Critical Standards

Select standards are considered "Critical" due to their disproportionate influence on clinical quality and patient safety. These standards are identified by the use of ** at the standard number and include the measurable elements of the standard. The first chapter of the manual, "Critical Safety Standards" (CS) address some of the most problematic areas of patient care, such as patient misidentification, medication errors, patient falls, and others. There are six critical standards within this chapter. There are 21 additional critical standards that are located elsewhere throughout this manual.

NOTE: Compliance with all the Critical Standards alone does not indicate the applicant organization will be accredited – all standards are included in the final accreditation decision. The table below identifies all the Critical standards in this document:

Critical Standards

Chapter	Standard	Standard Topic
Critical Patient Safety	CS.1	Patient identification
	CS.2	Effective communication
	CS.3	Medication safety
	CS.4	Healthcare associate infections
	CS.5	Safe surgical practices
	CS.6	Patient falls
Care Continuum	CP.2	Patient flow
Patient & Family Rights	PR.4	Granting consent
Clinical Patient Care	PC.4	Clinical practice guidelines
	PC.5	Blood and blood products
	PC.7	Change of patient's condition
	PC.8	Resuscitation Services
Anesthesia & Surgery	AS.2	Sedation
	AS.3	Anesthesia
	AS.4	Surgery and Invasive Procedures
Infection Prevention	IC.2	IC standards guide equipment cleaning
	IC.5	Protection from bloodstream pathogens
	IC.8	Protection from communicable disease
	IC.9	PPE availability
Physical Environment	PE.2	Safe and secure physical environment
	PE.3	Hazardous waste management
	PE.4	Fire safety
	PE.6	Medical equipment management
	PE.8	Essential utilities
	PE.9	Water monitoring
Staff qualifications	SQ.4	Credentialing process
	SQ.5	Privileging process

Monitoring Requirements

The concept that what gets measured/monitored gets improved is well established in the quality improvement field. Thus, measurement/monitoring is included in 57 measurable elements in this accreditation manual and are identified in the table of Monitoring Requirements found below. The data and information that results from this measurement/monitoring activity will be used in two ways; a) for scoring purposes as evidence of compliance with the requirements of the standard, and; b) in the rules of the accreditation decision process.

In scoring compliance with the requirements of the standards, the organization can present to the survey team different types of data/information such as trend data as evidence of positive change, or movement towards a quality target, or degree of implementation of policies or staff training, and so forth. The survey team will be interested in the process used to select the monitor, how the data was collected and analyzed and how the resulting information was used to make improvements. This use applies to all the standards listed in the table.

In relation to use in the accreditation decision process, the column on the right in the table below indicates which of the standards listed are considered Critical Standards. These standards require measurement/monitoring of aspects of care and care delivery that are more critical to overall quality of care in an organization. Thus, these standards are given more weight in the decision to grant accreditation or not to an organization. These Critical standards require that data be available to the survey team scoring the standard.

Organization Standard/ME	Monitoring Requirement Healthcare Organization Standards	Critical Standard
CS.1.4	Compliance with patient identification is monitored and actions are taken when adverse events occur.	CS.1
CS.2.4	Compliance with (handover) communication processes is measured and actions are taken when adverse events occur.	CS.2
CS. 3.4	Compliance with medication safety is measured and actions taken when adverse events occur.	CS.3
CS.4.4	Compliance with interventions to reduce the risk of healthcare-acquired infections is measured and actions taken when adverse events occur. (Handwashing)	CS.4
CS.5.4	Compliance with interventions to reduce the risk of surgical errors is measured and actions taken when adverse events occur.	CS.5
CS.6.4	Compliance with interventions to reduce the risk of patient falls is measured and actions taken when adverse events occur.	CS.6
CP.1.4	Referrals and transfers are monitored to ensure appropriateness, and actions are taken when adverse events occur.	
CP.2.4	The patient flow process is monitored for effectiveness to identify and implement process for improvement.	CP.2
CP.3.4	The processes for providing coordination and continuity of care are monitored and actions taken when adverse events occur.	
PR.4.4	Compliance with the consent process is monitored and actions taken when deviations are identified	PR.4
PR.7.4	Patient complaints and concerns are tracked and analyzed as part of quality improvement, patient safety, and/or risk management processes.	
PR.8.2.	Satisfaction data are aggregated, analyzed, and transformed into information to identify strategies for improvement.	
AP.7.3	The blood bank and transfusion services have quality control measures that are established, implemented, documented, and monitored for compliance.	
AP.8.4	The POCT program is monitored for quality control performance, documentation, and evaluation and included in quality improvement activities.	
AP.10.4	The organization has a system in place for monitoring and acting on radiological equipment hazard notices, recalls, reportable incidences, failures, and adverse events.	

PC.4.4	The standardized protocols, procedures and pathways and use or non-use and clinical outcomes are monitored as part of the program's quality improvement processes.	PC.4
PC.5.4	Staff are trained to monitor patients receiving blood and blood products, including the identification and response to potential transfusion reactions.	PC.5
PC.7.4	The organization monitors compliance the processes associated with changes in a patient's condition.	PC.7
PC.8.4	The organization monitors the outcomes of resuscitation services.	PC.8
AS. 2.4	Procedural sedation processes are monitored, and actions are taken when adverse events occur.	AS.2
AS. 3.4	Anesthesia processes are monitored, and actions are taken when adverse events occur.	AS.3
AS. 4.4	Surgical and invasive procedures are monitored, and actions are taken when adverse events occur.	AS.4
MM. 1.4	There is an annual review of the medication management program which includes monitoring of medication processes and actions taken when near miss or adverse events occur.	
MM. 2.4	The organization monitors the effectiveness of the antibiotic stewardship program.	
MM.3.3	There is a uniform process for the availability, storage, security, and monitoring of emergency medications when stored outside of the pharmacy.	
MM.7.2	When adverse effects occur, they are monitored and documented in the patient's record and included in the organization's quality program.	
IC.2.4	Throughout the organization, the methods for cleaning, disinfecting, sterilizing and storage are uniformly applied and monitored for compliance.	IC.2
IC. 3.1	The organization monitors environmental cleaning and disinfecting processes and uses data to implement improvements when needed.	
IC. 3.4	The organization monitors processes for the management of laundry and linen and uses data to implement improvements when needed.	
IC. 5.4	The infection prevention and control program monitors incidences of patient and staff exposure to blood and body fluids and takes action to minimize the risk of future exposures.	IC.5
IC.8.3	Negative pressure rooms for infectious patients who require airborne isolation are provided and monitored.	IC.8
IC.9.4	The organization monitors the availability and use of soap, disinfectants, and PPE throughout the facility.	IC.9
IC. 12.1	The infection prevention and control program collects and analyzes important epidemiological infection data (for example, catheter associated urinary tract infections, surgical site infections, and the like).	
LR. 2.2	The organization's leaders are accountable for developing, implementing, and updating as needed, strategic, operational, and financial plans and monitoring performance goals designated for these plans.	
LR. 3.4	Clinical care and processes specific to the department service are monitored and improved using selected measures that evaluate the clinical care provided.	
LR. 5.2	Resource decisions are monitored, and data results are used to make improvements.	
LR. 5.4	Contracts are monitored and reviewed at least annually, or when adverse events occur.	
QI. 3.2	Quality and patient safety improvements are monitored after implementation and sustained.	
QI.4.4	There is a process for analysis of adverse and near-miss events that identify	

	corrective actions to reduce the risk of patient harm.	
PE.2.2	There is a current and accurate inspection of the facilities and the results from the inspection are reviewed, prioritized, addressed, and monitored in the safety risk assessment.	PE.2
PE.3.4	The organization monitors data to ensure that risks related to hazardous materials and waste are reduced or eliminated	PE.3
PE.4.3	Fire detection and abatement equipment and systems are inspected, tested, and maintained according to manufacturers' recommendations and according to requirements from local codes and regulations and this information is documented and monitored.	PE.4
PE. 6.2	The program includes risk assessment and risk reduction activities for all medical equipment and identifies goals, implements improvements, and monitors data.	PE.6
PE.6.4	When there are medical equipment and implantable device hazard notices, recalls, reportable incidents, problems, and failures, the organization has a system in place for monitoring and taking action.	PE.6
PE.8.2	The organization assesses and monitors the risks of interruption, contamination, and failure of essential utilities are assessed, including the necessary amount available for back-up fuel sources, and the organization takes action to reduce those risks.	PE.8
PE. 9.1	The quality of potable and non-potable water is tested and documented based on local laws and regulations.	PE.9
PE.9.2.	Water used in hemodialysis is tested and documented monthly for bacterial growth and endotoxins and tested and documented annually for chemical contaminants.	PE.9
PE.9.3	Water lines used in dental services are treated and according to manufacturer's guidelines and testing and treatment are documented.	PE.9
SQ. 3.2	Organizational leadership provides procedures to promote well-being, for example, stress management, workload monitoring, management of work-life balance, and healthy lifestyle programs.	
SQ.5.2	The organization develops, implements, and monitors a process to ensure that medical staff members only provide the services and treatments they are privileged to perform and only those offered by the organization.	SQ.5
TH. 2.2	The organization leaders monitor compliance with applicable laws and regulations as well as professional practice standards within the relevant jurisdiction(s).	
TH. 3.4	Digital healthcare system infrastructure has systems and processes in place to maintain optimal performance and business continuity including proactively monitoring server performance, network latency, usability, effectiveness, staff outcomes, patient safety, and other key performance indicators; and improvements are identified and implemented based on results.	
TH. 7.1	The organization leaders identify and monitor key performance indicators (KPIs) and clinical outcomes to assess the quality and effectiveness of digital healthcare services.	
IM.1.4	The information management program is monitored, and actions taken when needed.	
IM. 2.4	The organization monitors compliance and takes actions when confidentiality, security, data, and information breaches are identified.	
IM. 3.4	The organization monitors compliance with policies, procedures, and plans, and actions are taken when needed.	
IM. 4.3	There are established and implemented guidelines for the electronic medical record on the use of copy and paste, autofill, auto correct, and templates; staff are trained on the guidelines, compliance is monitored, and actions taken.	

SECTION 1: PATIENT-FOCUSED CLINICAL SERVICES

CRITICAL PATIENT SAFETY STANDARDS (CS)

Overview and Intent of Standards

The critical patient safety standards address high-risk, high-volume, and problem-prone areas in the provision of patient care that often lead to patient injury. The purpose of these standards is to promote specific improvements in patient safety in these high-risk areas to ensure that "never events" do not occur. The term "never event" is meant to refer to errors that should never occur in health care, but has been expanded to include serious, preventable, and clearly identifiable adverse events. Each critical patient safety standard highlights significant problematic areas in healthcare and identify evidence-based solutions to these problems.

Standards and Measurable Elements

Standard **CS.1

The organization creates and implements a process to ensure correct identification of patients following WHO guidelines and local regulations.

Measurable Elements of CS.1

CS.1.1 A process is created and implemented for identifying the patient and labeling elements associated with the patient's care and treatment plan which uses at least two patient identifiers, which do not include the use of the patient's room number or location in the organization.
CS.1.2 Before performing diagnostic procedures, providing treatments, and performing other procedures, patients are identified using two patient identifiers.
CS.1.3 The organization creates and implements a patient identification process for special circumstances, such as the comatose patient or newborn who is not immediately named.
(m) CS.1.4 Compliance with patient identification is monitored and actions are taken when adverse events occur.

Standard **CS.2

The organization creates and implements effective communication processes throughout the continuum of care, including verbal communication and/or telephone communication.

Measurable Elements of CS.2

CS.2.1 There is a standardized process for handover communication between caregivers including shift change and between departments.
CS.2.2 There is a standardized process for verbal and/or telephone communication between caregivers and departments.
CS.2.3 There is a process for reporting and receiving critical results of tests.
(m) CS.2.4 Compliance with communication processes is measured and actions are taken when adverse events occur.

Standard **CS.3

The organization creates and implements processes to ensure medication safety.

Measurable Elements of CS.3

CS.3.1 The organization creates a list of high alert medications and implements a uniform process for reducing the risk of harm associated with high-alert medications.

