Facility Management and Safety (FMS)

Overview

Health care organizations work to provide safe, functional, and supportive facilities for patients, families, staff, and visitors. To reach this goal, the physical facility, medical and other equipment, and people must be effectively managed. In particular, management must strive to do the following:

- Identify, reduce, and control hazards and risks.
- Prevent accidents and injuries.
- Maintain safe conditions.

Effective management includes interdisciplinary planning, education, and monitoring as follows:

- The leaders plan the space, equipment, and resources needed to safely and effectively support the clinical services provided.
- All staff are educated about the facility, how to reduce risks, and how to monitor and to report situations that pose risk.
- Performance criteria are used to evaluate important systems and to identify needed improvements.
- Comprehensive, facilitywide risk assessments are developed and monitored on each of the facility management and safety programs when needed.

Written programs are developed and include the following eight areas, when appropriate to the facility and activities of the organization:

1. Safety—The degree to which the organization's buildings, construction areas, grounds, and equipment do not pose a hazard or risk to patients, staff, or visitors
2. Security—Conducting ongoing assessment of risk to enhance protection from loss, destruction, tampering, or unauthorized access or use
3. Hazardous materials and waste—Handling, storage, and use of radioactive and other materials are controlled, and hazardous waste is safely disposed of.
4. Fire safety—Conducting ongoing assessment of risks to enhance protection of property and occupants from fire and smoke.
5. Medical equipment—Equipment is selected, maintained, and used in a manner to reduce risks.
6. Utility systems—Electrical, water, and other utility systems are maintained to minimize the risks of operating failures.
7. Emergency management—Risks are identified and response to epidemics, disasters, and emergencies is planned and effective, including the evaluation of the structural and nonstructural integrity of patient care environments.
8. Construction and renovation—Risks to patients, staff, and visitors are identified and assessed during the construction, renovation, demolition, and other maintenance activities.

When the organization has nonhospital entities within the patient care facilities to be surveyed (such as an independently owned coffee shop or gift shop), the organization has an obligation to ensure that these independent entities comply with the following facility management and safety programs:

- Safety and security programs
- Hazardous materials and waste management programs

- Fire safety programs
- Construction and renovation

Laws, regulations, and inspections by local authorities largely determine how a facility is designed, used, and maintained. All organizations, regardless of size and resources, must comply with these requirements as part of their responsibilities to their patients, families, staff, and visitors.

Organizations are required to comply with laws and regulations, including building and fire codes. They are knowledgeable about the details of the physical facilities they occupy by performing regular facility inspections. They proactively gather data and carry out strategies to reduce risks and to enhance the patient care environment.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Leadership and Planning

FMS.01.00 The hospital complies with relevant laws, regulations, building and fire safety codes, and facility inspection requirements.

FMS.01.01 A qualified individual(s) oversees the facility management and safety structure.

Risk Assessment and Monitoring

FMS.02.00 The hospital develops and documents a risk assessment based on facility management and safety risks identified throughout the organization, prioritizes the risks, establishes goals, and implements improvements to reduce and eliminate risks.

Safety

FMS.03.00 The hospital implements a program to provide a safe physical facility.

Security

FMS.04.00 The hospital implements a program to provide a secure environment for patients, families, staff, and visitors.

Hazardous Materials and Waste

FMS.05.00 The hospital implements a program for the management of hazardous materials and waste.

Fire Safety

FMS.06.00 The hospital establishes and implements a program for fire safety that complies with national and local codes, laws, and regulations.

FMS.06.01 The hospital maintains fire safety equipment and fire safety building features.

FMS.06.02 All fire safety equipment and systems, including devices related to early detection, alarm notification, and suppression, are inspected, evaluated, and maintained.

FMS.06.03 The hospital conducts regular exercises with staff to evaluate the fire safety program.

FMS.06.04 The fire safety program includes limiting smoking by staff and patients to designated non–patient care areas of the facility.

Medical Equipment

FMS.07.00 The hospital develops and implements a program for the management of medical equipment throughout the organization.

FMS.07.01 The hospital has a process for monitoring and acting on medical equipment hazard notices, recalls, reportable incidents, problems, and failures.

Utility Systems

FMS.08.00 The hospital implements a program for the management of utility systems throughout the organization.

FMS.08.01 The hospital utility systems program ensures that essential utilities, including power, water, and medical gases, are always available, and alternative sources for essential utilities are tested and evaluated.

FMS.08.02 Designated individuals or authorities monitor water quality regularly.

FMS.08.03 Quality of water used in hemodialysis is tested and evaluated for chemical, bacterial, and endotoxin contaminants, and processes for hemodialysis services follow professional standards for water quality and for infection prevention and control.

FMS.08.04 The hospital reduces the risk of infection in the facility through the use of mechanical and engineering controls.

Emergency and Disaster Management

FMS.09.00 The hospital develops, maintains, and evaluates an emergency management program to respond to internal and external emergencies and disasters that have the potential of occurring within the hospital and community.

FMS.09.01 The hospital implements and evaluates an emergency management program to respond to the presentation of global communicable diseases.

Construction and Renovation

FMS.10.00 When planning for construction, renovation, and demolition projects, or maintenance activities that affect patient care, the organization conducts a preconstruction risk assessment.

Standards, Intents, and Measurable Elements

Leadership and Planning

Standard FMS.01.00

The hospital complies with relevant laws, regulations, building and fire safety codes, and facility inspection requirements.

Intent of FMS.01.00

Laws, regulations, and inspections by national and local authorities determine in large part how a facility is designed, used, and maintained. All hospitals, regardless of size and resources, must comply with these requirements as part of their responsibilities to their patients, families, staff, and visitors.

Requirements may differ depending on when the facility is built and approved. For example, many building construction codes and fire safety codes, such as for sprinkler systems, apply only to new construction. Hospitals begin by complying with laws and regulations.

Some hospitals are located inside larger, multiuse buildings, such as high-rise office buildings and shopping malls, and may lease or rent the space in which they provide care, treatment, and services. In these circumstances, it is necessary for hospital leaders to communicate with the property owner to ensure that the building complies with relevant laws, regulations, codes, and other requirements. In addition, hospital leaders communicate and collaborate with the property owner regarding shared building systems and building-related issues not under the hospital's control. It is important to understand expectations and who is responsible for maintaining these systems. Shared systems and building issues may include security and fire safety. Examples include video surveillance systems, entry and fire alarms, fire suppression systems, emergency exits, maintenance of utilities, power, ventilation, water quality, and other building issues. It is important for hospital leaders to have access to documents managed by the property owner, such as maintenance records and inspection reports relevant to the hospital's facilities. Hospital leaders evaluate compliance of the property to determine that the utilities and facilities belonging to the owner are managed accordingly to meet patient needs.

Hospital leaders and the hospital's facility management and safety structure are responsible for the following:

- Knowing what national and local laws, regulations, building and fire safety codes, and other requirements, such as licenses and permits, apply to the hospital's facilities
- Implementing the applicable requirements or approved alternative requirements
- Maintaining and documenting compliance with local and national laws, regulations, building and fire safety codes, inspection reports, and other facility requirements
- Planning and budgeting for the necessary replacement or upgrading of facilities, systems, and equipment to meet applicable requirements or as identified by monitoring data and providing evidence of progress toward implementing the improvements

When the hospital has been cited for not meeting requirements, hospital leaders take responsibility for planning and meeting the requirements in the prescribed time frame.

The hospital documents its building and fire safety laws, regulations, and codes and any corrective actions taken to address citations from external facility inspections and reports. When the hospital is located inside a multiuse building, hospitals must comply with relevant laws, regulations, and facility inspection reports, utility maintenance requirements, and other requirements related to shared systems and building issues. When hospital leaders are not able to receive the reports of inspections and documentation, a credible effort should be available (for example, documentation of communication efforts with the building ownership).

