed for most children, but some consent forms do not record who gave consent, or family presence is not recorded.

WHAT GOOD LOOKS LIKE

- A family information and consent procedure (**NEO-SOP-003**).
- Consent recorded with the name and relationship of the person who gave it.
- Family presence recorded in the notes, including kangaroo mother care where used.
- Interpreter use recorded when needed.

COMMON MISTAKES

- Consent signed by a parent who did not understand the procedure.
- Family presence limited without a clinical reason and without recording it.
- The child's age and capacity not considered when consent is obtained.
- Information given only verbally and not recorded.

> **Why it matters.** Parents know their child best, and they need to understand what is happening to their baby. Informing them and involving them in care supports the child and the family.

WHAT THE ASSESSOR CHECKS

Sample. Review consent and family involvement records for 15 children admitted in the last 3 months.

1 Parents or guardians are informed about the child's condition and plan.

Method. Check each sampled record for the information given and the date.

Evidence to show. Family information, consent and presence (**NEO-SOP-003**).

Pass when. Every sampled record shows the information given to the family.

2 Consent is obtained from the appropriate person.

Method. Check each consent form for the name and relationship of the person who gave it.

Evidence to show. Family information, consent and presence (**NEO-SOP-003**).

Pass when. Every consent form names the appropriate person.

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

Immediate fail. Parents not told about the newborn's condition and asked to sign consent for a procedure with no information. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
NEO-SOP-003	Family information, consent and presence	Manager (ISCO 1342)	Chief executive (ISCO 1120)	Manager (ISCO 1342)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Paediatric nurse (ISCO 2221)	Informs the family and supports family presence	Patient Identification, Informed Consent and Patient Rights (T-07) Essential
Social worker (ISCO 2635)	Supports families who need help to take part in care	Patient Identification, Informed Consent and Patient Rights (T-07) Essential

REFERENCES FOR THIS CRITERION

- WHO (2025). Parent counselling guide on kangaroo mother care (KMC). https://news.gmj.ge/guideline/parent-counselling-guide-on-kangaroo-mother-care-kmc/
- WHO (2019). Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities. https://news.gmj.ge/guideline/standards-for-improving-the-quality-of-care-for-children-and-young-adolescents-in-health-facilities/

30.4 Children Are Protected From Harm

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.** Staff are trained in child protection. A named safeguarding lead is in place. Concerns about a child's safety are escalated and recorded, and action is tracked to completion.

Rating rule. Minimum in humanitarian settings. Must in transition and standard settings: a named safeguarding lead is always in place.

GUIDANCE

Every member of staff who cares for children is trained in child protection, and the training is recorded. A named safeguarding lead is in place for every shift and is known to all staff.

Any concern about a child's safety is recorded at the time it is raised and escalated to the safeguarding lead the same day. Each action is tracked until it is closed and the outcome is recorded.

> **Good practice.** Every member of staff is trained, a named safeguarding lead is known on every shift, and every concern is escalated, recorded and tracked to closure.

> **Partial because.** Staff are trained and a lead is named, but some concerns are not escalated the same day, or actions are not tracked to closure.

WHAT GOOD LOOKS LIKE

- A child protection and safeguarding escalation procedure (**NEO-SOP-004**).
- A training record for every member of staff who cares for children.
- A concern record for each concern raised, with the time of escalation.
- Action tracked to closure, with the outcome recorded.

COMMON MISTAKES

- A concern noted in the notes but not escalated.
- Training recorded for some staff, not those on night shifts.
- No named safeguarding lead known to the ward staff.
- Actions open for months with no review.

> **Why it matters.** Children in hospital can be harmed by the people who care for them, or by others. Staff trained in child protection, with a named lead and a clear way to raise concern, keep children safe.

WHAT THE ASSESSOR CHECKS

Sample. Review safeguarding training and concern records for the last 12 months, including all concerns raised.

1 Staff are trained in child protection.

Method. Check the training record of each member of staff in the sample.

Evidence to show. Training records; **NEO-SOP-004** Child protection and safeguarding escalation.