CS.3.2 The organization creates a list of Look-alike/sound-alike medications and implements a uniform process for reducing the risk of harm associated with Look-alike/sound-alike medications.

CS.3.3 The organization creates a list of concentrated electrolytes and locations and implements a uniform process for minimizing the use of concentrated electrolytes.

(m) CS.3.4 Compliance with medication safety is measured and actions taken when adverse events occur.

Standard **CS.4

The organization reduces the risk of healthcare associated infections (HAIs).

Measurable Elements of CS.4

CS.4.1 The health care organization adopts and implements evidence-based hand-hygiene guidelines.

CS.4.2 Priority areas for improvement of health care -acquired infections are identified by organization and infection control leadership.

CS.4.3 Evidenced-based interventions for all patients to reduce HAIs are identified and implemented by organization and infection control leadership.

(m) CS.4.4 Compliance with interventions to reduce the risk of healthcare-acquired infections is measured and actions taken when adverse events occur.

Standard **CS.5

The organization creates and implements processes for ensuring safe surgical and invasive procedures.

Measurable Elements of CS.5

CS.5.1 The organization creates and implements a process that ensures correct verification at the pre-procedure stage, which includes the correct patient, procedure, and site and as applicable, any implants.

CS.5.2 The organization requires the person performing the procedure to unambiguously mark the operative/invasive procedure site with the patient's involvement to correctly identify the intended site of incision or insertion.

CS.5.3 The organization requires the performance of a time-out with all involved staff immediately before starting the procedure and related anesthetic, which includes correct patient, correct procedure, and correct site, in the area where the procedure will be performed, immediately before starting the procedure.

(m) CS.5.4 Compliance with interventions to reduce the risk of surgical errors is measured and actions taken when adverse events occur.

Standard **CS.6

The organization creates and implements a process to reduce the risk of patient falls.

Measurable Elements of CS.6

CS.6.1 The organization creates and develops a process for assessing all patients for the risk of falls.

CS.6.2 Patients are reassessed for fall risk due to change in condition.

CS.6.3 The organization adopts and implements evidence-based, area-specific interventions associated with reducing the risk of falls.

(m) CS.6.4 Compliance with interventions to reduce the risk of patient falls is measured and actions taken when adverse events occur.

CONTINUUM OF PATIENT CARE (CP)

Standards and Measurable Elements

Standard CP.1

Patients presenting to the organization for care, treatment, or services, whether inpatient or outpatient, are screened to identify if their health care needs match the organization's mission and resources, and those with emergent, urgent, or immediate needs are given priority for assessment and treatment.

Measurable Elements of CP.1

CP.1.1 The organization identifies, from multiple sources, the primary procedures and clinical services to be provided to patients.
CP.1.2 The organization ensures a process for prioritizing those patients with emergent, urgent, or immediate needs.
CP.1.3 The organization transfers, refers, or assists patients in identifying appropriate healthcare services when the patient's needs do not match the organization's mission and resources.
(m) CP.1.4. Referrals and transfers are monitored to ensure appropriateness, and actions are taken when adverse events occur.

Standards **CP.2

There is a process for managing the flow of patients throughout the organization that includes admitting inpatients and registering outpatients.

Measurable Elements of CP.2

CP.2.1 The flow of patients throughout the care continuum is supported by a process created and implemented by the organization.
CP.2.2 There is a process to ensure timely admission of all patients, such as emergency, surgical, direct admission, transfers, and others, to the organization.
CP.2.3 The organization plans and provides for the care of patients who are not able to be admitted in a timely manner.
(m) CP.2.4 The patient flow process is monitored for effectiveness to identify and implement process for improvement.

Standard CP.3

The organization creates and implements processes to provide continuity of patient care services.

Measurable Elements of CP.3

CP.3.1 The organization creates and implements processes to ensure coordination among health care practitioners, and access to information related to the patient's care.
CP.3.2. There are criteria that have been established for admission and discharge from the departments/wards providing intensive or specialized services.
CP.3.3 During all phases of care, the organization identifies a qualified individual who is responsible for the patient's care who is responsible for the patient's care through all phases from admission to discharge.
(m) CP.3.4 The processes for providing coordination and continuity of care are monitored and actions taken when adverse events occur.

Standard CP.4

The organization creates and implements processes for patient discharge.

Measurable Elements of CP.4

CP.4.1 The organization ensures a process to identify patient's readiness for discharge.
CP.4.2 The patient is assessed for the need for support services after discharge and the organization ensures coordination of services when they are required.
CP.4.3 The organization ensures patients and families are involved and educated on the need for any ongoing care following discharge including new medications to take and when any medications related to their care can be discontinued.
CP.4.4 A summary of the patient's hospitalization and/or out-patient care is documented, and the patient's discharge plan is documented in the patient's health record.

PATIENT AND FAMILY RIGHTS (PR)

Standards and Measurable Elements

Standards PR.1

The patient's and family's rights during care are supported through a process developed by the organization.

Measurable Elements of PR.1

PR.1.1 The rights of patients are defined in a patient bill of rights or other documents.
PR.1.2 Each patient, and when appropriate the family, is provided with Information about patient rights and responsibilities, as well as information about their admission and the organization's services in a written document as applicable, in a language the patient understands.
PR.1.3 The staff of the organization listen to patients and respect their views about their health and assist with exercising their right to participate in care decisions, including the right to refuse care or treatment in accordance with the laws and regulations of the country.
PR.1.4 Patients have the right to be informed of any unanticipated outcomes that may have occurred during the course of their care and treatment, and this communication is documented in the patient's record.

Standard PR.2

The organization ensures patient privacy and confidentiality of care and information within the context of existing law and regulations.

Measurable Elements of PR.2

PR.2.1 Confidentiality of patient information is maintained according to laws and regulations.
PR.2.2 The organization has a process for providing patients with access to their health information.
PR.2.3 The organization has a process for granting permission to the release of health information within the context of existing laws and regulations.
PR.2.4 The patient's need for privacy and confidentiality is respected during interviews and clinical processes.

Standard PR.3

There is a documented policy and procedure that identifies potential barriers to accessing and receiving care and provides reasonable accommodations and accessible formats to meet the needs of patients/families with disabilities.

Measurable Elements of PR.3

PR.3.1 The organization's leaders identify common barriers and challenges patients may experience when accessing services.
PR.3.2 The organization's leaders develop and implement strategies to overcome these barriers.
PR.3.3 Patients are provided with information about care, treatment, and services in a manner and language that they understand.

PR.3.4 Staff members receive training on available accommodations for patients with disabilities, and on appropriate interactions.

Standard **PR.4

A uniform process has been established for the granting of consent by patients.

Measurable Elements of PR.4

PR.4.1 There is a policy and procedure for the uniform granting of consent.
PR.4.2 The clinical practitioner providing the service educates the patient to make informed decisions and grant consent, including at least:

- the diagnosis and the planned treatment/procedure;
- expected benefits, common side effects and alternative options;
- potential risks and complications;
- comprehensive outcomes and recovery implications.

PR.4.3 Patient consent is provided in a manner and language that the patient can understand and documented in the patient record.
(m) PR.4.4 Compliance with the consent process is monitored and actions taken when deviations are identified.

Standard PR.5

The organization provides care that is respectful of the patient's dignity, personal values, and beliefs, including cultural and spiritual values.

Measurable Elements of PR.5

PR. 5.1 The values, beliefs, spirituality, language, diet and other preferences of the target populations served are identified.
PR. 5.2 The clinical and operational policies and procedures are designed to support culturally and linguistically appropriate services and processes.
PR.5.3 The organization makes available professional interpreters for patients based on patient needs or upon request.
PR.5.4 The organization ensures that all communication is in the patient's language of choice.

Standard PR.6

The organization supports the patient's right to refuse or discontinue treatment, withhold resuscitative services, and decline or remove life-sustaining treatments, and ensures patients and families are educated on these rights.

Measurable Elements of PR.6

PR.6.1 In accordance with laws and regulations, the organization establishes its position on withholding resuscitative services and declining or removing life-sustaining treatments and ensures patients and families are informed about these rights.
PR.6.2 The organization guides health care practitioners on the ethical and legal considerations in carrying out patient wishes regarding treatment alternatives.
PR.6.3 The organization creates and implements a process for managing patients who notify staff that they are leaving against medical advice
PR.6.4 The organization creates and implements a process for patients who elope from the organization or leave before completion of treatment without informing staff.

Standard PR.7

Policies and procedures have been developed and implemented for receiving and addressing patient complaints, disputes, disagreements, and ethical dilemmas within a defined timeframe and the complaint process is made publicly available.

Measurable Elements of PR.7

PR.7.1 All patient complaints and expressions of concern regarding their care are documented in the patient's record, or in a complaint log and are in a standardized format for analysis and timely response.
PR.7.2 The organization has well-developed procedures for the response and resolution of patient complaints, disputes, disagreements, and ethical dilemmas.
PR.7.3 The organization works to quickly resolve patient complaints, disputes, disagreements, and ethical issues to the satisfaction of all parties and within the timeframe defined in program policy.
(m) PR.7.4 Patient complaints and concerns are tracked and analyzed as part of quality improvement, patient safety, and/or risk management processes.

Standard PR.8

The organization implements a process for collecting and analyzing data related to patient and companion satisfaction, and implements improvements as needed.

Measurable Elements of PR.8.

PR.8.1 The organization develops and implements a process for assessing patient and/or family/companion satisfaction.
(m) PR.8.2. Satisfaction data are aggregated, analyzed, and transformed into information to identify strategies for improvement.
PR.8.3. The organization identifies priorities for improving the quality of patient care.
PR.8.4. Identified strategies for improving patient care are implemented, analyzed, and revised to optimize impact on the quality of patient care.

ASSESSMENT OF PATIENTS (AP)

Standards and Measurable Elements

Standard AP.1

The organization defines an assessment process for all patients.

Measurable Elements of AP.1

AP. 1.1 All inpatients and outpatients have an initial assessment performed by qualified individuals, permitted by license, laws, regulations, and certification.
AP. 1.2 The initial assessment includes a health history and physical examination consistent with the requirements defined in the organization policy.
AP.1.3 The initial medical and nursing assessment, which are documented in the patient record, is completed in a timeframe defined by the organization consistent with the patient's condition.
AP.1.4 The initial assessment results in a patient diagnosis.

Standard **AP.2

The organization defines an assessment process to identify the needs of emergency, surgical, and special population patients.

Measurable Elements of AP.2

AP. 2.1 All patients presenting to the emergency department have a documented initial medical assessment based on their needs and condition identified by an evidenced-based triage protocol.
AP. 2.2 All patients having an invasive procedure require a documented medical assessment completed within 30 days prior to their procedure.

AP.2.3 Patients undergoing procedural sedation or anesthesia have a documented medical assessment by a qualified individual.
AP.2.4 Special populations cared for by the organization require an individualized initial assessment consistent with their needs.

Standard AP.3

The initial assessment includes screening for nutritional, functional, pain status, and self-harm/suicide.

Measurable Elements of AP.3

AP. 3.1 Patients are screened for nutritional status and those identified at risk receive a specialized nutritional assessment that is documented in the patient record.
AP. 3.2 Patients are screened for functional status and those identified at risk receive a specialized functional assessment that is documented in the patient record.
AP.3.3 Patients are screened for pain and those identified with pain receive a comprehensive pain assessment that is documented in the patient record.
AP.3.4 Patients are screened for self-harm and suicide and those identified at risk receive a comprehensive suicide/self-harm assessment.

Standard AP.4

The organization defines the reassessment intervals required for patients based on their needs, condition, and treatment.

Measurable Elements of AP.4

AP. 4.1 Qualified individuals conduct patient reassessments.
AP. 4.2 Reassessment of patients occurs after treatment to determine their response, or when there has been a change in condition, plan of care, or individual needs.
AP.4.3 In-patients are reassessed by a physician at least daily unless the organization defines circumstances and types of patients that do not require daily physician assessments, such as a stable psychiatric patient receiving group therapy sessions.
AP.4.4 The reassessments conducted are documented in the patient's health record.