Measurable Elements of FMS.01.00

1. Hospital leaders implement the national and local laws, regulations, building and fire safety codes, and other requirements applicable to the hospital's facilities.
2. Ⓓ Corrective actions taken to meet the conditions of external facility reports and inspections by national and local authorities are documented.
3. Hospital leaders plan and budget for replacing or upgrading facilities, systems, and equipment needed to meet requirements and for the continued operation of a safe, secure, and effective facility.
4. When the hospital is located inside a multiuse building, hospital leaders obtain evidence of compliance with relevant laws, regulations, codes, facility inspection reports, utility maintenance requirements, and other requirements related to shared systems and building issues.

Standard FMS.01.01

A qualified individual(s) oversees the facility management and safety structure.

Intent of FMS.01.01

Hospitals work to provide safe, functional, and supportive facilities for patients, families, staff, and visitors. The hospital must strive to do the following:

- Reduce and control hazards and risks.
- Prevent accidents and injuries.
- Maintain safe conditions.

Effective management includes multidisciplinary planning, education, and monitoring as follows:

- Hospital leaders plan the space, technology, and resources needed to safely and effectively support the clinical and nonclinical services provided.
- Relevant staff are educated about the facility, how to reduce risks, and how to monitor and to report situations that pose risk.
- Performance criteria are used to evaluate important systems and to identify needed improvements.

Hospital leaders identify an individual qualified by training and experience to oversee the facility management and safety structure. Training and experience may include but is not limited to risk management, facility management, and hospital operations. The individual who oversees the structure may be a member of the leadership team, a leader in charge of one or more of the facility management and safety programs, or another designated individual. All facility management and safety programs report to this individual, who is responsible for integrating and coordinating the activities and functions of the overall facility management and safety structure. In a small hospital, one individual may be assigned part-time to oversee the structure. In a larger hospital, several engineers or other specially trained individuals may be assigned to manage one or more facility management and safety programs under the direction of the individual who is responsible for the overall structure.

The facility management and safety structure must be managed effectively and in a consistent and continuous manner.

Depending on the hospital's size and complexity, a facility safety/environmental risk committee or some other mechanism may be formed to support the individual responsible for the facility management and safety structure. For example, this committee could coordinate activities of the facility management and safety programs, such as completing risk assessment activities, analyzing monitoring data, and implementing facility improvements. The mechanism chosen by the hospital to support the individual responsible for the facility management and safety structure must consider a multidisciplinary team and include representatives from the various facility management and safety programs, leadership, infection prevention and control, laboratory and radiation safety programs, laser safety, housekeeping services, and the quality and patient safety program, among others.

When independent business entities are present within the organization, the hospital has an obligation to ensure that these entities comply with relevant facility management and safety programs. Independent business entities are independently owned businesses occupying space within the hospital (for example, coffee shops, gift shops, banks).

Measurable Elements of FMS.01.01

1. Ⓓ Oversight and direction of the facility management and safety structure is assigned to an individual(s) qualified by experience and training, and evidence of the experience and training is documented. (*See also* GLD.06.00, ME 1)
2. The qualified individual(s) is responsible for ensuring the following:
   - Recommendations for space, technology, and other resources to support the facility management and safety structure are provided to hospital leaders.
   - The facility management and safety programs are current and fully implemented.
   - Staff and others are trained on the programs.
   - The programs are coordinated, evaluated, and monitored.
   - The programs are reviewed and revised at least annually, or more frequently if needed (for example, when there are changes to requirements in the country's laws and regulations, or changes to the hospital's facilities, systems, or equipment).
3. When independent business entities are present within the organization, the entities comply with the applicable facility management and safety programs.

Risk Assessment and Monitoring

Standard FMS.02.00

The hospital develops and documents a risk assessment based on facility management and safety risks identified throughout the organization, prioritizes the risks, establishes goals, and implements improvements to reduce and eliminate risks.

Intent of FMS.02.00

Risk assessment identifies and evaluates potential failures and sources of errors in a process and includes prioritizing areas for improvement based on the actual or potential impact of care, treatment, or services provided.

The hospital develops and documents a facilitywide risk assessment, at least annually, that integrates all eight facility management and safety programs to maximize safety to patients, patients' families, staff, and visitors. For example, risks including but not limited to safety/security risks related to infant abduction or active shooter; risks from hazardous waste such as materials contaminated with blood or body fluids, or handling of hazardous chemicals such as high-level disinfectants and chemical sterilants; specific fire risks such as surgical fires (where alcohol-based skin prep is in use with electrocautery devices), or electrical or grease fires in the kitchen; utility system risks such as loss of external electrical power supply, or water management risks from waterborne pathogens such as *Legionella*; risks from plumbing or roofing water leaks in the building leading to hazardous mold growth; risks from medical gas or vacuum systems such as risks of explosion; or construction risks related to dust and dissemination of fungal spores near vulnerable patients, or hazardous materials such as asbestos. The hospital prioritizes the specific risks identified in the risk assessment. Goals are established and improvements are implemented to reduce and eliminate the risks. The goals and improvements are monitored for effectiveness, including progressing and sustained improvement. Changes may be required to goals and improvements based on successes and challenges identified in monitoring data.

Measurable Elements of FMS.02.00

1. Ⓓ The hospital develops and implements an annual risk assessment that includes eight facility management and safety programs:
   - Safety (*See also* FMS.03.00, ME 2)
   - Security
   - Hazardous materials and waste
   - Fire safety (*See also* FMS.06.00, ME 3)
   - Medical equipment
   - Utility systems
   - Emergency and disaster management (*See also* GHI.05.00, ME 4)
   - Construction and renovation (*See also* FMS.10.00, ME 1)
2. Ⓓ The hospital prioritizes the risks, identifies goals and key performance improvements, and implements improvements to reduce and eliminate risks. (*See also* GLD.06.01, ME 1)
3. Ⓓ The hospital evaluates the effectiveness of the improvements, and, based on the results, the hospital updates the applicable facility management and safety programs. (*See also* GLD.06.01, ME 2)
4. Ⓓ Hospital leaders provide the annual risk assessment report and the effectiveness of the facility management and safety programs to the governing entity, and the governing entity takes actions based on the report. (*See also* GLD.04.01, ME 1)

Safety

Standard FMS.03.00

The hospital implements a program to provide a safe physical facility.

Intent of FMS.03.00

Safety refers to ensuring that the building, property, medical and information technology, equipment, and systems do not pose a physical safety risk to patients, families, staff, and visitors. Prevention and planning are essential to creating a safe and supportive patient care facility.

Effective planning requires the hospital to be aware of all the risks present in the facility. The goals are to prevent accidents and injuries and to maintain safe and secure conditions for patients, staff, and others, such as families, contractors, vendors, volunteers, visitors, trainees, and students. The hospital develops and implements a written safety program. As part of the safety program, the hospital conducts and documents an ongoing inspection of its physical facilities. The results of the inspection are reviewed and addressed in a documented comprehensive, facilitywide risk assessment, at least annually, to identify areas in which safety risks and potential for harm exist.

A worksite analysis, conducted annually to assess the safety of the hospital's workplace violence prevention program, includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations. All safety incidents and issues may be reported to staff in quality assessment, improvement, or other functions as well as to the designated leader of the workplace violence reduction effort. A summary of such incidents may also be shared with the person designated to coordinate safety management activities. Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.