Pass when. Every member of staff who cares for children has a recorded training.

2 **Every concern is escalated and recorded.**

Method. Check each concern for the time raised, the time escalated and the action.

Evidence to show. Child protection and safeguarding escalation (**NEO-SOP-004**).

Pass when. Every concern is escalated the same day and has a recorded action.

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

Immediate fail. A safeguarding concern noted in the notes with no escalation for a week. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
NEO-SOP-004	Child protection and safeguarding escalation	Manager (ISCO 1342)	Chief executive (ISCO 1120)	Manager (ISCO 1342)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Social worker (ISCO 2635)	Named safeguarding lead and point of contact for concerns	Incident Reporting, Just Culture and Open Disclosure (T-09) Essential
Paediatrician (ISCO 2212)	Escalates and reviews medical concerns about a child	Incident Reporting, Just Culture and Open Disclosure (T-09) Essential

REFERENCES FOR THIS CRITERION

- WHO (2019). Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities. https://news.gmj.ge/guideline/standards-for-improving-the-quality-of-care-for-children-and-young-adolescents-in-health-facilities/
- WHO (2017). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines.

30.5 Newborns Are Transferred Safely to a Higher Level of Care

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.** Transfers of newborns and children to a higher level of care meet the transfer requirements of Standard 42 (Critical Interfacility Transfer). The receiving unit confirms it can accept the child before the transfer begins.

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

GUIDANCE

Before a newborn or child is moved to a higher level of care, the receiving unit confirms that it can accept the child. The confirmation is recorded with the name of the person who gave it and the time.

The transfer follows the structured handover in **NEO-SOP-005** and the transfer requirements of Standard 42. Every transfer has a transfer record, and the receiving team is informed before the child leaves.

> **Good practice.** Every transfer to a higher level of care has a recorded acceptance from the receiving unit, a transfer record, and a structured handover to the receiving team.

> **Partial because.** Transfers are recorded, but acceptance is sometimes confirmed by telephone without a record, or the receiving team is informed only after the child has left.

WHAT GOOD LOOKS LIKE

- A transfer procedure (**NEO-SOP-005**) that meets the requirements of Standard 42.
- A recorded acceptance from the receiving unit before every transfer.
- A structured handover record that goes with the child.
- Regular review of transfers against the procedure.

COMMON MISTAKES

- A baby sent to another unit with no record of acceptance.
- The receiving team learns of the transfer from the ambulance crew.
- No handover record kept after an urgent transfer.
- Transfers reviewed only when something goes wrong.

> **Why it matters.** A sick newborn who must move to a higher level of care is at high risk during the journey. A safe, structured transfer protects the baby on the way.

WHAT THE ASSESSOR CHECKS

Sample. Review transfer records for 15 newborns and children moved to a higher level of care in the last 6 months.

1 The receiving unit confirms acceptance before each transfer.

Method. Check each transfer record for the acceptance, the name of the person and the time.

Evidence to show. Transfer of newborns and children to a higher level of care (**NEO-SOP-005**).

Pass when. Every sampled transfer has a recorded acceptance before departure.

2 **Each transfer has a transfer record and a structured handover.**

Method. Check each sampled transfer for the record and the handover content.

Evidence to show. Transfer of newborns and children to a higher level of care (**NEO-SOP-005**).

Pass when. Every sampled transfer has both records completed.

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

Immediate fail. A newborn transferred to another unit with no transfer record and no receiving team informed. This fails the criterion on its own, whatever else is in place.

EVIDENCE AND DOCUMENTS

Code	Document	Writes	Approves	Checks
NEO-SOP-005	Transfer of newborns and children to a higher level of care	Manager (ISCO 1342)	Chief executive (ISCO 1120)	Manager (ISCO 1342)

POSITIONS RESPONSIBLE

Position	Why it applies	Training
Neonatologist (ISCO 2212)	Accepts the transfer and confirms the receiving arrangement	Handover & Communication for ASF Accreditation (MT-04) Essential
Paediatrician (ISCO 2212)	Coordinates the transfer and its record	Handover & Communication for ASF Accreditation (MT-04) Essential

REFERENCES FOR THIS CRITERION

- WHO (2020). Standards for improving the quality of care for small and sick newborns in health facilities. https://news.gmj.ge/guideline/standards-for-improving-the-quality-of-care-for-small-and-sick-newborns-in-health-facilities/
- 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

10 Questions and answers

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

Who does Standard 30 apply to?
Hospitals with neonatal and paediatric inpatient care, including newborn units and children's wards.