Laboratory and Diagnostic Imaging Services

Standard AP.5

The organization has laboratory services available to meet patient needs, and all services meet applicable local and national standards, laws, and regulations.

Measurable Elements of AP.5

AP. 5.1 Laboratory services are under the direction of one or more qualified individuals and all staff have the required education, training, and qualifications.
AP. 5.2 Laboratory results are available to the patient's physician in a timely manner, and a process for reporting critical results is defined and implemented by the organization.
AP.5.3 There is a laboratory safety program which includes the availability of showers, spill kits, eye wash capabilities, and response to needle sticks, which is integrated into the organization's facility management programs and reports any safety events that occur.
AP.5.4 There is a laboratory biohazard program which ensures personal protective equipment availability, which is integrated into the organization's infection control program and reports any biohazard events that occur.

Standard AP.6

The organization's laboratory is organized with adequate supplies and equipment and provides proper specimen management.

Measurable Elements of AP.6

AP. 6.1 Procedures for collecting, identifying, handling, safely transporting, retention, and disposing are developed and implemented.
AP. 6.2 Laboratory reagents and supplies are consistently available, evaluated for accuracy of results, and accurately labeled.
AP.6.3 There is a documented quality control program that establishes quality control checks on each test performed and on each piece of testing equipment as recommended by the manufacturer and identified by the organization.
AP.6.4 The laboratory participates in a proficiency testing program, or an acceptable, alternative process.

Standard AP.7

Blood and/or transfusion services, when provided by the organization, adhere to laws and regulations and recognized standards of practice.

Measurable Elements of AP.7

AP. 7.1 Blood bank services are under the direction of one or more qualified individuals and all staff have the required education, training, and qualifications.
AP. 7.2 There are established, implemented, and documented processes for blood donor selection, screening for disease, collection, storage, compatibility testing, and distribution.
(m) AP.7.3 The blood bank and transfusion services have quality control measures that are established, implemented, documented, and monitored for compliance.
AP.7.4 There is a process for reporting, investigating, and mitigating blood bank and/or transfusion adverse events that occur.

Standard AP.8

The organization has a Point of Care Testing (POCT) program that meets required laws and regulations, and professional standards.

Measurable Elements of AP.8

AP. 8.1 The POCT program is under the direction of one or more qualified individuals.
AP. 8.2 The staff participating in the POCT program are competent to perform testing as evidenced by the required qualifications and training.
AP.8.3 Abnormal results reporting, including critical results, is reported in a manner defined by the organization.
(m) AP.8.4 The POCT program is monitored for quality control performance, documentation, and evaluation and included in quality improvement activities.

Standard AP.9

The organization provides or arranges for radiology and diagnostic imaging services to meet patient needs, and all services meet applicable local and national standards, laws, and regulations.

Measurable Elements of AP.9

AP. 9.1 Radiology and diagnostic imaging services are under the direction of one or more qualified individuals and all staff have the required education, training, and qualifications.
AP. 9.2 Radiology and diagnostic imaging results are available to the patient's physician in a timely manner, and a process for reporting critical results is defined and implemented by the organization.
AP.9.3 A radiology and diagnostic imaging safety program for patients, staff, and visitors is defined and implemented and is consistent with professional standards such as minimizing exposures to radiation, manufacturer's requirements, and laws, and regulations.

AP.9.4 The radiation and diagnostic imaging safety program is integrated into the organization's facility management and infection control program and reports any adverse events that occur.

Standard AP.10

The radiology and diagnostic imaging services create, implement, and document a program to manage equipment.

Measurable Elements of AP.10

AP. 10.1 There is a documented inventory of all equipment used in the radiology and diagnostic imaging services.
AP. 10.2 The equipment used in the radiology and diagnostic imaging services is inspected, maintained, and calibrated according to manufacturer's recommendations, and results are documented.
AP.10.3 There is an inspecting and testing program for radiology equipment that is performed when the equipment is new, according to age, use, and according to manufacturer's recommendations.
(m) AP.10.4 The organization has a system in place for monitoring and acting on radiological equipment hazard notices, recalls, reportable incidences, failures, and adverse events.

Standard AP.11

The organization creates and implements a radiology and diagnostic imaging quality control program.

Measurable Elements of AP.11

AP. 11.1 The radiology and diagnostic imaging quality control program includes validating test methods.
AP. 11.2 The radiology and diagnostic imaging quality control program includes regular surveillance and documentation of imaging results.
AP.11.3 The radiology and diagnostic imaging quality control program includes rapid correction and documentation when a deficiency is identified.
AP.11.4 When the organization contracts with outside services for radiology and diagnostic imaging services, the organization ensures regular review of quality control results.

CLINICAL PATIENT CARE (PC)

Standards and Measurable Elements

Standard PC.1

Care of patients is uniform throughout the organization, follows applicable laws and regulations, and is integrated and documented.

Measurable Elements of PC.1

PC. 1.1 There are uniform care processes developed and implemented by the organization's department/service leaders that do not vary according to time of day, patient's ability to pay, acuity of patient's condition, and are consistent throughout the organization.
PC. 1.2 Settings, departments, and services integrate and coordinate care planning and care delivery to patients.
PC.1.3 A uniform process is created and implemented for prescribing patient orders, verbally, via telephone/texting, and written.
PC.1.4 Only qualified individuals are permitted to prescribe orders.

Standard PC.2

A plan of care is that is specific to the patient's needs is developed and documented for each patient, and communicated to the patient and, when appropriate, family.

Measurable Elements of PC.2

PC. 2.1 The care identified for the patient and the desired outcome from the assessment process are documented in a plan of care that is an integration of all planned procedures, treatments, and services, including the intended goals or outcomes of the procedures, treatments, and services to be delivered.
PC. 2.2 The plan of care reflects any unique needs or preferences of the patient such as family involvement, religion, or faith implications of care choices, learning preferences and recuperation preferences.
PC.2.3 The plan of care is reviewed with the patient and, when appropriate, the family.
PC.2.4 The plan of care is updated as needed and documented in the patient's medical record.

Standard PC.3

All patients identified at risk for nutrition, functional, pain, and self-harm/suicide receive care according to professional guidelines.

Measurable Elements of PC.3

PC.3.1 The organization creates and implements a process for providing nutritional therapy.
PC.3.2 The organization creates and implements a process for managing functional status.
PC.3.3 The organization implements evidence-based guidelines for managing and treating patients in pain.
PC.3.4 Protocols and procedures to mitigate the risk of patient suicide and/or self-harm are created and implemented by the organization.

Standard **PC.4

Professional practice guidelines, laws and regulations guide the care of high-risk patients and high-risk services that are provided by the organization.

Measurable Elements of PC.4

PC. 4.1 The organization identifies and defines a list of high-risk patients and high-risk services provided by the organization.
PC. 4.2 Evidence-based clinical practice guidelines, endorsed by relevant authoritative sources, along with standardized protocols, procedures, and/or pathways are adopted and implemented for the identified high-risk patients and high-risk procedures and clinical services provided by the organization.
PC.4.3 Staff are trained on the guidelines, protocols, procedures, and pathways, as well as on the specialized medical equipment used for the care of high-risk patients and high-risk services.
(m) PC.4.4 The standardized protocols, procedures and pathways and use or non-use and clinical outcomes are monitored as part of the program's quality improvement processes.

Standard **PC.5

When blood and blood products are used within the organization, clinical guidelines and procedures are created and implemented to ensure safe handling, use, and administration.

Measurable Elements of PC.5

PC.5.1 The organization defines a process for obtaining consent and identifies situations in which consent cannot be obtained, for the administration of blood and blood products.
PC.5.2 The organization creates and implements procedures based on professional guidelines and laws and regulations for the storage and procurement of blood and blood products.
PC.5.3 The organization creates and implements procedures
based on professional guidelines and laws and regulations for the administration of blood and blood products.
(m) PC.5.4 Staff are trained to monitor patients receiving blood and blood products, including the identification and response to potential transfusion reactions.

Standard PC.6

There is a program for the safe use of lasers and other optical radiation devices based on industry standards and professional guidelines that is established and implemented by the organization.

Measurable Elements of PC.6

PC.6.1 There is a qualified individual that oversees and supervises the program, and ensures all staff involved receive safety training and continuing education regarding the use of lasers or other optical radiation devices.
PC.6.2 The organization creates and implements a laser and optical radiation safety program that includes administrative and engineering controls, and appropriate PPE that reduces the risk of injury to patients and staff.
PC.6.3 Qualified and trained individuals perform the processes created by the organization for inspecting, testing, and maintaining lasers and optical radiation devices, including routine calibration and alignment checks of lasers.
PC.6.4 The laser and optical radiation safety program is integrated with the organization's facility management, infection control, and quality and risk programs.

Standard **PC.7

The organization creates and implements procedures that ensure the early identification and management of patients experiencing changes in their condition.

Measurable Elements of PC.7

PC.7.1 The organization creates and implements an age-specific, systematic process for early identification and timely response to early warning signs of a change in the patient's condition.
PC.7.2 The process includes when and how to seek further assistance.
PC.7.3 The organization ensures staff are trained in these processes.
(m) PC.7.4 The organization monitors compliance with the processes associated with changes in a patient's condition.

Standard **PC.8

Resuscitation services are available throughout the organization.

Measurable Elements of PC.8

PC.8.1 Resuscitation services, including medical equipment and medications for basic and advanced life support are available to be provided to patients 24 hours per day, every day throughout the organization.
PC.8.2 Staff training, medical equipment, and medications for basic and advanced life-support are standardized for use based on the patient population served (for example, neonate, pediatric, adult, elderly).
PC.8.3 The organization identifies health professional staff required to have basic and/or advance life support and ensures they are trained, certified, and recertified.
(m) PC.8.4 The organization monitors the outcomes of resuscitation services.

Standard PC.9

When the organization provides organ and tissue transplant services, evidence-based guidelines, and local laws and regulations are followed.

Measurable Elements of PC.9

PC. 9.1 The organization provides resources, a qualified individual to oversee, and trained staff to support the program.
PC. 9.2 There is a designated coordination mechanism for all transplant activities involving physicians, nurses, and other healthcare practitioners for each organ-specific transplant service offered.

PC.9.3 There are documented protocols, practice guidelines, and procedures for identifying the suitability of the patient for transplant and for organ recovery and receipt to ensure compatibility, safety, efficacy, and suitability of organs and tissues for transplantation.
PC.9.4 The organization utilizes organ-specific clinical practice guidelines for developing individualized patient care plans to address each phase of the transplantation process.

ANESTHESIA AND SURGERY (AS)

Standards and Measurable Elements

Standard AS.1

The organization provides sedation and anesthesia services to meet patient needs, based on professional and national standards, and applicable laws and regulations.

Measurable Elements of AS.1

AS.1.1 Selection of appropriate sedation or anesthesia is based on the assessment of the patient and the planned procedure and any licensure or other requirements.
AS.1.2 Administration of sedation and anesthesia is performed by qualified individuals.
AS.1.3 Patients are monitored during sedation and anesthesia by a qualified individual and emergency equipment and medication is immediately available.
AS.1.4 Patients are monitored during recuperation from sedation and anesthesia, and criteria are used for decisions to move the patient to an in-patient care unit or to a pre-discharge unit.

Standard **AS.2

The organization ensures standardization of procedural sedation throughout all areas of the organization.

Measurable Elements of AS.2

AS.2.1 Practitioners privileged to provide procedural sedation and individuals monitoring patients receiving procedural sedation are qualified.
AS.2.2 Professional practice guidelines are used in the administration, monitoring, and recovery of procedural sedation.
AS.2.3 Patients receiving procedural sedation are assessed prior to sedation by a qualified individual and that assessment is documented in the patient's record.
(m) AS.2.4 Procedural sedation processes are monitored, and actions are taken when adverse events occur.

Standard **AS.3

Anesthesia services are provided by qualified individuals and follow professional guidelines and laws and regulations.