The risk assessment also considers a review of processes and an evaluation of new and planned services that may pose safety risks. It is important to involve a multidisciplinary team when conducting safety inspections in the hospital. Examples of safety risks that pose a potential for injury or harm include sharp and broken furniture, broken windows, water leaks in the ceiling, ergonomic risks (for example, risks to staff when moving patients or heavy objects), and fall risks (for example, due to uneven or slippery floors or missing handrails).

Conducting regular rounds to inspect for safety risks, and the annual safety risk assessment, helps the hospital identify, prioritize, plan for, and carry out improvements. Prioritizing and planning also includes budgeting for longer-term facility, system, and equipment upgrading or replacement.

Measurable Elements of FMS.03.00

1. Ⓓ The hospital develops and implements a written program to provide a safe physical facility. (*See also* COP.05.00, ME 1; GLD.07.02, ME 2; HCT.02.00, ME 1; PCI.01.01, ME 2)
2. Ⓓ The hospital has a documented, current, accurate safety inspection of its physical facilities. Results of facility inspection are reviewed and addressed in a comprehensive, facilitywide risk assessment. (*See also* FMS.02.00, ME 1)
3. Ⓓ The hospital identifies goals, implements improvements, and monitors data to ensure that safety risks related to workplace violence are reduced or eliminated. (*See also* GLD.07.02, ME 3)
4. Based on its process(es), the hospital reports and investigates safety incidents involving patients, staff, or others within its facilities.
5. Based on its process(es), the hospital reports and investigates safety incidents related to workplace violence involving patients, staff, or others within its facilities. (*See also* GLD.07.02, ME 3)

Security

Standard FMS.04.00

The hospital implements a program to provide a secure environment for patients, families, staff, and visitors.

Intent of FMS.04.00

Security refers to protecting the organization's property and the patients, families, visitors, and staff from harm or loss. Examples of vulnerabilities and threats related to security risks include workplace violence, infant abduction, theft, and unlocked/unsecured access to restricted areas in the hospital. Security incidents can be caused by individuals from either outside or inside the hospital.

The hospital develops and implements a written security program to ensure that everyone in the hospital is protected from personal harm and loss or damage to property. This may include coordination with local law enforcement. As part of the security program, the hospital conducts and documents a risk assessment, at least annually, to identify areas in which security risks exist. The risk assessment also considers a review of processes and an evaluation of new and planned services that may pose security risks.

Staff, students, trainees, contract workers, volunteers, vendors, individuals associated with independent business entities, and others, as determined by the hospital, are identified by badges (temporary or permanent) or another form of identification. Others, such as families and visitors in the hospital, may be identified depending on hospital policy, laws, and regulations.

Restricted areas such as the pharmacy, newborn nursery, and operating theatres must be secure and monitored. Children, elderly adults, and vulnerable patients not able to protect themselves or signal for help must be protected from harm. In addition, remote or isolated areas of the facility and grounds may require the use of security cameras.

Measurable Elements of FMS.04.00

1. Ⓓ The hospital develops and implements a written program to provide a secure environment.
2. Ⓓ The security program identifies all security risk areas and restricted areas and ensures that they are monitored and kept secure. (*See also* COP.05.00, ME 1; MMU.03.00, ME 6; MMU.03.01, ME 2; PCC.01.03, ME 1)
3. The security program ensures that relevant patients, as well as staff, students, trainees, contract workers, volunteers, vendors, and individuals associated with independent business entities, are identified.
4. All security equipment and systems, including devices related to detection, alarm notification, and timely response, are inspected, evaluated, and maintained.
5. The security program includes education of relevant staff on roles and responsibilities during a security-related event.
6. The hospital conducts regular exercises with staff to evaluate the security program and integration with local responders.
7. The hospital conducts an annual worksite analysis related to its workplace violence prevention program and takes actions to mitigate or resolve the identified workplace violence security risks. (*See also* GLD.07.02, ME 2)
8. Based on its process(es), the hospital reports and investigates security incidents involving patients, staff, or others within its facilities.
9. Based on its process(es), the hospital reports and investigates security incidents related to workplace violence involving patients, staff, or others within its facilities. (*See also* GLD.07.02, ME 3)

Hazardous Materials and Waste

Standard FMS.05.00

The hospital implements a program for the management of hazardous materials and waste.

Intent of FMS.05.00

The hospital uses a variety of hazardous materials and waste. When staff are educated about safe handling, storage, and disposal of hazardous materials and waste, they are more likely to follow the process that will maintain a safe environment for patients, staff, and visitors. Therefore, it is critical for a hospital to develop and implement a written program for the management of hazardous materials and waste that includes identifying and safely controlling these materials and waste throughout the facility.

The hospital identifies and develops an inventory of its hazardous materials. The hospital starts by doing a thorough search for all areas within the organization where hazardous materials may be located. Documentation from this search should include information about the type of each hazardous material being stored, the quantities of the material(s), and the location(s) in the organization. This documentation should also address the maximum quantities allowed for storing the hazardous material in one location/area. For example, if the material is highly flammable or toxic, there are limits on the quantities of the material that can be stored in one location. An inventory of hazardous materials is created and updated, at least annually, to reflect changes in the hazardous materials used and stored in the organization.

Hazardous materials can be categorized by the following:

- Chemicals (for example, chemicals used for cleaning, disinfection, sterilization, water treatment, pathology, pharmacy, hand hygiene)
- Cytotoxic and hazardous drugs
- Radioactive material
- Hazardous gases and vapors

The hospital also establishes the types of hazardous waste generated by the organization and how they are identified (for example, color-coded and labeled waste bags/bins). The following are categories of hazardous waste:

- Infectious
- Sharps
- Pathological and anatomical
- Pharmaceutical
- Chemicals/heavy metals/pressurized containers
- Genotoxic/cytotoxic
- Radioactive material

The hospital's hazardous materials and waste program complies with all applicable laws and regulations and national standards, and addresses hazardous materials and hazardous waste to include processes for the following:

- Taking inventory of hazardous materials and waste, including the type, the location(s), and the quantities (for example, approximate or average in each location)
- Updating the maximum allowed quantity for each location at least annually
- Safely handling, storing, and using hazardous materials
- Properly and clearly labeling hazardous materials, consistent with information from the safety data sheets (SDS)
- Establishing and identifying categories of hazardous waste
- Safely handling and storing hazardous waste

- Tracking the quantity of and proper disposal of hazardous waste in accordance with local laws and regulations
- Employing proper protective equipment and procedures for spills and exposures
- Reporting and investigating spills, exposures, and other incidents
- Documenting permits, licenses, or other regulatory requirements

Information regarding procedures for handling or working with hazardous materials and waste in a safe manner must be immediately available at all times and includes information about the physical data of the material (such as its boiling point, flashpoint, and the like), its toxicity, what effects using the hazardous material may have on health, identification of proper storage and disposal after use, the type of protective equipment required during use, and spill-handling procedures, which include the required first aid for any type of exposure. Many manufacturers provide this information in the form of SDS.

In the event of a hazardous materials spill, the hospital has procedures for responding to and managing spills and exposures. Procedures include having spill kits available where needed with the appropriate personal protective equipment and spill control materials for the potential type and size of spill. Procedures also address how to report spills and exposures.

