Measurable Elements of GLD.07.00

1. Hospital leaders establish a framework for the hospital's ethical management that promotes the following:
   - A culture of ethical practices and decision-making to ensure the protection of patients and their rights (*See also* COP.10.02, ME 2; HRP.01.02, ME 1; HRP.01.03, ME 3)
   - A mechanism by which health care practitioners and other staff may raise ethical concerns without fear of retribution (*See also* GLD.07.01, ME 5)
   - Structure(s) and processes support oversight of professional and business ethical issues.
2. The ethical framework ensures that patient care is provided within business, financial, ethical, and legal norms.
3. The hospital ensures nondiscrimination in employment practices and provision of patient care in the context of the cultural and regulatory norms of the country.
4. Hospital leaders identify applicable national and international ethical norms when developing the hospital's framework for ethical conduct.
5. The hospital accurately bills for services and ensures that financial incentives and payment arrangements do not impact patient care, treatment, or services.
6. The hospital provides an effective resolution to ethical conflicts that arise within a defined time frame.

Standard GLD.07.01

Hospital leaders create and maintain a culture of safety and quality throughout the hospital.

Intent of GLD.07.01

Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital. Hospital leaders demonstrate their commitment to a culture of safety, and leaders set expectations for those who work in the hospital.

A *culture of safety* has been defined as "a collaborative environment in which clinicians treat each other with respect, leaders drive effective teamwork and promote psychological safety, teams learn from errors and near misses (or close calls), 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."

Hospital leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to patient care. Leaders must address such behavior in individuals working at all levels of the hospital, including management, medical, clinical, and administrative staff, and governing body members. Key features of a program for a culture of safety include the following:

- Acknowledgment of the high-risk nature of a hospital's activities and the determination to achieve consistently safe operations
- An environment in which individuals can report errors or near misses without fear of reprimand or punishment
- Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- Organizational commitment of resources, such as staff time, education, a safe method for reporting issues, and the like, to address safety concerns

Health care continues to have a culture of individual blame, which impairs the advancement of a safety culture. There are instances in which individuals should not be blamed for an error; for example, when there is poor communication between patient and staff, when there is a need for rapid decision-making, or when there are human factor design flaws in a treatment process. However, certain errors are the result of unsafe behavior and

do require accountability. Examples of unsafe behavior include failure to follow hand-hygiene guidelines, not performing the time-out before surgery, or not marking the surgical site.

A maturing safety culture is reflected in the increasing number of patients and families who are highly satisfied with your care and sustained decrease or absence of near misses and all adverse events, including sentinel events.

A culture of safety includes identifying and addressing issues related to systems that lead to unsafe behaviors. At the same time, though, hospitals must maintain accountability by establishing zero tolerance for unsafe behavior. Accountability distinguishes between human error (such as a mix-up), at-risk behavior (for example, taking shortcuts), and unsafe behavior (such as ignoring required safety steps). Establishing and supporting an organizational culture of safety may include committee appointments involving different hospital departments (for example, pharmacy, laboratory, engineering, nursing departments). The appointed committee presents periodic updates to the governing entity to identify issues that impact overall quality and patient safety. Hospital leaders evaluate the culture on a regular basis using a variety of methods, such as formal surveys, focus groups, staff interviews, and data analysis. Hospital leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Hospital leaders must address undesirable behaviors of individuals working at all levels of the hospital, including management, clinical and nonclinical staff, independent health care practitioners, and governing entity members.

Measurable Elements of GLD.07.01

1. Hospital leaders establish and support an organizational culture that encourages reporting and discussion of opportunities for improving culture of safety in the organization. (*See also* Sentinel Event Policy and APR.09.00, ME 1)
2. Ⓓ Hospital leaders develop a code of conduct that identifies and corrects behaviors that are unacceptable.
3. Hospital leaders establish regularly scheduled education and provide resources (such as literature and advisories) relevant to the hospital's culture of safety to all individuals who work in the hospital. (*See also* SQE.01.07, ME 3; SQE.07.00, ME 2)
4. Hospital leaders provide an accessible and confidential system for reporting issues relevant to a culture of safety in the hospital.
5. Hospital leaders implement a process to prevent retribution against individuals who report culture of safety issues and ensure that all reports are investigated within a defined time frame. (*See also* GLD.07.00, ME 1)
6. Hospital leaders identify and act on systems issues that lead health care practitioners to engage in unsafe behaviors.

Standard GLD.07.02

The hospital implements a workplace violence prevention program to provide a safe and secure workplace.

Intent of GLD.07.02

A workplace violence prevention program establishes a framework for hospitals to effectively implement and manage workplace violence prevention systems, including leadership oversight, policies and procedures, reporting systems, data collection and analysis, and post-incident strategies.

The rate of violence against health care workers has reached epic proportions. What is more, with only an average of 20% to 60% of incidents reported, the full scope of the problem has not yet been realized. *Workplace violence* is defined as "an act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving all staff, patients, or visitors." Violence in the workplace has become an increasingly