Measurable Elements of AS.3

AS.3.1 Prior to the delivery of anesthesia, a pre-anesthesia and pre-induction assessment is conducted by a qualified individual.
AS.3.2 The patient's physiological status is monitored and documented during anesthesia and the intraoperative procedure based on professional practice guidelines.
AS.3.3 Post-anesthesia care requires documented monitoring and discharge from recovery requires an assessment by a qualified individual using established criteria.
(m) AS.3.4 Anesthesia processes are monitored, and actions are taken when adverse events occur.

Standard **AS.4

Surgical and invasive procedures are provided by qualified individuals, and the care is planned and documented in the patient's record.

Measurable Elements of AS.4

AS.4.1 A qualified individual assesses the patient prior to the surgical/invasive procedure and develops a pre-operative diagnosis and planned procedure which is documented in the patient's medical record.
AS.4.2 A surgical note is documented in the patient's medical record and includes

- postoperative diagnosis;
- name of operative surgeon and assistants;
- procedures performed and description of each procedure findings;
- perioperative complications;
- surgical specimens sent for examination;
- amount of blood loss and amount of transfused blood; and
- date, time, and signature of responsible physician.

AS.4.3 The organization creates and implements policies and procedures that follow evidence-based guidelines, laws, and regulations when implantable devices are used.
(m) AS.4.4 Surgical and invasive procedures are monitored, and actions are taken when adverse events occur.

MEDICATION MANAGEMENT (MM)

Standards and Measurable Elements

Standard MM.1

Medication use throughout the organization is under the direction of a qualified individual(s), meets applicable laws and regulations and is integrated wherever medications are stored and/or used.

Measurable Elements of MM.1

MM.1.1 One or more qualified individuals provide direction and oversight for the planning, selection, procurement, data analysis and evaluation of the medication management program.
MM.1.2 The distribution and dispensing of medications is uniform throughout the organization.
MM.1.3. There is a list of medications within the organization and a process to add or delete medications as needed, including any manufacturer's recalls.
(m) MM.1.4 There is an annual review of the medication management program which includes monitoring of medication processes and actions taken when near miss or adverse events occur.

Standard MM.2

The organization creates and implements a multidisciplinary program for antibiotic stewardship that involves infection prevention and control professionals, physicians, nurses, pharmacists, microbiologists, and others as appropriate.

Measurable Elements of MM.2

MM.2.1 The organization's antibiotic stewardship program's foundation is evidence-based guidelines, scientific evidence, and local laws and regulations.
MM.2.2 There are guidelines for the optimal use of antibiotic therapy in treating infections and includes proper prophylactic antibiotic therapy.
MM.2.3 The antibiotic stewardship program has oversight for the use of antibiotics within the organization.
(m) MM.2.4 The organization monitors the effectiveness of the antibiotic stewardship program.

Standard MM.3

Medications are safely stored under suitable conditions.

Measurable Elements of MM.3

MM.3.1 Wherever medications are located throughout the organization, the conditions are suitable for product stability as identified by the manufacturers and secured.
MM.3.2 The organization follows applicable laws and regulations to accurately account for controlled substances.
(m) MM.3.3 There is a uniform process for the availability, storage, security, and monitoring of emergency medications when stored outside of the pharmacy.
MM.3.4 The organization ensures safe storage and use of medications that require special handling, such as radioactive medications, investigational medications, and others.

Standard MM.4

There is a uniform process for ordering medications by a qualified individual.

Measurable Elements of MM.4

MM.4.1 The organization defines the elements of a complete medication order or prescription.
MM.4.2 There is a defined place in the patient medical record where medications are ordered or transcribed.
MM.4.3 The medical record contains a complete list of the patient's medications taken prior to admission/registration, and new medication orders are compared to that list and reviewed for appropriateness.
MM.4.4 The organization defines the process for managing incomplete, illegible, or unclear orders.

Standard MM.5

The organization's processes for medication preparation and dispensing adhere to laws and regulations and professional standards of practice. Staff compounding and preparing medications are trained in the principles of medication preparation and aseptic technique.

Measurable Elements of MM.5

MM.5.1 Only qualified staff are permitted to prepare and dispense medication, and all medications must be labeled with required information identified by professional standards of practice (for example, ISMP).
MM.5.2 Medications are prepared, whether inside or outside of the pharmacy, in a standardized manner that ensures a clean, safe, and functionally separate environment.
MM.5.3 The organization creates and implements guidelines that are integrated into the medication process for the use of single-use and multidose vials.
MM.5.4 The organization creates and implements processes for the preparation/compounding of sterile products/medication, ensures staff are trained and competent in the principles of medication preparation and aseptic techniques, and provides resources to support the medication preparation process.

Standard MM.6

The organization designates qualified individuals to administer medications.

Measurable Elements of MM.6

MM.6.1 Only qualified individuals are permitted to administer medications.
MM.6.2 A medication administration process verifies the medication is correct based on the order and is administered to the right patient, at the right time, and in the right form and route of administration.
MM.6.3 Medications that are administered are documented in the patient's medical record, including time of administration.
MM.6.4 Prior to administration of medications, patients are informed about the medication being given and provided with an opportunity to ask questions.

Standard MM.7

The organization ensures that the effects of medications on patients are monitored.

Measurable Elements of MM.7

MM.7.1 The organization monitors and documents the effects of any medications administered to the patient.
(m) MM.7.2 When adverse effects occur, they are monitored and documented in the patient's record and included in the organization's quality program.
MM.7.3 The organization defines medication errors and near misses,
MM.7.4 There is a process for reporting and acting on medication errors and near misses.

INFECTION PREVENTION AND CONTROL (IC)

Standards and Measurable Elements

Standard IC.1

The infection prevention and control program is overseen by one or more qualified individuals and guided by appropriate policies and procedures.

Measurable Elements of IC.1

IC.1.1 The infection control prevention and control program includes a qualified leader(s) working collaboratively with physicians, nurses, and other staff (for example, facility maintenance, housekeeping, pharmacy, and the like) to mitigate and manage infection risks throughout the organization.
IC.1.2 The organization's leadership provides appropriate staff and resources to support the infection control program.
IC.1.3. The organization designs and implements a comprehensive infection prevention and control plan that identifies, prioritizes, and mitigates infection risks throughout the organization based on the identified services.
IC.1.4 There is an annual risk assessment to identify and prioritize areas of high risk within the organization.

Standard **IC.2

The infection prevention and control program utilizes professional standards of practice for the adequate cleaning, disinfecting, sterilizing, and storing of medical equipment and supplies.

Measurable Elements of IC.2

IC.2.1 The professional practice and manufacturer guidelines for sterilization and disinfection techniques that fit the type of situation and specific devices are implemented.
IC.2.2 Staff processing clinical equipment, devices, and supplies are oriented, trained, and competent and are properly supervised.
IC.2.3. The organization ensures that designated storage areas for clean and sterile supplies are protected from dust, moisture, and temperature extremes.
(m) IC.2.4 Throughout the organization, the methods for cleaning, disinfecting, sterilizing and storage are uniformly applied and monitored for compliance.

Standard IC.3

The infection prevention and control program identifies standards from recognized authoritative sources to address cleaning and disinfecting of the environment, and cleaning and disinfecting of laundry and linens.

Measurable Elements of IC.3

(m) IC.3.1 The organization monitors environmental cleaning and disinfecting processes and uses data to implement improvements when needed.
IC.3.2 The cleaning and disinfection of infectious rooms during hospitalization or during out-patient treatments and after discharge use appropriate guidelines.

IC.3.3. The organization creates and implements processes to ensure that laundry and linens are handled, transported, processed, and stored in a manner that prevents cross-contamination.
(m) IC.3.4 The organization monitors processes for the management of laundry and linen and uses data to implement improvements when needed.

Standard IC.4

The handling and disposal of infectious waste and sharps and needles is managed to minimize the risk of infection.

Measurable Elements of IC.4

IC.4.1 Policies and procedures are created and implemented for minimizing infection transmission risk in the handline of infectious waste, for example, blood, body fluids, and tissues.
IC.4.2 Policies and procedures are created and implemented for minimizing infection transmission risks in the handling of sharps and needles.
IC.4.3. The organization provides puncture-proof, leak-proof containers that can be closed to dispose of sharps and needles.
IC.4.4 Staff are trained to prevent cross-contamination from the handling of infectious waste and sharps and needles.

Standard **IC.5

The infection prevention and control program creates and implements processes to protect patients and staff from bloodborne pathogens related exposures to blood and body fluids.

Measurable Elements of IC.5

IC.5.1 The infection prevention and control program identifies processes that present a risk for patient or staff exposure to blood and body fluids.
IC.5.2 The infection prevention and control program implements processes to reduce the risk of exposure to blood and body fluids.
IC.5.3. The infection prevention and control program creates and implements processes for reporting and acting on patient and staff exposures to blood and body fluid.
(m) IC.5.4 The infection prevention and control program monitors incidences of patient and staff exposure to blood and body fluids and takes action to minimize the risk of future exposures.

Standard IC.6

The infection prevention and control program creates and implements processes to reduce the risk of infection associated with food and food services.

Measurable Elements of IC.6

IC.6.1 The infection prevention and control program has processes in place to properly store food and nutritional products that reduce the risk of infection throughout the organization.
IC.6.2 The infection prevention and control program adopts and implements sanitation measures and guidelines that prevent cross contamination and infection in the food preparation areas.
IC.6.3. The organization prepares and transports food and nutrition products using proper sanitation and temperature.
IC.6.4 For nutritional products that require special storage and preparation requirements (such as human milk, baby formula), the infection prevention and control program adopts professional standards and guidelines.

Standard IC.7

The infection prevention and control program creates and implements processes to reduce the risk of infection throughout the facility and during demolition and construction through the use of mechanical and engineering controls.

Measurable Elements of IC.7

IC.7.1 In accordance with local and national laws and regulations and professional standards, the organization operates and maintains negative and positive pressure ventilation systems.
IC.7.2 In accordance with local and national laws and regulations and professional standards the organization operates and maintains temperature controls for water and steam.
IC.7.3. In accordance with local and national laws and regulations and professional standards the organization operates and maintains air flow, ventilation, and humidity controls.
IC.7.4 During renovation and new construction the organization implements a pre-construction risk assessment (PCRA) and an infection control risk assessment (ICRA) to protect patients, staff, and visitors from exposure to dust and debris to reduce the risk of infection.

Standard **IC.8

The infection prevention and control program provides barrier precautions and isolation procedures to protect patients, visitors, and staff from communicable diseases.

Measurable Elements of IC.8

IC.8.1 In accordance with professional practice guidelines, the organization creates and implements a process to isolate patients with infectious diseases and staff use appropriate transmission-based precautions.
IC.8.2 In accordance with professional guidelines, the infection prevention and control program protects patients who are at an increased risk of contracting a communicable disease, such as patients who are immunosuppressed, through the isolation and the use of reverse/protective isolation.
(m) IC.8.3. Negative pressure rooms needed for infectious patients who require airborne isolation are provided and monitored.
IC.8.4 When negative pressures are not immediately available, the infection prevention and control program creates and implements a process for temporarily managing patients requiring airborne isolation for a short period of time.

Standard **IC.9

Personal protective equipment (PPE), soap, and disinfectants are available and used correctly when required.

Measurable Elements of IC.9

IC.9.1 The infection prevention and control program identifies situations in which PPE is required and ensures it is available.
IC.9.2 The infection prevention and control program ensures staff, and when required, patients and visitors, are trained in the proper use of PPE, soap, and disinfectants.
IC.9.3. In areas where handwashing and hand disinfectant procedures are required, liquid soap, disinfectants, towels, and other means of drying are available.
(m) IC.9.4 The organization monitors the availability and use of soap, disinfectants, and PPE throughout the facility.

Standard IC.10

The healthcare organization has developed a comprehensive pandemic response plan that outlines its approach to managing pandemics.

Measurable Elements of IC.10

CI.10.1 - An early detection surveillance program is in place to alert the organization and public health to the possibility of an emerging infectious disease or increases in the incidence of a disease.
CI.10.2 - The plan identifies assigned roles and responsibilities for individuals and departments and ensures staff training and education on the plan and responsibilities.