Hospitals implement procedures for responding to a hazardous material exposure, including initial first aid, obtaining appropriate medical care, reporting incidents, and so on. Exposure to a hazardous material requires immediate access to the appropriate first aid. In some cases, such as with an exposure to a corrosive or caustic chemical, access to an eyewash or shower station may be necessary for immediate and continuous flushing to prevent or minimize injury. An eyewash station is designed to flush both eyes simultaneously for 15 continuous minutes at a flow rate of 1.5 liters per minute (0.4 gallons per minute). However, an eyewash station may not be needed in all cases of hazardous material exposures. Hospitals should conduct a risk assessment to identify where in the organization eyewash stations are required, taking into account the physical properties of the hazardous chemicals used, how these chemicals are used by staff to perform their work activities, and staff's use of personal protective equipment. Alternatives to an eyewash station may be appropriate depending on the types of risks and potential for exposures. For example, personal eyewash bottles may be appropriate in areas where exposure to a mild irritant is a risk, or where individuals could use the bottles for immediate flushing as they make their way to a proper eyewash station or get to an area for medical attention. Hospitals that have eyewash or shower stations installed must ensure proper maintenance, including a weekly flush and annual preventive maintenance.

Measurable Elements of FMS.05.00

1. Ⓓ The hospital develops and implements a written program for the management of hazardous materials and waste. (*See also* HRP.02.01, ME 2)
2. Ⓓ The hazardous materials and waste program identifies the type, quantities, and locations of hazardous materials and waste, and has a complete inventory, which is updated at least annually, to reflect changes in the hazardous materials used and stored in the organization. (*See also* AOP.03.05, MEs 1 and 5; MMU.03.00, ME 2; PCI.05.00, ME 1)
3. The hazardous materials and waste program establishes and implements procedures for clear labeling, safe handling, storage, and use of hazardous materials that is consistent with safety data sheets.
4. The hazardous materials and waste program establishes and implements the proper protective equipment required during handling and use of hazardous materials.
5. The hazardous materials and waste program establishes and implements procedures for the management of spills and exposures, including the use of proper protective equipment and reporting of spills and exposures.
6. Information about the hazardous materials related to safe handling, spill-handling procedures, and procedures for managing exposures are up to date and available at all times.
7. Staff can describe and/or demonstrate precautions and procedures for handling and managing hazardous materials and waste, as applicable to the staff member's role and responsibilities.

Fire Safety

Standard FMS.06.00

The hospital establishes and implements a program for fire safety that complies with national and local codes, laws, and regulations.

Intent of FMS.06.00

Hospitals must be vigilant about fire safety, as fire is an ever-present risk in the health care environment. To protect all occupants of the hospital's facilities from fire and smoke, the hospital develops and implements a written program for fire safety.

An ongoing assessment of compliance with the country's codes, laws, and regulations related to fire safety is important for identifying and minimizing risks.

An interim measure(s) may be necessary when the planned improvement to address the fire safety risk cannot be implemented right away. The purpose of implementing interim measures is to ensure the safety of the building's occupants during times when features and systems for fire safety are defective, compromised, or inoperable due to construction, maintenance, or a breakdown or repair. The type of and need for an interim measure(s) will depend on the type and scope of the fire safety risk and the amount of time until the planned improvement to fully address the risk will be implemented.

The fire safety program includes criteria for evaluating when and to what extent interim measures should be implemented.

Examples of interim measures include posting signs to identify alternative exits; inspecting exits/exit routes on a daily basis in the affected area; providing temporary but equivalent fire alarm and detection systems when a system is impaired; providing additional firefighting equipment; increasing fire safety surveillance of buildings, grounds, and equipment; and providing additional training of staff on the use of firefighting equipment; among other interim measures.

The hospital considers the risk posed to patients, staff, and others when determining the plan and time frame for implementing improvements and/or interim measures. The ongoing risk assessment and time frame for implementing interim measures and improvements are documented.

Note: A list of additional interim measures can be found in the "Interim Measures" appendix in this manual.

Measurable Elements of FMS.06.00

1. Ⓓ The hospital develops and implements a written program for fire safety to protect all occupants of the hospital's facilities from fire and smoke emergencies.
2. Ⓓ The fire safety program includes implementing interim measures, when necessary, to ensure that the safety of the hospital's patients, staff, and visitors is maintained when fire safety risks cannot be immediately addressed.
3. Ⓓ The hospital's comprehensive, facilitywide risk assessment as required by FMS.02.00, ME 1 includes evaluation of the following fire-related risks:
   - Fire separations
   - Smoke separations/compartments
   - Hazardous areas (and spaces above the ceilings in those areas) such as soiled linen rooms, trash collection rooms, and medical gas storage rooms
   - Fire exits
   - Kitchen and kitchen grease-producing cooking devices
   - Laundry and trash chutes
   - Emergency power systems and equipment
   - Medical gas and vacuum system components
   - Storage and handling of potentially flammable materials (for example, flammable liquids, combustible gases, oxidizing medical gases such as oxygen and nitrous oxide)
   - Procedures and precautions to prevent and manage surgical fires
   - Fire hazards related to construction, renovation, or demolition projects

Standard FMS.06.01

The hospital maintains fire safety equipment and fire safety building features.

Intent of FMS.06.01

Every hospital needs to plan how it will keep its occupants safe in case of fire and smoke emergencies. Health care facility structure and design can help prevent, detect, and suppress fires and provide safe exit from the facility. Hospitals are better prepared for fire emergencies when the fire safety program includes the early detection, suppression, and containment of fire and smoke and measures to ensure safe exit from the facility when fire and smoke emergencies occur.

The hospital's program for fire safety addresses the following:

- Early warning, early detection, and notification systems, such as smoke detectors, fire alarms, and fire patrols
- Suppression mechanisms that are appropriate for the area (for example, information technology rooms, electrical rooms) and type of fire to be expected, such as water hoses, fire extinguishers, chemical suppression systems, and sprinkler systems
- Containment of fire and smoke, including fire separations and smoke compartments, when required by local laws and regulations; features for containment of fire and smoke are maintained to ensure their effectiveness.
- Safe and unobstructed access to exits in the event of a fire or smoke emergency, including clear exit signage that is understandable to the hospital's occupants (for example, with a pictogram and/or language[s] that the majority of occupants understand) and emergency lighting

Features such as these give patients, staff, and visitors adequate time to safely exit the facility or reach a safe location within the facility in the event of fire or smoke emergencies. These features are effective no matter what the age, size, or construction of the facility.

Measurable Elements of FMS.06.01

1. The fire safety program includes equipment/systems for the early detection and alarm notification of fire and smoke.
2. The fire safety program includes equipment/systems for the suppression of fire.
3. The fire safety program includes the safe exit from the facility through free and unobstructed access to exits.
4. The fire safety program includes clearly visible exit signage that is understandable to the hospital's occupants.
5. The fire safety program includes lighting for emergency exit corridors and stairs.
6. When required by local laws and regulations, the fire safety program includes containment of fire and smoke, and these features are maintained to ensure effectiveness and safety.

Standard FMS.06.02

All fire safety equipment and systems, including devices related to early detection, alarm notification, and suppression, are inspected, evaluated, and maintained.

Intent of FMS.06.02

The hospital's fire safety program identifies the frequency of inspecting, testing, and maintaining fire protection and safety systems, consistent with requirements. Fire safety equipment and systems in hospitals include but are not limited to the following:

- Heat and smoke detectors
- Fire alarms
- Fire pumps
- Standpipe systems
- Sprinklers
- Fire suppression systems
- Fire hoses
- Portable fire extinguishers
- Fire doors and assemblies (including sliding and roll-down doors)
- Automatic shutdown devices for air handling systems
- Automatic smoke management systems

The hospital inspects, evaluates, and maintains all fire safety equipment and systems within its building(s), including equipment for early detection and suppression of fire and smoke. Activities and frequencies for inspection, testing, and maintenance are consistent with manufacturers' recommendations. When local codes, laws, and regulations include requirements for inspection, testing, and maintenance of fire safety equipment and systems, the hospital follows the more stringent requirements, whether those are the manufacturers' recommendations or the local codes, laws, and regulations.