Do I need to meet every criterion in Standard 30?
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 child medicine dosed from the adult table with no weight recorded.

What do the colours mean for this standard?
Red (Must) is required. Yellow (Medium) is required, adapted to what a transition setting can realistically do. Green (Minimum) is the lowest acceptable level in humanitarian settings. In standard settings every criterion is Must.

Can a child's medicine be dosed from the adult table?
No. Under 30.1 medicines are dosed for the child's weight and age, and a child medicine dosed from the adult table is an immediate fail.

Is a newborn's level of care matched to their need?
Yes. Under 30.2 newborn care is matched to a defined level of care.

Are parents involved in their baby's care?
Under 30.3 families are informed and present in care, where the family wishes to be.

What happens to a safeguarding concern?
Under 30.4 a concern is escalated to the safeguarding lead the same day, recorded, and tracked to closure.

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 unit, 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
Clinical Standards for Accreditation (H-04)	Manager; Nurse	None	30.1, 30.2	GMJ Academy, course code H-04
Patient Identification, Informed Consent and Patient Rights (T-07)	Manager; Nurse	None	30.3	GMJ Academy, course code T-07
Incident Reporting, Just Culture and Open Disclosure (T-09)	Manager; Nurse	None	30.4	GMJ Academy, course code T-09
Handover & Communication for ASF Accreditation (MT-04)	Manager; Nurse	None	30.5	GMJ Academy, course code MT-04

12 References

CITED FOR CRITERIA

1. World Health Organization (2021). Global Patient Safety Action Plan 2021–2030: Towards Eliminating Avoidable Harm in Health Care. Geneva: WHO. https://www.who.int/publications-detail-redirect/9789240032705 (criterion 30.1, 30.5)
2. WHO (2020). Standards for improving the quality of care for small and sick newborns in health facilities. https://news.gmj.ge/guideline/standards-for-improving-the-quality-of-care-for-small-and-sick-newborns-in-health-facilities/ (criterion 30.2, 30.5)
3. WHO (2025). Parent counselling guide on kangaroo mother care (KMC). https://news.gmj.ge/guideline/parent-counselling-guide-on-kangaroo-mother-care-kmc/ (criterion 30.3)
4. WHO (2019). Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities. https://news.gmj.ge/guideline/standards-for-improving-the-quality-of-care-for-children-and-young-adolescents-in-health-facilities/ (criterion 30.3, 30.4)
5. WHO (2017). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. (criterion 30.4)

13 Document register

Every document code used in Standard 30, 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
NEO-SOP-002	Paediatric medicine dosing	Procedure (SOP)	To set how child medicines are dosed against a recorded current weight, with a paediatric dosing check before the first dose.	30.1
NEO-POL-001	Neonatal level of care	Policy	To define each level of neonatal care and the staffing it requires.	30.2
NEO-REG-001	Neonatal staffing against level of care register	Register	To record the staffing on each shift against the level of care of each area.	30.2
NEO-FRM-001	Neonatal level of care assessment record	Form (record)	To record each step-up to a higher level of care, with the reason and the decision.	30.2
NEO-SOP-003	Family information, consent and presence	Procedure (SOP)	To set how families are informed, how consent is obtained and how family presence is supported.	30.3
NEO-SOP-004	Child protection and safeguarding escalation	Procedure (SOP)	To set how child protection concerns are escalated, recorded and tracked to closure.	30.4
NEO-SOP-005	Transfer of newborns and children to a higher level of care	Procedure (SOP)	To set how a newborn or child is transferred, including acceptance, transfer record and handover.	30.5