CI.10.3 - The organization plans for patient triage, isolation, and treatment, as well as plans for surge staffing and maintaining an adequate supply of infection control equipment.
CI.10.4 – The organization has established clear communication and coordination with local, regional, and national public health authorities, as well as communication to staff and patients.

Standard IC.11

The Infection Prevention and Control program follows national and international guidelines for preventing and controlling infections, including reporting instances of suspected or confirmed diseases of public health concern.

Measurable Elements of IC.11

IC.11.1 The organization has identified and educated staff on the ongoing surveillance procedures and prevention and control measures to facilitate the quick identification, isolation, and management of epidemiologically significant infectious agents at risk to patients and staff to prevent spread.
IC.11.2 Assigned infection control staff regularly review microbiology reports to identify and respond to disease-specific infectious agents requiring additional facility precautions to prevent spread, such as isolation and the use of personal protective equipment.
IC.11.3 A mechanism exists for front-line healthcare personnel to report IC concerns to infection control personnel to aid in the identification and response to infectious diseases.
IC.11.4 The Infection Prevention and Control program maintains a list of reportable diseases and has documented procedures for reporting suspected or confirmed infections to the appropriate public health authorities.

Standard IC.12

Infection risks and rates are monitored as a component of the organization's risk management and quality improvement program.

Measurable Elements of IC.12

(m) IC.12.1 The infection prevention and control program collects and analyzes important epidemiological infection data (for example, catheter associated urinary tract infections, surgical site infections, and the like).
IC.12.2 The monitoring data is used to evaluate and support improvement to the program at least annually.
IC.12.3. The infection prevention and control program monitoring data includes benchmarking infection rates.
IC.12.4 The infection prevention and control program provides leadership with an analysis of the monitoring data at a timeframe defined by the organization.

SECTION 2: HEALTHCARE ORGANIZATION STANDARDS

LEADERSHIP (LR)

Standards and Measurable Elements

Standard LR.1

The organization's executive structure is established to include governance, executive leadership, and department/service leaders.

Measurable Elements of LR.1

LR.1.1. The Governing entity is identified, and the roles and responsibilities of the governing entity are defined in policies and procedures, implemented, and annually reviewed.
LR.1.2. The Chief Executive Officer is identified, and the roles and responsibilities of the Chief Executive Officer are defined in policies and procedures, implemented, and annually reviewed.
LR.1.3 The Executive Leadership Team and the Department/Service Leaders are identified, and the roles and responsibilities of the Executive Leadership Team and Department/Service Leaders are defined in policies and procedures, implemented, and annually reviewed.
LR.1.4 The organizational structure is represented in or displayed in a document, such as an organizational chart, showing the lines of authority and accountability.

Standard LR.2

The organization's leaders work collaboratively to identify and plan for the type of clinical care and services required to meet the needs of the patients served by the organization.

Measurable Elements of LR.2

LR.2.1 The organization's leaders are accountable for defining, reviewing, and updating as needed, the organization's mission and vision, values, code of conduct, and quality and patient safety program; and for creating services and programs necessary to meet the mission and vision and ensure they are consistent with the organization's values.
(m) LR.2.2 The organization's leaders are accountable for developing, implementing, and updating as needed, strategic, operational, and financial plans and monitoring performance goals designated for these plans.
LR.2.3 The organization's leaders define their communities and patient populations to understand the types of patients being served and their healthcare needs.
LR.2.4 The organization's leaders involve key stakeholders, including staff, patient/service users, the community, and local organizations to determine and the type of care and services to be provided that meet the needs of the patient/service users and are consistent with the organization's mission, vision, and values.

Standard LR.3

Department/service leaders identify and oversee the services to be provided by the individual department, and coordinate with the services of other departments.

Measurable Elements of LR.3

LR.3.1. There is a qualified individual(s) that provides direction for each department or service in the organization.
LR.3.2. Department/Service leaders create and implement a staff structure to support their responsibilities, authority, and services provided.
LR.3.3 Qualified individuals within each service select and implement evidence-based clinical practice guidelines, and related clinical pathways/protocols, to guide clinical care
(m) LR.3.4 Clinical care and processes specific to the department service are monitored and improved using selected measures that evaluate the clinical care provided.

Standard LR.4

The organization's leadership provides effective communication throughout the organization that includes the governing body and all staff.

Measurable Elements of LR.4

LR.4.1. Leaders of the organization create and implement processes for communicating relevant information throughout the organization.
LR.4.2. The organization's vision, mission, values, policies, and plans are communicated to the staff by leadership.

LR.4.3 The organization's leaders ensure communication is coordinated and integrated among all departments and services in the organization.
LR.4.4 The quality improvement and patient safety program information is communicated by leaders to the governing entity and all staff.

Standard LR.5

The organization's leadership determines the purchase and use of resources, including staff and technical resources, and determines which resources are provided through contractual arrangements.

Measurable Elements of LR.5

LR.5.1. The organization's leadership uses data and information and recommendations of professional organizations in making resource decisions, medical equipment, and staffing choice.
(m) LR.5.2. Resource decisions are monitored, and data results are used to make improvements.
LR.5.3 There is a written description of the nature and scope of contracted services to be provided.
(m) LR.5.4 Contracts are monitored and reviewed at least annually, or when adverse events occur.

Standard LR.6

The organization ensures safety of the supply chain that includes quality supplies, medications, and equipment that are available from reliable resources and properly maintained to meet the needs of the organization and the patients served.

Measurable Elements of LR.6

LR.6.1 Policies, procedures and/or protocols are developed and implemented related to the availability and use of medical, and any other supplies, medications and equipment and address the following:

a) inventory of supplies and medication,
b) appropriate storage, regular inspections and preventive maintenance;
c) a process for tracking in the event of product recalls; and
d) the availability of supplies for patients

LR.6.2 A list is maintained of approved vendors who ensure products and supplies are free from contamination and substitution and have been stored safely by the vendor prior to delivery.
LR.6.3 Staff are trained on the use of medical equipment and only properly trained and qualified staff operate medical equipment
LR.6.4 There is an adequate number of qualified staff, working with adequate storage space and all necessary logistics for supply management.

Standard LR.7

The organization's leaders create and implement a program for the ethical management of operational and business issues, and the oversight and handling of ethical issues in the provision of clinical care.

Measurable Elements of LR.7

LR.7.1. The program ensures that the care provided to patients is within business, financial, ethical, and legal principles, and promotes practices that protect patient rights.
LR.7.2. The program is transparent when communicating the services provided and ensures patients are accurately billed for the services received.
LR.7.3 The program provides a means by which staff are able to raise ethical issues without fear of retribution and provides a process for the effective resolution of ethical issues in a timeframe identified by the organization.
LR.7.4 Organization leaders create a culture of safety that promotes transparency and accountability and include a code of conduct that identifies expectations for behavior.

QUALITY IMPROVEMENT AND PATIENT SAFETY (QI)

Standards and Measurable Elements

Standard QI.1

The organization's leadership and a designated qualified individual(s), have accountability and oversight for the quality improvement and patient safety program, develop a plan for quality improvement and patient safety in the organization.

Measurable Elements of QI.1

QI.1.1. The designated, qualified leader along with support staff identify the goals and objectives of the quality improvement and patient safety program
QI.1.2. The plan identifies and incorporates evidence-based best practices from the World Health Organization (WHO) or other national and international authoritative sources.
QI.1.3 The quality improvement and patient safety program is integrated throughout the organization.
QI.1.4 The quality improvement and patient safety program coordinates and provides support to department and service leaders in the selection, collection, and analysis of measures through the organization including priorities for improvement.

Standard QI.2

The quality improvement and patient safety program has an established process to aggregate and analyze the collected quality and patient safety data related to the priority measures of the organization.

Measurable Elements of QI.2

QI.2.1. Data and information are aggregated, validated, and analyzed by qualified staff and used to make improvements
QI.2.2. Qualified staff review the data analysis and determine areas requiring improvements.
QI.2.3 Measures requiring improvement are prioritized by leadership for implementation in the organization.
QI.2.4 The priority measures for improvements to be implemented are communicated throughout the organization.

Standard QI.3

The quality improvement and patient safety program takes actions to implement and sustain the priority improvements.

Measurable Elements of QI.3

QI.3.1. The aggregated data supports patient care, organization management, professional practice review and the overall quality improvement and patient safety program.
(m) QI.3.2. Quality and patient safety improvements are monitored after implementation and sustained.
QI.3.3 Quality improvement and patient safety improvements are communicated to staff.
QI.3.4 The quality improvement and patient safety plan is annually revised based on improvements implemented and sustained.

Standard QI.4

Sentinel events, adverse events, and near miss event data are collected, analyzed and improvements are made to prevent recurrence.

Measurable Elements of QI.4

QI.4.1. The organization defines sentinel events, adverse events, and near miss events.
QI.4.2. The organization creates and implements a system for reporting and collecting event data.

QI.4.3 A thorough and credible systematic analysis (such as a Root Cause Analysis – RCA) is performed on all sentinel events, within a timeframe defined by the organization, which identifies all system and process origins that contributed to the event.
(m) QI.4.4 There is a process for analysis of adverse and near-miss events that identify corrective actions to reduce the risk of patient harm.

Risk Management

Standard QI.5

There is a documented risk management program that includes a plan that sets priorities for risk identification, the recording of risks in a risk register, and the management and mitigation of risks.

Measurable Elements of QI.5

QI.5.1. There is a system for identification, including an adverse incident reporting process, and collection of risk data that is maintained in a risk register.
QI.5.2. Based on the risk register, organization leadership sets priorities for management and mitigation of risks.
QI.5.3 A proactive risk reduction exercise is conducted annually on one of the priority risks identified by the organization's leadership.
QI.5.4 Based on the analysis of the proactive risk reduction exercise, processes are redesigned and improved.

Standard QI.6

Effective Communication and patient and family engagement in risk mitigation are components of the risk management plan.

Measurable Elements of QI.6

QI.6.1 Organization leadership develops and implements communication strategies to staff, governance, and stakeholders as appropriate
QI.6.2 Effective communication mechanisms are used with patients and families to mitigate risk and reduce potential harm.
QI.6.3 The organization takes responsibility related to complications that occur because of error or negligence on the part of the organization if appropriate, or the licensed care provider, when applicable.
QI.6.4 An adverse incident reporting process is maintained that incorporates the unique vulnerabilities of patients and any unintended consequences that may occur.

PHYSICAL ENVIRONMENT (PE)

Standards and Measurable Elements

Standard PE.1

A qualified individual oversees the facility management and safety structure to reduce and control risks in the care environment.

Measurable Elements of PE.1

PE.1.1. National and local laws, regulations, building and fire safety codes and other requirements applicable to the healthcare organization's facilities are identified and followed.
PE.1.2. To ensure operations of a safe, secure, and effective facility, organization leadership in conjunction with facilities management plan and budget for replacing or upgrading facilities systems and equipment needed.
PE.1.3 Qualified individual(s) responsible for the facility management and safety structures create and implement risk assessment and risk reduction activities.

PE.1.4 There is a mechanism in place to address internal identified risks and external citations from national or local inspections and corrective actions taken are documented.

Standard **PE.2

The organization creates and implements a program to provide a safe and secure facility for patients, families, staff, and visitors, through planning to reduce identified risks

Measurable Elements of PE.2

PE.2.1. The organization creates and implements a written program for safety that includes risk assessment and risk reduction activities.
(m) PE.2.2. There is a current and accurate inspection of the facilities and the results from the inspection are reviewed, prioritized, addressed, and monitored in the safety risk assessment.
PE.2.3 The organization creates and implements a written program for security that includes a risk assessment and risk reduction activities.
PE.2.4 The organization determines all security risk areas and restricted areas, and other security risks and identifies goals and improvements to reduce or eliminate the security risks.

Standard **PE.3

The organization creates and implements a hazardous waste and materials program that addresses inventory, handling, storage, and use of hazardous materials, and the inventory, handling, storage, and disposal of hazardous waste.