Any deficiencies identified, such as impaired or nonfunctioning systems and equipment, are immediately corrected. When corrections cannot be immediately carried out, interim measures are implemented to reduce fire risk and ensure safety of patients, staff, and visitors until deficiencies can be fully corrected. The results of all inspections, testing, and maintenance are documented, including corrections and interim measures that are implemented.

Measurable Elements of FMS.06.02

1. All fire safety equipment and systems, including those for smoke and fire detection and suppression, are inspected, evaluated, and maintained according to manufacturers' recommendations or as required by local codes, laws, and regulations, whichever sets the more stringent requirement.
2. Ⓓ Inspection, testing, and maintenance of all fire safety equipment and systems are documented, including results and corrective actions.
3. Any deficiencies identified in fire safety equipment and systems are immediately corrected, or interim measures are implemented to reduce fire risk until deficiencies can be fully corrected.

Standard FMS.06.03

The hospital conducts regular exercises with staff to evaluate the fire safety program.

Intent of FMS.06.03

The hospital's fire safety program includes but is not limited to the following:

- Plan for reporting and responding to a fire emergency
- Plan for safely evacuating the facility in the event of fire or smoke emergencies
- Process for evaluating all portions of the fire safety program during each 12-month period
- Responsibilities of different staff members during a fire emergency
- Necessary education of staff to effectively protect and evacuate patients when an emergency occurs
- Participation of staff members in at least one fire safety exercise per year, or more frequently when required by laws and regulations, national fire protection standards, or other authorities

Exercises to evaluate the fire safety program can be accomplished in multiple ways but should always include a physical component in which staff must respond to an alarm and take appropriate actions during a fire alarm exercise. Staff are trained in what to do, how to exit, and where to assemble (the "assembly points"). The hospital may choose to conduct evacuation exercises during various shifts, including nights and weekends. (Simulated evacuation exercises in areas such as the intensive care unit, operating theatre, or on high floors of the building may provide additional insights but are not mandatory.) **Note:** Evacuation exercises to evaluate the fire safety program should not directly involve patients or visitors; however, it must address how staff would protect patients and visitors in a fire emergency. It is also important to note that high-risk areas of hospitals that are identified in its risk assessment, such as operating theatres and hyperbaric treatment areas and equipment, may have unique risks that require additional elements of its fire safety exercises. In this case, the hospital should conduct exercises based on these risks, as well as laws and regulations, Ministry of Health requirements, or other authorities.

Another example of an exercise to evaluate the fire safety program is assigning a "fire marshal" to each unit and having them randomly quiz the staff about what they would do if a fire occurred on their unit. The staff can be asked specific questions, such as, "Where is the oxygen shutoff valve? If you have to shut off the oxygen valve, how do you take care of patients who need oxygen? Where are the fire extinguishers on your unit located and how/in what circumstances would you use one? How do you report a fire? How do you protect the patients during a fire? If you need to evacuate patients horizontally or vertically, what is your process?" Staff should be able to respond correctly to these questions. The fire marshal should keep a record of those who participated. Other examples of exercises include computer-based teaching and testing or a written test for staff to take relating to the fire safety program.

Whatever the exercise chosen to evaluate the fire safety program, staff should be knowledgeable of the program and be able to describe how to bring patients to safety. Staff who do not pass are reeducated and retested.

Measurable Elements of FMS.06.03

1. All hospital personnel, including the night shift and weekends, are trained in the fire safety program and participate in drills to evaluate the fire safety program at least annually, or more frequently when required by laws and regulations or other authorities.
2. Staff who provide patient care can describe and demonstrate how to bring patients to safety.
3. Ⓓ Results of exercises to evaluate the fire safety program are documented, and staff who do not pass are reeducated and retested on the fire safety program.

Standard FMS.06.04

The fire safety program includes limiting smoking by staff and patients to designated non–patient care areas of the facility.

Intent of FMS.06.04

The fire safety program addresses limiting smoking and meets the following criteria:

- Applies to all patients, families, staff, and visitors.
- Eliminates smoking in the hospital's facilities or minimally limits smoking to designated non–patient care areas that are ventilated to the outside.
- Prohibits smoking in all areas under construction or renovation.

Smoking includes but is not limited to the use of cigarettes, cigars, pipes, hookahs, electronic cigarettes (including e-cigarettes and vaping devices), and other ignition sources for smoking.

The fire safety program that addresses limiting smoking identifies any exceptions related to patients, such as the medical or psychiatric reasons a patient may be permitted to smoke, and those individuals permitted to grant such an exception. When an exception is made, the patient smokes in a designated, nontreatment area, away from other patients.

Measurable Elements of FMS.06.04

1. The fire safety program addresses eliminating or limiting smoking within the hospital facility.
2. The program applies to patients, families, visitors, and staff.
3. The program identifies who may grant patient exceptions for smoking and when those exceptions apply.

Medical Equipment

Standard FMS.07.00

The hospital develops and implements a program for the management of medical equipment throughout the organization.

Intent of FMS.07.00

Management of medical equipment is performed to ensure that all equipment is functioning properly and available for use.

The medical equipment management program includes the following:

- An inventory of all medical equipment
- Regular inspections
- Testing according to use and manufacturers' requirements
- Documentation of results

- Performance of preventive maintenance, significant repairs, and disposal when necessary
- Completed documentation of all repair work

As part of the medical equipment program, the hospital conducts and documents a risk assessment, at least annually, to identify areas in which medical equipment risks exist.

Medical equipment management is performed by a qualified individual(s) based on background experience, education, and training. Medical equipment is used by departments throughout the hospital (for example, facilities team, bioengineering team, environmental services) and should have unified management processes to maintain an integrated system. Testing and inspection are performed when equipment is new and then on an ongoing basis according to age, use, and manufacturers' instructions. Inspections, testing results, any maintenance, and repairs are documented to ensure continuity of processes and guide capital planning for replacements, upgrades, and other changes.

Measurable Elements of FMS.07.00

1. Ⓓ The hospital develops and implements a written program for the management of medical equipment that is hospital owned and non-hospital owned (leased, rented, patient owned). (*See also* GLD.05.02, ME 1; HRP.02.01, ME 2)
2. Ⓓ The equipment program includes the following:
   - An inventory of all medical equipment
   - Regular inspections when equipment is new and as required by manufacturers' guidelines
   - Testing according to use and manufacturers' requirements
   - Documentation of results
   - Performance of preventive maintenance and calibration as applicable
   - Adherence to local laws and regulations

   (*See also* AOP.03.04, ME 2; AOP.05.04, ME 2)
3. Ⓓ The hospital identifies goals, implements improvements, and monitors data to ensure that medical equipment risks are reduced or eliminated.

Standard FMS.07.01

The hospital has a process for monitoring and acting on medical equipment hazard notices, recalls, reportable incidents, problems, and failures.

Intent of FMS.07.01

Medical equipment malfunctions pose risks to patients, providers, and other staff members, and having processes in place ensures awareness of issues and allows for action to prevent harm.

The hospital has a system in place for monitoring and acting on medical equipment hazard notices, recalls, reportable incidents, problems, and failures sent by the manufacturer, supplier, or regulatory agency. Some countries require reporting of any medical equipment that has been involved in a death, serious injury, or illness. Hospitals must identify and comply with the laws and regulations pertaining to the reporting of medical equipment incidents. The hospital conducts a root cause analysis in response to any sentinel events.

Measurable Elements of FMS.07.01

1. The hospital has a process for monitoring and acting on medical equipment and implantable device hazard notices, recalls, reportable incidents, problems, and failures. (*See also* AOP.03.04, ME 5; AOP.05.04, ME 5)
2. The hospital reports any deaths, serious injuries, or illness that are a result of medical equipment through the hospital's incident and adverse event reporting process. (*See also* GLD.04.00, ME 7)
3. The medical equipment management program addresses the use of any medical equipment with a reported problem or failure, or that is the subject of a hazard notice or is under recall.

Utility Systems

Standard FMS.08.00

The hospital implements a program for the management of utility systems throughout the organization.

Intent of FMS.08.00

Utilities can be defined as the systems and equipment that support essential services that provide safe health care. Such systems include electrical distribution; power; plumbing; boiler/steam; heating, ventilating, and air-conditioning (HVAC); medical gas; medical/surgical vacuum; waste management; and communication and data systems. The safe, effective, and efficient operation of utility and other key systems in the hospital is necessary for patient, staff, and visitor safety and for meeting patient care needs. Patient care, both routine and urgent, is provided on a 24-hour basis, every day of the week in a hospital. Thus, an uninterrupted source of essential utilities is critical to meeting patient care needs.

The hospital develops and implements a written program for the management of utility systems throughout the hospital. The utility systems program includes inspection, testing, and maintenance to ensure that utilities operate effectively and efficiently to meet the needs of patients, staff, and visitors.

A good utilities management program ensures the reliability of the utility systems and minimizes the potential risks. For example, water contamination, ineffective ventilation in critical care areas, oxygen cylinders that are not secured when stored, leaking oxygen lines, and frayed electrical lines all pose hazards. To avoid these and other risks, the hospital has a process for regularly inspecting such systems and performing preventive and routine maintenance. During testing, attention is paid to the critical components (for example, switches and relays) of systems.

Hospitals should have a complete inventory of all utility systems components and identify which components have the greatest impact on life support, infection prevention and control, environmental support, and communication. The utilities management program includes strategies for utility maintenance that ensure that these key systems components, such as electricity, water, waste, ventilation, and medical gas, are regularly inspected, evaluated, maintained, and, when necessary, improved, to reduce and eliminate risks.

Measurable Elements of FMS.08.00

1. Ⓓ The hospital develops and implements a written program for the management of utility systems throughout the hospital. (*See also* HCT.01.04, ME 1)
2. Ⓓ The hospital identifies goals, implements improvements, and monitors data to ensure that the utility systems risks are reduced or eliminated.
3. Ⓓ The hospital inventories its utility systems components and maps their current distribution.
4. Ⓓ The hospital identifies, in writing, the activities and intervals for inspecting, evaluating, and conducting preventive and routine maintenance on all operating components of the utility systems on the inventory, based on criteria such as manufacturers' recommendations, risk levels, and hospital experience.
5. The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.

Standard FMS.08.01

The hospital utility systems program ensures that essential utilities, including power, water, and medical gases, are available at all times, and alternative sources for essential utilities are tested and evaluated.

Intent of FMS.08.01

Patient care, both routine and urgent, is provided on a 24-hour basis, every day of the week in a hospital. Hospitals have different utility system needs based on their mission, patient needs, and resources. However, an uninterrupted source of essential utilities, including water, power, and medical gas, is critical for meeting patient care needs.

An emergency power system is required for all hospitals that intend to provide continuous service under emergency conditions. Such a system provides sufficient power to maintain essential functions during power failures. It also reduces the risks associated with such failures. Emergency and backup power sources are tested under planned circumstances that simulate actual load requirements. For example, for quarterly testing, requirements are that the test run for 30 minutes and should achieve 30% of the nameplate load. The 30-minute time frame does not include the time it takes for the warm-up or cool-down period. Hospitals may choose other methods for testing that meet industry standards.

Water quality can change suddenly from many causes, some of which occur outside of the hospital, such as a break in the supply line to the hospital. When there is a disruption in the usual source of water supplied to the organization, emergency potable water supplies must be immediately available.

Regardless of the type of system and level of its resources, a hospital needs to protect patients and staff in emergencies, such as when essential utilities fail, are interrupted, or become contaminated. To prepare for such emergencies, the hospital does the following:

- Identifies its essential utilities based on the systems, equipment, and locations that pose the highest risks to patients and staff if the utilities were interrupted, failed, or otherwise became unavailable (for example, key systems, equipment, and locations that require illumination, refrigeration, life support, water for cleaning and sterilization of supplies).
- Assesses and minimizes the risks of utility system failures in these areas.
- Plans emergency power and clean water sources for these areas and needs.
- Tests the availability and reliability of emergency sources of power and water.
- Documents the results of tests.
- Ensures that the testing and evaluation of alternative sources of water occurs at least annually or more frequently if required by local laws, regulations, or conditions of the sources for water (examples of conditions of the sources for water that may increase the frequency of testing include repeated repair of the water system and frequent contamination of the water source).
- Ensures that the testing and evaluation of power occurs at least quarterly or more frequently if required by local laws, regulations, manufacturers' recommendations, or conditions of the sources for power (examples of conditions of the sources for power that may increase the frequency of testing include unreliable electrical grids and recurrent, unpredictable power outages).

When the emergency power system requires a fuel source, determining how much fuel to store on-site should include consideration of past outages and any anticipated delivery problems caused by shortages, weather, and geographic conditions and locations. The hospital may determine the amount of fuel stored unless laws and regulations/local authority specifies the amount.

Measurable Elements of FMS.08.01

1. The hospital ensures backup availability/continuity of essential utilities (including power, water, and medical gas) 24 hours a day, 7 days a week. (*See also* FMS.09.00, ME 1)
2. Ⓓ The hospital tests and evaluates the availability and quality of the alternative source(s) of water at least annually or more frequently if required by local laws and regulations or conditions of the source of water. The hospital documents the results of the tests.
3. Ⓓ The hospital tests and evaluates alternative sources of power at least quarterly or more frequently if required by local laws and regulations, manufacturers' recommendations, or conditions of the source of power. The hospital documents the results of the tests.

Standard FMS.08.02

Designated individuals or authorities monitor water quality regularly.

Intent of FMS.08.02

Water quality is prone to sudden change, including changes outside the control of the hospital. It is imperative for hospitals to maintain water quality, as it is a crucial factor in clinical care processes, including dental procedures and hemodialysis. Thus, the hospital establishes a process to monitor and maintain water quality and implements actions when water quality is found to be unsafe.

The number of sites tested for water quality is determined by the hospital based on its own risk assessment. Testing of potable and/or non-potable water is conducted regularly. The frequency of testing can be based on any or all of the following:

- Local laws and regulations
- Conditions of the sources for water
- Previous experience with water quality problems

The testing can be carried out by individuals designated by the hospital, such as staff from the clinical laboratory, or by public health or water control authorities outside the hospital, or others judged competent to perform such tests. Whether performed by qualified hospital staff or by authorities outside the hospital, or other qualified individuals, it is the responsibility of the hospital to ensure that the testing is completed and documented.

In addition to testing water quality, to prevent and reduce the risks of contamination and growth of bacteria such as *Escherichia coli*, *Legionella*, and many others, guidance is sought from the hospital's infection prevention and control program as well as data from water quality–related patient adverse events. These sources help inform whether actions should be taken, such as preventive measures, to reduce the risk of contamination and growth of bacteria.

Water is an integral part of dental care. Hospitals that provide dental services take measures to ensure that the water used in dental treatments and procedures is safe. This includes following manufacturer's guidelines for treating and testing dental unit waterlines. The hospital ensures that dental staff are trained and understand the dental unit waterline treating and testing requirements and procedures.