Measurable Elements of PE.3

PE.3.1 The organization develops a hazardous materials and waste program that identifies the type, quantities, and locations of hazardous materials, has a complete inventory of the hazardous materials used and stored in the organization, and ensures clear labeling consistent with information from safety data sheets (SDS).
PE.3.2 The hazardous materials and waste program develops and implements procedures for safe handling, storage, use, and proper disposal, according to laws and regulations, of hazardous materials, including providing proper protective equipment required during use.
PE.3.3 The program creates and implements procedures for the management of spills and exposures, and ensures all staff are educated.
(m) PE.3.4 The organization monitors data to ensure that risks related to hazardous materials and waste are reduced or eliminated

Standard **PE.4

The healthcare organization creates and implements a program for fire and smoke safety that complies with national and local laws and regulations and includes an ongoing assessment of fire and smoke risks.

Measurable Elements of PE.4

PE.4.1. The organization creates and implements a written program for fire and smoke safety that includes a risk assessment and risk reduction activities, and addresses using interim measures when fire safety risks cannot be immediately addressed.
PE.4.2. The fire safety program includes early detection, a means of suppression, and containment of fire and smoke, and safe exit.
(m) PE.4.3 Fire detection and abatement equipment and systems are inspected, tested, and maintained according to manufacturers' recommendations and according to requirements from local codes and regulations and this information is documented and monitored.
PE.4.4 Staff are trained in fire equipment, the processes involved in the management of fire and smoke emergencies and bringing patients to safety when a fire or smoke emergency occurs.

Standard PE.5

The healthcare organization has an emergency and disaster management program to respond to internal and external emergencies and disasters, including global infectious disease outbreaks, which have the potential of occurring within the organization and community.

Measurable Elements of PE.5

PE.5.1 The emergency and disaster management program provides processes for at least

- determining the organization's role in such events;
- determining communication strategies for events.
- managing resources during events, including alternative sources;
- managing clinical activities during an event, including alternative care sites; and
- identifying and assigning staff roles and responsibilities during an event.

PE.5.2 The organization has identified the major internal and external disasters and the impact, such as community emergencies, and natural or other disasters that pose significant risks of occurring, taking into consideration the organization's geographic location.

PE.5.3 Staff are trained on the program and participate in an annual test of the program's processes.

PE.5.4 The organization conducts a debriefing of the test performed at the conclusion of every test and follow-up actions are developed and implemented.

Standard **PE.6

The organization creates and implements a program for the management of medical equipment which includes inspection, testing, preventive maintenance, management of recalls and documentation of the results.

Measurable Elements of PE.6

PE.6.1. The organization creates and documents an inventory of all medical equipment within the facility.

(m) PE.6.2. The program includes risk assessment and risk reduction activities for all medical equipment and identifies goals, implements improvements, and monitors data.

PE.6.3 The medical equipment program includes inspecting and testing medical equipment when new, according to age, use, manufacturer's recommendations and includes preventive maintenance and calibration as needed.

(m) PE.6.4 When there are medical equipment and implantable device hazard notices, recalls, reportable incidents, problems, and failures, the organization has a system in place for monitoring and taking action.

Standard PE.7

The healthcare organization establishes and implements a program to ensure that all utility systems operate effectively and efficiently.

Measurable Elements of PE.7

PE.7.1. The organization creates and implements a written program for utilities that includes a risk assessment and prioritizes the utility system risks identified.

PE.7.2. The organization inventories its utility system's components and maps the current distribution of them.

PE.7.3 The activities and intervals for inspecting, testing, and maintaining all operating components of the utility system inventory are based on manufacturer's recommendations and risk levels and are documented.

PE.7.4 To facilitate safe management of partial or complete emergency utility system shutdowns, the utility system controls are accurately labeled.

Standard **PE.8

Essential utilities, which include power, water, and medical gases, are available at all times within the organization and established and tested alternate sources are available.

Measurable Elements of PE.8

PE.8.1 The organization ensures back-up availability of the essential utilities (water, power, and medical gases) 24 hours per day, 7 days per week for the areas and services identified at greatest risk when essential utilities are unavailable.
(m) PE.8.2. The organization assesses and monitors the risks of interruption, contamination, and failure of essential utilities, including the necessary amount available for back-up fuel sources, and takes action to reduce those risks.
PE.8.3 The availability and quality of alternate sources of water are tested and documented in a timeframe designated by the organization according to local laws and regulations.
PE.8.4 Alternate sources of power are tested and documented in a timeframe designated by the organization based on laws, regulations, manufacturer's recommendations, or conditions.

Standard **PE.9

Designated individuals or authorities monitor water quality regularly.

Measurable Elements of PE.9

(m) PE.9.1. The quality of potable and non-potable water is tested and documented based on local laws and regulations.
(m) PE.9.2. Water used in hemodialysis is tested and documented monthly for bacterial growth and endotoxins and tested and documented annually for chemical contaminants.
(m) PE.9.3 Water lines used in dental services are treated according to manufacturer's guidelines and testing and treatment are documented.
PE.9.4 Measures are created and implemented to prevent and reduce the risks of contamination and growth of bacteria in water and actions are taken and documented when water quality is found to be unsafe.

STAFF QUALIFICATIONS (SQ)

Standards and Measurable Elements

Standard SQ.1

Leaders for each department/service identify the numbers, type, and qualifications, including the education, training, knowledge, and skills needed to provide patient care and treatment, and other services.

Measurable Elements of SQ.1

SQ.1.1. Organization leadership ensures that the knowledge and skills of clinical staff are consistent with the services provided and meet patient needs.
SQ.1.2. Organization leadership ensures that the knowledge and skills of non-clinical staff are consistent with the services provided by the organization and the organization's needs.
SQ.1.3 Organization leadership creates and implements a staffing strategy that addresses the number, types, and desired qualifications of staff.
SQ.1.4 The organization maintains a personnel file for all staff that includes qualifications, work history, job description (when applicable) record of orientation, in-service education, performance reviews, and health information.

Standard SQ.2

The organization's leaders ensure there is an orientation program for all clinical and non-clinical staff, and staff are evaluated on an annual basis.

Measurable Elements of SQ.2

SQ.2.1 Organization leaders ensure clinical and nonclinical staff and any contracted staff that are used are oriented to the organization and the department/service to which they are assigned, and to their specific job responsibilities.
SQ.2.2 Upon completion of the orientation, new clinical staff are evaluated for their competency in providing the services described in their job description.
SQ.2.3 There is at least one documented evaluation for both clinical and non-clinical staff, as well as any contracted staff used, annually.
SQ.2.4 The organization provides arrangements for relevant on-going education (courses and training sessions) that are necessary to acquire and maintain the required level of performance and competency.

Standard SQ.3

There is an occupational health and safety program available for all organization staff.

Measurable Elements of SQ.3

SQ.3.1. All staff have access to an occupational health and safety (OHS) program that addresses the physical and mental health of staff, and safe working conditions that meet applicable legislation and/or regulation and staff needs.
(m) SQ.3.2. Organizational leadership provides procedures to promote well-being, for example, stress management, workload monitoring, management of work-life balance, and healthy lifestyle programs.
SQ.3.3 Organization leadership ensures staff receive continuous occupational health and safety (OHS) training, and this is documented.
SQ.3.4 There is a process to report safety and security issues, including a process for protecting patients, visitors, and staff from violence and for summoning the assistance of security/police/protection services in the case of an emergency.

Standard **SQ.4

The organization has a process for gathering the credentials of those clinical staff members permitted to provide patient care.

Measurable Elements of SQ.4

SQ.4.1 The credentials of all health professional staff are gathered and verified from the primary source, when possible, and kept within the staff member's file.
SQ.4.2 The organization implements a process to ensure the licenses of licensed health professional staff are current, and a copy is kept in the staff member's file.
SQ.4.3 A thorough background check is completed prior to the hiring or engagement in any type of collaboration or clinical activities of all local, foreign, or visiting clinical professionals and those outside healthcare professionals who seek temporary or short-term permission to provide clinical care.
SQ.4.1 A job description identifying specific services that may be provided is required for health professionals who are not permitted to practice independently.

Standard **SQ.5

The organization has a process to grant privileges to medical staff members and evaluate the quality and safety of the patient care provided.

Measurable Elements of SQ.5

SQ.5.1 The process for granting privileges to admit, treat, and provide other clinical services is ongoing, standardized, objective, and evidence-based
(m) SQ.5.2 The organization develops, implements, and monitors a process to ensure that medical staff members only provide the services and treatments they are privileged to perform and only those offered by the organization.

SQ.5.3 In a timeframe determined by the organization, each medical staff member receives an ongoing professional practice evaluation and determination of continued clinical privileges.
SQ.5.4 When medical staff seek new or expanded privileges, the organization has a standardized process to verify the documentation and the skills that are being requested.

TECHNOLOGIES IN HEALTHCARE (TH)

TH.1 Organization leaders are accountable for the assessment, implementation, and ongoing management of digital technologies.

Measurable Elements of TH.1

TH.1.1 Organization leaders are accountable for evaluating new and existing healthcare technologies including clinical, patient experience and business processes.
TH.1.2 Organization leaders provide guidance to the professional staff for the acceptable use of healthcare technology in the patient care management process.
TH.1.3 Organization leaders ensure appropriate use of healthcare technology by providing information and resources in a language that can be understood by users, patients and staff.
TH.1.4 Organization leaders provide or contract for timely healthcare technology support to ensure continuous, effective and appropriate education and use.

Standard TH.2

TH.2 The organization leaders ensure the provision of digital healthcare technologies adhere to applicable laws and regulations, data protection and privacy regulations, and comply with professional standards of practice within all jurisdictions in which such services are provided.

Measurable Elements of TH.2

TH.2.1 The organization leaders implement systems and processes to identify and comply with applicable laws and regulations and professional standards of practice related to digital healthcare within the relevant jurisdiction(s).
(m) TH.2.2 The organization leaders monitor compliance with applicable laws and regulations as well as professional practice standards within the relevant jurisdiction(s).
TH.2.3 The organization has clear, well-defined data protection and privacy rules, including use, storage, retention, and destruction.
TH.2.4 When risks, problems, and/or incidents related to compliance with laws and regulation or professional standards are identified, the organization implements corrective actions to prevent recurrence.

Standard TH.3

The organization provides access to technical expertise to support the effective use of digital care systems to ensure technology is reliable and available at all times, with minimal downtime or disruptions.

Measurable Elements of TH.3

TH.3.1 The organization leaders provide direction, support, resources, and technical expertise to support all digital healthcare systems in use.
TH.3.2 If the organization allows transmission of patient data and information using emerging technology, such as text messaging, email, WhatsApp, a secure messaging platform is ensured.
TH.3.3 Digital healthcare systems have redundancy measures, such as backup servers and failover systems, to ensure that services can continue in the event of any disruptions (downtime), such as technical issues or outages and incorporate updates and corrective actions as needed.

(m) TH.3.4 Digital healthcare system infrastructure has systems and processes in place to maintain optimal performance and business continuity including proactively monitoring server performance, network latency, usability, effectiveness, staff outcomes, patient safety, and other key performance indicators; and improvements are identified and implemented based on results.

Standard TH.4

The organization leaders ensure barriers to access, and delivery of digital healthcare services are identified and mitigated.

Measurable Elements of TH.4

TH.4.1 The organization leaders provide accommodations in the delivery of digital services for persons with disabilities, such as assistive technologies for hearing and visually impaired users.
TH.4.2 Patients receiving digital healthcare services are assessed for appropriateness of services in accordance with professional standards of care, applicable guidelines and local/regional laws and regulations.
TH.4.3 Organization leaders ensure that healthcare services are fully accessible to those patients/ service users who cannot use a digital route.
TH.4.4 The organization has a process for assessing the cultural and linguistic characteristics of its patient populations, including the most common languages, beliefs, values, preferences, and expectations of the patients who receive digital healthcare services.

Standard TH.5

The organization leaders ensure patients/service users are informed about the use of digital healthcare services and obtain patient/family consent.

Measurable Elements of TH.5

TH.5.1 The organization has a well-defined scope of digital healthcare services/technologies offered that is clearly declared to the patient population served to enable the patient (and/or family) to make informed decisions.
TH.5.3 Informed consent is obtained from the patient or legal guardian for the use of digital healthcare services, and the consent is documented in the patient's medical record.
TH.5.2 The organization clearly informs users about how data will be collected, used, stored, distributed, and destroyed based on applicable legislation.
TH.5.4 The telehealth provider respects the patient's autonomy by allowing patients to make their own healthcare decisions, supporting their right to refuse or discontinue digital healthcare services if desired.

Standard TH.6

The organization leaders support a patient-centered approach and continuity of services when using digital technology and ensure that the care provided is consistent with established protocols and guidelines that are based on best practices in healthcare.

Measurable Elements of TH.6

TH.6.1 The organization leaders ensure that providers of digital healthcare services involve patients in the development and implementation of their treatment plans and ensure that care, treatment, and services are tailored to their unique needs and preferences.
TH.6.2 The providers of digital healthcare services ensure that the clinical evaluation, indication, appropriateness, and safety considerations for care, treatment, and/or services meet the applicable standards of care.
TH.6.3 Care planning and care delivery in digital healthcare are integrated and coordinated throughout the organization
TH.6.4 Healthcare providers offer personalized care by integrating patient medical profiles into treatment plans.

Standard TH.7

The organization leaders establish a quality improvement plan, outlining specific goals, strategies, and timelines for enhancing the quality and performance of their digital healthcare services.

Measurable Elements of TH.7

(m) TH.7.1 The organization leaders identify and monitor key performance indicators (KPIs) and clinical outcomes to assess the quality and effectiveness of digital healthcare services.

TH.7.2 The organization leaders ensure staff feedback is obtained related to system performance and any identified issues associated with providing digital healthcare services.

TH.7.3 The organization leaders provide opportunities for patient feedback about the quality of digital healthcare services.

TH.7.4 Data collected on digital healthcare services is aggregated, validated, and analyzed by qualified staff and used to make improvements.

INFORMATION MANAGEMENT (IM)

Standards and Measurable Elements

Standard IM.1

The information management processes of the healthcare organization are designed to meet the information needs of the organization's leaders, those who provide clinical services, departments within the organization, and those outside the organization who require data and information from the organization.

Measurable Elements of IM.1

IM.1.1 There is a qualified individual(s) who oversees the organization's information management program, including sharing information with outside sources.

IM.1.2 The organization has a process for retention of documents and medical records that meets laws and regulations.

IM.1.3 The organization has a process for destruction of documents and medical records in accordance with laws and regulations.

(m) IM.1.4 The information management program is monitored, and actions taken when needed.

Standard IM.2

The organization maintains confidentiality, security, privacy, and integrity of data, records, and information through processes to manage and control access and protect against loss, theft, damage, and destruction.

Measurable Elements of IM.2

IM.2.1 Protocols have been created and implemented based on laws and regulations to safeguard the security and integrity of identifiable personal medical information that is transmitted.

IM.2.2 Protocols have been instituted to authorize access to identifiable personal medical and all other healthcare information, based on roles and responsibilities.

IM.2.3 There is a risk assessment to identify and prioritize data and security risks throughout the organization.

(m) IM.2.4 The organization monitors compliance and takes actions when confidentiality, security, data, and information breaches are identified.

Standard IM.3

The healthcare organization fully implements policies, procedures, plans and other documents that guide clinical and non-clinical processes in a uniform and consistent manner.

Measurable Elements of IM.3

IM.3.1 The organization defines requirements in a guidance document for maintaining policies, procedures, and plans in a standardized format.
IM.3.2 Implementation of the guidance document is evident when reviewing policies procedures, and plans.
IM.3.3 Staff understand the content of the policies, procedures, and plans relevant to their job responsibilities and are trained in how to access these documents.
(m) IM.3.4 The organization monitors compliance with policies, procedures, and plans, and actions are taken when needed.

Standard IM.4

A medical record is initiated for every patient assessed or treated within the healthcare organization that includes a standardized format, content, and location of entry.

Measurable Elements of IM.4

IM.4.1 The medical record is identified using two identifiers contained within the medical record that is unique to each patient.
IM.4.2 Information in the medical record contains information that supports the diagnosis and continuity of care and includes the author, date, and time of each entry in the medical record.
(m) IM.4.3 There are established and implemented guidelines for the electronic medical record on the use of copy and paste, autofill, auto correct, and templates; staff are trained on the guidelines, compliance is monitored, and actions taken.
IM.4.4 A representative sample of medical records is reviewed by a multi-disciplinary team for timeliness, accuracy, completeness, and legibility.

APPENDIX A

Glossary of Terms

abnormal result: A result that is outside of the expected range for the test but not immediately life threatening. Also see critical result.

accreditation: The determination by an accrediting body that an eligible program, institution, or organization, complies with a required set of standards, indicating a level of quality, performance has been met.

accreditation decisions: Based on GHA accreditation decision rules, an organization can achieve the following categories of accreditation based on a GHA survey: (see accreditation manual for details)

Accreditation with Excellence The organization demonstrates exceptional compliance with standards.
Accreditation The organization demonstrates acceptable compliance with all standards.
Accreditation Pending The organization must complete post survey follow-up activities.
Accreditation not Achieved The organization is not in compliance with GHA standards.

accreditation surveys: An evaluation of an organization to assess compliance with applicable standards to determine its accreditation status. A GHA accreditation survey includes the following:

- Evaluation of documents provided by the organization
- Verbal information about the implementation of standards or examples of their implementation that enables compliance to be determined
- On-site or virtual observations by surveyors
- Tracking of patients through the care process using tracer methodology

- Education about standards compliance and performance improvement

adverse event: An unanticipated, undesirable, or potentially dangerous occurrence

aggregate: To combine standardized data and information.

ambulatory care: Types of health care services provided to individuals on an outpatient basis.

anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. Also see procedural sedation.

Artificial Intelligence (AI): Artificial intelligence in healthcare refers to the use of machine-learning algorithms and software to copy human cognition in the analysis, presentation, and understanding of complex medical and health care data. It can also exceed human capabilities by providing new ways to diagnose, treat, or prevent disease. (Artificial intelligence in healthcare - Wikipedia)

assessment (patient): The process for obtaining necessary information (such as physiological, psychological, health history, spiritual/cultural, social, and/or economic information) about each individual seeking entry into a health care setting.

best practice: Clinical, scientific, or professional technique, method, or process that is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice. Also sometimes referred to as professional standards of practice, good practice or better practice, are typically evidence based and consensus driven.

bias: An influence on results that causes them to routinely depart from their true value.

blood transfusion services: Services relating to infusing individuals with blood, blood components, or blood derivatives

care plan: See plan of care.

clinical pathways: A standardized treatment regimen that includes all elements of care by organizing, sequencing, and scheduling major interventions by clinicians and other staff. Also known as critical paths and care maps.

clinical practice guidelines: See evidence-based guidelines

clinical staff: See staff.

certification: The determination by an accrediting body that an eligible program, such as a medical travel program, institution, or organization, complies with a required set of standards, indicating a level of quality performance has been met.

certification decisions: Based on GHA certification decision rules, an organization or program can achieve the following categories of certification based on a GHA survey: (see certification manual for details)

Certification with Excellence The organization or program demonstrates exceptional compliance with standards.

Certification The organization or program demonstrates acceptable compliance with all standards.

Certification Pending The organization or program must complete post survey follow-up activities.

Certification not Achieved The organization or program is not in compliance with GHA standards.

certification surveys: An evaluation of an organization or program to assess compliance with applicable standards to determine its accreditation status. A GHA accreditation survey includes the following:

- Evaluation of documents provided by the organization or program
- Verbal information about the implementation of standards or examples of their implementation that enables compliance to be determined
- On-site or virtual observations by surveyors
- Tracking of patients through the care process using tracer methodology
- Education about standards compliance and performance improvement

clinical practice guidelines: See evidence-based guidelines

competence: A determination of an individual's skills, knowledge, and capability to meet defined expectations, as frequently described in a job description.

confidentiality: The restricted access to data and information to health care practitioners and clinical staff who have a need, a reason, and permission for such access. An individual's right to personal and informational privacy, including for his or her medical/health records.

continuity of care: The degree to which the care of individuals is coordinated among practitioners, among organizations, and over time. Also see handover.

continuum of care: Matching the individual's ongoing needs with the appropriate level and type of care, treatment, and services within an or across multiple organizations.

contracted services: The provision of services through a written agreement with another organization, agency, or individual. The agreement specifies the services to be provided on behalf of the applicant organization and the fees to provide these services or staff.

credentialing: The process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization. The process of periodically checking staff qualifications is called re-credentialing.

credentials: Evidence of competence, current and relevant licensure, education, training, and experience. Other criteria may be added by a health care organization.

critical result: A variance from normal range that represents a physiological state that is high-risk or life-threatening, is considered emergent in nature, and in which immediate medical action is likely necessary to preserve life or prevent a catastrophic occurrence.

culture of safety: Also known as a safe culture, a collaborative environment in which skilled clinicians treat each other with respect, leaders drive effective teamwork and promote psychological safety, teams learn from errors and near misses, caregivers are aware of the inherent limitations of human performance in complex systems (stress recognition), and there is a visible process of learning and driving improvement through debriefings.

data: Facts, clinical observations, or measurements collected during an assessment or monitoring activity.

data integrity: The accuracy, consistency, and completeness of data.

denominator: The number below the line in a fraction used to calculate a rate, proportion, or ratio. A statement that depicts the primary or overall population of interest that the measure is interested in evaluating (for example, all patients with a specific diagnosis requiring a specific medication)

department/service leaders: The individuals who manage and direct the "subgroups" of an organization.

digital healthcare: Digital health, also known as digital healthcare, is the use of digital technologies in healthcare. This broad term includes numerous categories of technology, including mobile health (mHealth) apps, electronic health records (EHRs), electronic medical records (EMRs), wearable devices, telehealth and telemedicine, and personalized medicine. (What is Digital Health (Digital Healthcare)? | Definition From TechTarget)

disaster: A sudden, unexpected event that causes widespread damage and disruptions, as well as injury and/or loss of life; may be naturally occurring or man-made.

disaster preparedness: The ability of the health care organization to maintain operations, respond to the potentially increased volume and acuity of patients, and meet the needs of the community affected by the disaster.
discharge: The point at which an individual's active involvement with an organization or program ends and the organization or program no longer maintains active responsibility for the care of the individual.

disinfection: A process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects, usually by using liquid chemicals or wet pasteurization.

downtime: Data system interruption.

efficiency: The relationship between the outcomes (results of care) and the resources used to deliver care. For example, when two programs use the same number of resources, the one that achieves a higher immunization coverage rate is the more efficient. Increasing efficiency involves achieving the same outputs with fewer resources or more outputs with the same number of resources.

employment practices: Analysis, screening, or other methods used to recruit, hire, select, transfer, promote, provide benefits, or similarly affect staff or future staff.

evidence-based guidelines: Making clinical decisions based on empirical evidence or, in the absence of empirical evidence, expert consensus (such as consensus statements promoted by professional societies). The approach requires understanding conflicting results and assessing the quality and strength of evidence. Finally, practitioners must know how this applies to patient care and health care policy.

failure mode and effects analysis: (FMEA) A systematic approach to examining a design prospectively for possible ways failure may occur. The ways failure may occur are then prioritized to help organizations create design improvements that will have the most benefit. This tool assumes that no matter how knowledgeable or careful people are, errors will occur in some situations and may even be likely to occur.

family: The person(s) with a significant role in the patient's life. This may include a person(s) not legally related to the patient. This person(s) is often referred to as a surrogate decision maker if authorized to make care decisions for a patient if the patient loses decision-making ability.

hazardous materials and waste: Materials for which handling, use, storage, and disposal are guided or defined by local, national, or regional regulations. Types of hazardous materials and waste include pharmaceutical, chemical, cytotoxic, and infectious.

hazardous medications: Medications that (as indicated by studies in animals or humans) have potential for causing cancer, developmental or reproductive toxicity, genotoxicity, or harm to organs. Chemotherapy, antiviral drugs, hormones, and some bioengineered drugs are examples of hazardous medications.