Measurable Elements of FMS.08.02

1. Ⓓ Quality of potable water is tested and evaluated at least quarterly or more frequently in accordance with laws and regulations, conditions of the sources for water, and previous experience with water quality problems. The testing results are documented.
2. Ⓓ Quality of non-potable water is tested and evaluated at least every six (6) months or more frequently based on local laws and regulations, conditions of the sources for water, and previous experience with water quality problems. The testing results are documented.
3. Preventive measures and strategies are implemented to reduce the risks of contamination and growth of bacteria in water.
4. Ⓓ Dental unit waterlines are treated, tested, and evaluated according to manufacturer's guidelines, and treatments and testing are documented.

Standard FMS.08.03

Quality of water used in hemodialysis is tested and evaluated for chemical, bacterial, and endotoxin contaminants, and processes for hemodialysis services follow professional standards for water quality and for infection prevention and control.

Intent of FMS.08.03

Water quality is essential for the safe and effective delivery of hemodialysis, as those patients may be more vulnerable to infection risk and adverse outcomes.

It is necessary that the processes and procedures used in hemodialysis strictly follow industry standards and professional guidelines for water quality and infection prevention and control measures, such as the Association for the Advancement of Medical Instrumentation (AAMI). This includes but is not limited to testing water used for hemodialysis prior to and during dialysis treatments in accordance with evidence-based guidelines and other authorities, monthly at minimum for bacterial growth and endotoxins, and testing annually at minimum for chemical and other contaminants such as arsenic and heavy metals. It is also important to sample water for testing from both pre- and post-dialysis machine/reverse osmosis treatment unit/filter when required by industry standards and professional guidelines, to ensure that incoming water supply is not contaminated and meets water quality standards and that the machines and reverse osmosis units are performing as expected.

Other actions to ensure appropriate water quality and reduce infection risk in the hemodialysis services include routine disinfection of the water distribution system and testing hemodialysis machines. Frequency for disinfecting the water distribution system depends on such factors as the design of the system and the degree of prevention needed to control bacterial biofilm from forming on the interior of the water pipes.

Water quality treatments and testing results are documented.

When applicable to its services, the hospital establishes and implements procedures for reprocessing dialyzers, such as processes for cleaning, testing, and storing the dialyzers and the frequency for reusing/replacing them.

When problems with water quality are encountered in the hospital, actions are taken to address the problems while maintaining patient safety in the organization. For example, water quality problems may require the hospital to limit certain services or use alternative water sources until the problem is addressed. After the issue is resolved and water quality monitoring demonstrates that the water is safe, the hospital returns to its regular patient care services.

Measurable Elements of FMS.08.03

1. Hemodialysis services in the hospital follow industry standards and professional guidelines for maintaining water quality and implementing infection prevention and control measures.
2. Ⓓ Water used in hemodialysis is tested in accordance with evidence-based guidelines prior to and during treatments and evaluated monthly for bacterial growth and endotoxins and evaluated annually for chemical contaminants. The testing results are documented.
3. Ⓓ The hospital performs routine disinfection of the hemodialysis water distribution system.
4. Ⓓ The hospital conducts testing and evaluation on all hemodialysis machines annually, including machines not in use, and testing results are documented.
5. Ⓓ The hospital establishes and implements procedures for reprocessing dialyzers, including, as applicable, frequency for reusing/replacing dialyzers and processes for cleaning and testing dialyzers.

Standard FMS.08.04

The hospital reduces the risk of infection in the facility through the use of mechanical and engineering controls.

Intent of FMS.08.04

Engineering controls, such as positive and negative pressure ventilation systems, biological hoods in laboratories, and thermostats on refrigeration units and on water heaters used to sterilize dishes and kitchen equipment, are examples of how environmental standards and controls contribute to good sanitation and the reduction of infection risks in the hospital.

Positive pressure ventilation systems are used in protective areas of the hospital that require the highest level of cleanliness; for example, operating theatres, sterile storage areas, and rooms for immunocompromised patients. Positive pressure ventilation ensures that air is directed out of the area, minimizing the likelihood that microorganisms are introduced into the environment.

Hospitals identify and follow local and national laws and regulations and professional standards regarding the use and maintenance of positive pressure ventilation systems.

Proper water and steam temperatures are required to prevent the growth of microorganisms and to successfully carry out cleaning, disinfection, and sterilization procedures. Hospital leaders consult local and national laws and regulations, as well as professional guidelines, to determine appropriate water and steam temperatures to minimize the likelihood of infection transmission through water. In addition, hospital leaders ensure that water and steam reach the necessary temperatures for the proper duration to effectively carry out any cleaning, disinfection, or sterilization process; for example, proper water temperature for dishwashing and steam temperatures for autoclaving.

The hospital operates and maintains airflow, ventilation systems, and humidity controls to maintain indoor air quality. This includes maintaining heating, ventilating, and air-conditioning (HVAC) systems in a manner that minimizes infection risks to patients, staff, and visitors. Airborne contaminants can be spread through exhaust, through general ventilation, and during cleaning. Maintenance of airflow and ventilation systems can minimize this risk. Operation and maintenance are completed in accordance with local and national laws and regulations and professional guidelines and include proper maintenance of inlets, outlets, fans, filters, diffusers, ductwork, humidifiers, and so on.

Measurable Elements of FMS.08.04

1. The hospital operates and maintains negative and positive pressure ventilation systems in accordance with local and national laws and regulations and professional standards.
2. The hospital operates and maintains temperature controls for water, steam, and others in accordance with local and national laws and regulations and professional standards.
3. The hospital operates and maintains airflow, ventilation systems, and humidity controls in a manner that minimizes infection risk in the hospital in accordance with local and national laws and regulations and professional guidelines.

Emergency and Disaster Management

Standard FMS.09.00

The hospital develops, maintains, and evaluates an emergency management program to respond to internal and external emergencies and disasters that have the potential of occurring within the hospital and community.

Intent of FMS.09.00

Community emergencies and disasters may directly involve the hospital, such as damage to patient care areas as a result of an earthquake, tsunami, or terrorist attack that keeps staff from coming to work. To plan, prepare, and respond effectively to emergencies and disasters, the hospital develops and implements an emergency and disaster management program.

The development of the program begins by identifying the types of emergencies and disasters that are likely to occur in the hospital's region (for example, earthquakes, typhoons, floods, landslides, explosions) and the impact these emergencies and disasters would have on the hospital. For example, a hurricane or tsunami is more likely to occur in areas where the ocean is near; however, facility damage or mass casualties as a result

of war or a terrorist attack could potentially occur in any hospital. The program should address all six critical elements:

- Communication
- Resources and assets
- Safety and security
- Staff responsibilities
- Utilities management
- Patient clinical and support activities

Hospitals play a significant role in the community during emergencies and disasters. In order for hospitals to maintain operations during and after emergencies and disasters, it is important to evaluate and identify the structural and nonstructural limitations of the hospital's buildings. Determining how buildings will respond to the emergencies and disasters that are likely to occur in the region is an important aspect in developing evacuation plans and identifying priority areas for building improvements.

An evaluation of structural elements includes the type of building design and materials as well as components of the building's load-bearing system, including the foundation, columns, beams, walls, floor slabs, and so on. The building's location is also considered part of the structural elements (for example, risks related to proximity to other buildings, location in a hazard zone such as a floodplain, and other issues). An evaluation of nonstructural elements includes architectural elements that are not load-bearing (such as the roof, ceilings, windows, and doors); emergency access and exit routes to and from the hospital; critical systems (such as electricity, plumbing, waste management, and fire protection); medical and laboratory equipment; and other nonstructural elements that are crucial for the safe operation of the hospital. An evaluation of structural and nonstructural elements allows the hospital to identify vulnerabilities and develop plans for addressing these vulnerabilities and improving hospital safety and preparedness.