health care–associated infection(s): (HAIs) Any infection(s) acquired by an individual while receiving care or services in a health care organization. Common HAIs are urinary infections, surgical wound infections, pneumonia, and bloodstream infections.

health care organization: A general term used to describe many types of organizations that provide health care services, such as ambulatory care centers, hospitals, laboratories, and the like.

health care practitioner: Any person who has completed a course of study and is skilled in the field of health care. This includes a nurse, physician, dentist, pharmacist, respiratory therapist, physical therapist, and dietitian, among others. Health care practitioners are licensed by a government agency or certified by a professional organization. Also see licensed independent practitioner.

host organization: A hospital or ambulatory center that provides a base of organizational support for a medical travel program and may integrate the program into many existing programs and processes.
Implants or prosthetics: A device or tissue that is permanently placed inside or on the surface of a body, to continuously assist, restore, or replace a function or structure of the body throughout the useful life of the device.

informed consent: The process of informing a patient about a procedure or treatment so that the patient can make a voluntary, informed decision to accept or refuse to have the procedure or treatment. The patient must be fully informed and understand the information they are provided before giving consent. The elements of informed consent include, but are not limited to, information about the proposed procedure/treatment, potential benefits and risks, and possible alternatives to the procedure/treatment.

inpatient: In general, a person admitted to and housed in a health care organization at least overnight.

in-service education: Organized education, usually provided in the workplace, is designed to enhance the skills of staff members or to teach them new skills relevant to their jobs and disciplines.

intent: A brief explanation of a standard's rationale, meaning, and significance. Intents may contain examples of compliance and detailed expectations of the standard evaluated in the on-site or virtual survey process.

job description: Explanation of an employment position, including duties, responsibilities, and conditions required to perform the job.

key performance indicator: Quantifiable measurements used to assess an organization's performance in particular areas, such as patient satisfaction, quality and safety of care, financial performance, and the like

laws and regulations: Statements or directions specifying required decisions and actions. Penalties, legal or otherwise, are normally assessed when laws and regulations are not followed.

leader: An individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of an organization's management, clinical, and support functions and processes.

licensed independent practitioner: An individual qualified by education and training and permitted by license and law (when applicable) and the organization to provide care and services, without direction or supervision, within the scope of the individual's practice. In many countries, licensed independent practitioners include physicians, dentists, some categories of nurses, podiatrists, optometrists, and chiropractors.

licensure: A legal right that is granted by a government agency in compliance with a statute governing an occupation (such as physicians, dentists, nurses, psychiatry, or clinical social work, or the operation of a health care facility).

medical travel program: Also referred to as international patient services or global patient services program, or organization, that is designed to facilitate medical/dental care and ancillary services for medical travel and/or international patients (see page 6).

medication: Any prescription medications; sample medications; herbal remedies; vitamins; nutraceuticals; over-the-counter drugs; vaccines; diagnostic and contrast agents used on or administered to persons to diagnose, to treat, or to prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; and intravenous solutions (plain, with electrolytes and/or drugs).

medications, high-alert: Medications involved in a high percentage of errors and/or sentinel events, as well as medications that carry a higher risk for abuse or other adverse outcomes. Examples of high-alert medications include investigational medications, controlled medications, anticoagulants, and look- alike/sound-alike medications.

medication error: Any preventable event that may cause inappropriate medication use or jeopardize patient safety.
medication reconciliation: The process of identifying the medications currently being taken by an individual. These medications are compared to newly ordered medications, and discrepancies are identified and resolved.

mission statement: A written expression that sets forth the purpose, or "mission," of an organization or one of its components. The generation of a mission statement usually precedes the formation of goals and objectives.

monitoring: The review of information on a regular basis. The purpose of monitoring is to identify the changes in a situation.

near miss: Any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a "near miss" falls within the scope of the definition of an adverse event.

numerator: The number above the line in a fraction used to calculate a rate, proportion, or ratio. The numerator depicts the part of the denominator population that meets the condition of the performance measure to be an indicator event (for example, the number of patients who were given a particular medication for a specific condition).

organization: A hospital or ambulatory center

organizational chart: A graphic representation of individuals' titles and reporting relationships in an organization; sometimes referred to as an organogram or organization table.

organizational leadership: A group or groups of clinical, non-clinical and administrative individuals who typically report to the chief executive of the organization and may include the chief executive.

outcome: The effect(s) that an intervention has on a specific health problem. It reflects the purpose of the intervention.

outpatient: Generally, persons who do not need the level of care associated with the more structured environment of an inpatient or a residential program. In many countries, outpatient care is also known as "ambulatory care."

pathways: See clinical pathways

patient: An individual who receives care, treatment, and services.

patient record: patient record/medical record/clinical record. A written account of a variety of patient health information, such as assessment findings, care plan, medication list, treatment details, progress notes, and discharge summary. This record is created by health care professionals with entries by members of the patient's care team.

patient-centered care: The delivery of health services that are respectful of, and responsive to, individual patient preferences, needs, and values.

performance improvement: The process of identifying and analyzing performance issues, creating and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.

plan: A method for outlining detailed strategies and resource needs for meeting short- and long-term goals and objectives.

plan of care: A plan that identifies the patient's care needs, lists the strategy or care and treatment to meet those needs, documents treatment goals and objectives, outlines the criteria for ending interventions, and documents the individual's progress in meeting specified goals and objectives. It is based on data gathered during patient assessment. The format of the plan in some organizations may be guided by specific policies and procedures, protocols, practice guidelines, clinical paths, or a combination of these. The plan of care may include prevention, care, treatment, habilitation, and rehabilitation.

point-of-care testing: Analytical testing performed at sites outside the traditional laboratory environment, usually at or near where care is delivered to individuals, such as at the bedside or procedure area.

policy: A statement of expectations meant to influence or determine decisions and actions. Policies are the rules and principles that guide and inform the organization's procedures and processes.

practice guidelines: See evidence-based (or scientific-based) guidelines; clinical practice guidelines.

primary source verification: Confirmation of an individual health care practitioner's reported qualifications by the original source or an approved agent of that source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source or reports from credentials verification organizations.

privileging: The process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual's credentials and performance.

procedural sedation: A technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardiorespiratory function. Also see anesthesia.

procedure: How a task is performed, usually including step-by-step instructions.

process: A set of actions that produce or lead to a particular result.

professional practice guideline: A guideline published by a recognized professional organization on specialized practices or activities related to a specific healthcare service.

professional standards of practice: See best practice.

protocol: A scientific medical treatment plan or study outline for a new or experimental procedure or treatment with the intent of measuring human applications (for example, management of diabetes mellitus type 2). Protocols frequently include components such as types of participants, scheduling, procedures used, types of medications and dosages, among others.

qualified individual: An individual or staff member who can participate in one or all the organization's care activities or services. Qualification is determined by the following, as applicable: education, training, experience, competence, applicable licensure, laws or regulations, registration, or certification.

quality improvement: An approach to the continuous study and improvement of the processes of providing health care services to meet the needs of patients and others. Synonyms include continuous quality improvement, continuous improvement, organization-wide performance improvement, and total quality management.

quality of care: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include the following: patient perspective issues; safety of the care environment; and accessibility, appropriateness, continuity, effectiveness, efficacy, efficiency, and timeliness of care.

recall: When a piece of medical equipment, or a medication is removed from the market, either because it was found to be defective or because it was found to be potentially harmful.

rehabilitation services: The use of medical, social, educational, and vocational measures together for training or retraining individuals disabled by disease or injury. The goal is to enable patients to achieve their highest level of functional ability.

reliability: A characteristic of a measure that indicates how accurately and consistently the measure produces comparable results. For example, a reliable measure or measurement tool yields accurate and consistent results when used by different individuals, across different settings, with different patients, and so on, as applicable.

retrospective tracing: As it relates to supply chain management, the process of identifying and tracking unstable, contaminated, defective, or counterfeit supplies after they have entered the organization. When applicable, the organization notifies the manufacturer and/or distributor about the unstable, contaminated, defective, or counterfeit supply.

risk management program: Clinical and administrative activities that organizations undertake to identify, to evaluate, and to reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself.

root cause analysis: A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or occurrence of a sentinel event. Also see sentinel event.

routine maintenance: The performance of basic safety checks—that is, the visual, technical, and functional evaluations of equipment—to identify obvious deficiencies before they have a negative impact. It normally includes inspections of the case, power cord, structural frame, enclosure, controls, indicators, and so on.

Safety: The degree to which the organization's buildings, grounds, and equipment do not pose a hazard or risk to patients, staff, or visitors.

scope of practice: The range of activities performed by a practitioner in a health care organization. The scope is determined by training, tradition, laws or regulations, or by the organization.

scope of services: The range of activities performed by governance, managerial, clinical, and support staff.

security: Protection from loss, destruction, tampering, or unauthorized access or use.

sentinel event: An unanticipated occurrence involving death or serious physical or psychological injury.

staff: All people who provide care, treatment, and services in the organization (for example, medical staff, nursing staff, housekeeping staff, registration clerks, engineers, and so on), including those receiving pay (permanent, temporary, and part-time staff, as well as contract staff), and trainees and students (for example, medical students, nursing students, and so on).

> **clinical staff**- Those who provide direct patient care (physicians, dentists, nurses, physical therapists, dietitians, among others).
>
> **nonclinical staff**- Those whose roles and responsibilities in the organization indirectly support patient care (admissions, food service, housekeeping, among others).

stakeholder: An individual or group involved in and/or affected by a policy, process, or course of action. In health care, stakeholders may include patients and their families; physicians, nurses, and other clinicians and practitioners; nonclinical staff members; leaders; contracted services and staff; and members of the community.

standard: A statement that defines the performance expectations, structures, or processes that must be in place for an organization to provide safe and high-quality care, treatment, and service.

supply chain: The steps in moving a finished product (drug, medical equipment, medical device, or medical supply) from its source (a manufacturer) to its customer (a healthcare organization). Key considerations in the supply chain are the risks to the product (for example, protection from losing stability, becoming contaminated, and becoming defective); the potential risk points in the steps of the supply chain (for example, quality of product, storage conditions, customs, delivery methods); and the selection of vendor, distributor, and so on, based on the risks in the supply chain.

surgery: Those procedures that investigate and/ or treat diseases and disorders of the human body through cutting, removing, altering, or insertion of diagnostic/therapeutic scopes.

telehealth: An umbrella term which may include Tele-medicine, Tele-psychology, Tele-radiology, eHealth and others. They all represent digital health solutions that connect patients and clinicians through audio and video communication technology and represent an alternative to traditional in-person care delivery.

time-out: A pause, just prior to performing a surgical or other procedure, during which the entire surgical or procedural team verifies the correct patient, procedure, or site. Even when there is only one person doing the procedure, a brief pause to confirm the correct patient, procedure, and site is appropriate.

tracer methodology: A process that accreditation surveyors use during the on-site or virtual survey to analyze an organization's processes and systems by following individual patients through the organization's health care process in the sequence experienced by the patients. Depending on the health care setting, this may require surveyors to visit multiple care units, departments, or areas within an organization or a single care unit to "trace" the care rendered to a patient.

patient tracer- These occur during the survey and focus on evaluating an individual patient's total care experience within a health care organization.

system tracer- These occur during the survey and focus on evaluating high-priority safety and quality-of-care issues on a system-wide basis throughout the organization. Examples of such issues may include infection prevention and control, medication management, facility management, and the use of data.

utility system: Organization-wide systems and equipment that support the following: electrical distribution; emergency power; water; vertical and horizontal transport; heating, ventilating, and air- conditioning; plumbing, boiler, and steam; piped gases; vacuum systems; or communication systems, including data-exchange systems. May also include systems for life support; surveillance, prevention, and control of infection; and environment support.

validity: A characteristic of a measure that indicates the degree to which the measure assesses what it is intended to measure. For example, the measure or measurement tool is valid when it captures the intended clinical outcome, patient experience, and so on.

variation: The differences in results obtained in measuring the same event more than once. The sources of variation can be grouped into two major classes: common causes and special causes. Too much variation often leads to waste and loss, such as the occurrence of undesirable patient health outcomes and increased cost of health services.