It is just as important to identify the probable effects of an emergency or disaster as it is to identify the types of emergencies and disasters likely to occur. This helps in planning the strategies that are needed in the event that the hospital experiences an emergency or disaster. For example, what is the likelihood that a natural disaster, such as an earthquake, will affect water and power? Could an earthquake prevent staff from responding to the disaster, either because roads are blocked or because they or their family members are also victims of the event? In such situations, staff responsibilities for their families and/or personal safety may make it difficult or impossible to be at the hospital responding to an emergency or disaster. Hospitals need to identify and plan for other resources when staff may not be able to come to the hospital to provide and support patient care during an emergency or disaster.

In addition, hospitals need to identify their role within the community. For example, what resources will the hospital be expected to provide to the community in the event that an emergency or disaster occurs, and what communication methods will be used within the community?

The emergency and disaster management program is evaluated by an annual test of the full program internally or as part of a communitywide test or testing of critical elements of the program during the year.

If the hospital experiences an actual emergency or disaster, activates its program, and debriefs properly afterward, this situation represents the equivalent to an annual test.

Measurable Elements of FMS.09.00

1. Ⓓ The hospital develops, evaluates, and maintains a written emergency and disaster management program that provides processes for the following:
   - Determining the type, likelihood, and consequences of hazards, threats, and events (*See also* GHI.05.00, ME 2)
   - Identifying the structural and nonstructural vulnerabilities of the hospital's patient care environments and how the hospital will perform in the event of an emergency or disaster
   - Planning for alternative sources of power and water in emergencies and disasters
   - Determining the hospital's role in such events
   - Determining communication strategies for events
   - Managing resources during events, including alternative sources (*See also* FMS.08.01, ME 1)
   - Managing clinical activities during an event, including alternative care sites
   - Identifying and assigning staff roles and responsibilities during an event (including contract staff, vendors, and others identified by the hospital) (*See also* GHI.05.00, ME 4)
   - Managing emergencies and disasters when personal responsibilities of staff conflict with the hospital's responsibility for providing patient care
2. Ⓓ The hospital identifies major internal and external emergencies and/or disasters such as community emergencies, and natural or other disasters that pose significant risks of occurring, taking into consideration the hospital's geographic location. (*See also* GHI.05.00, ME 2)
3. Ⓓ The hospital identifies and conducts annual evaluation of critical elements of the emergency and disaster management program. At a minimum, critical elements include the following:
   - Type, likelihood, and consequences of hazards, threats, and events
   - Structural and nonstructural vulnerabilities of the hospital's patient care environments and how the hospital will perform in the event of an emergency or disaster (*See also* GHI.05.00, ME 3)
   - Alternative sources of power and water in emergencies and disasters
4. Follow-up actions identified from testing and debriefing are developed and implemented.

Standard FMS.09.01

The hospital implements and evaluates an emergency management program to respond to the presentation of global communicable diseases.

Intent of FMS.09.01

In addition to community emergencies and disasters that may be unique based on the hospital's geographic location, the hospital also requires an emergency management program for global communicable diseases. The globalization of society has increased the likelihood of the rapid spread of communicable diseases from one country to another as seen during the COVID-19 pandemic. During the COVID-19 pandemic, hospitals were faced with an unprecedented high demand for health care services and had to quickly implement an emergency management program to address the COVID-19 crisis. To respond effectively to the presentation of global communicable diseases, the hospital develops a program to manage these emerging infectious diseases.

The World Health Organization (WHO) has identified the importance of detecting communicable disease outbreaks early and stopping the mortality, spread, and potential impact. An essential element in detecting and limiting the spread of infection is communications—with local and regional governmental agencies or university centers of excellence participating in worldwide surveillance activities that identify and track globally emerging infections. Examples of organizations participating in surveillance activities include the UK Public Health Laboratory Service, the French Pasteur Institutes, the Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET), and the US Centers for Disease Control and Prevention (CDC). In addition, organizations need to connect with the epidemiology department of their local public health agencies when available.

The program is evaluated to ensure proper response when an actual event occurs. Evaluation involves local, regional, and/or national authorities, when applicable; for example, a communitywide response drill or participation in a tabletop drill led by national public health authorities. If the hospital experiences an actual event, activates its program, and debriefs properly afterward, this represents the equivalent to an annual evaluation. Debriefing following an annual evaluation or actual event can identify vulnerable processes that may need to be reevaluated.

Measurable Elements of FMS.09.01

1. Ⓓ The hospital develops and implements an emergency preparedness program to respond to global communicable diseases that includes the following:
   - A process to determine when emergency management procedures are activated in response to emerging or reemerging infectious diseases (*See also* PCI.07.00, ME 1)
   - Internal and external communication strategies, including local and global disease surveillance authorities
   - Identification and assignment of staff roles and responsibilities
   - Identification of alternative supply chains for personal protective equipment and other critical supplies (*See also* PCI.07.01, ME 2)
2. The hospital implements emergency staffing plans to ensure continuity of operations and provision of patient care.
3. Ⓓ The hospital identifies the first points of patient entry into the hospital system and has a procedure to restrict access to predetermined access points. (*See also* PCI.07.02, ME 1)
4. Ⓓ The hospital evaluates the entire program at least annually and, when applicable, involves local, regional, and/or national authorities.
5. Follow-up actions identified from the evaluation process and debriefing are developed and implemented.
6. The hospital implements a process for managing a sudden influx of patients with contagious diseases.

Construction and Renovation

Standard FMS.10.00

When planning for construction, renovation, and demolition projects, or maintenance activities that affect patient care, the organization conducts a preconstruction risk assessment.

Intent of FMS.10.00

Construction, renovation, demolition, and maintenance activities in a hospital can have an impact on everyone in the organization; however, patients may suffer the greatest impact. For example, the noise and vibration associated with these activities can affect patients' comfort level, and dust and odors can change air quality, which may pose a threat to a patient's respiratory status. The risks to patients, staff, visitors, independent business entities, and others in the hospital will vary depending on the extent of the construction, renovation, demolition, or maintenance activity and its impact on patient care, infrastructure, and utilities. For example, maintenance activity that involves medical gases may impact patient care; however, resurfacing the staff parking lot may have no impact on patient care.

Demolition, construction, renovation, and routine maintenance projects anywhere within the hospital can also be a major infection control risk. Exposure to construction dust and debris, and other hazards, can transmit infection and be potentially dangerous to the health and safety of staff, patients, and visitors.

In order to assess the risks associated with a construction, renovation, or demolition project, or a maintenance activity that affects patient care, the hospital brings relevant departments together, including, as needed, representatives from project design, project management, facilities engineering, facility security/safety, infection prevention and control, fire safety, housekeeping, information technology services, and clinical departments and services.

Risks are evaluated by conducting a preconstruction risk assessment, also known as PCRA, throughout the life cycle of the project. The risk assessment is used to comprehensively evaluate risks in order to develop plans and implement preventive measures that will minimize the impact the project will have on the quality and safety of patient care. For example, measures to reduce fire risk and ensure safe exit are implemented when fire safety risks are identified.

In addition, the hospital ensures that contractor compliance is monitored, enforced, and documented. As part of the risk assessment, patient risk of infection from construction is evaluated through an infection control risk assessment, also known as ICRA.

Measurable Elements of FMS.10.00

1. Ⓓ When planning for construction, renovation, or demolition projects, or maintenance activities that affect patient care, the hospital conducts a preconstruction risk assessment (PCRA) that includes, at minimum, the following:
   - Air quality
   - Infection prevention and control
   - Utilities
   - Noise
   - Vibration
   - Hazardous materials and waste
   - Fire safety
   - Security
   - Emergency procedures, including alternate pathways/exits and access to emergency services
   - Other hazards that affect care, treatment, and services

   (*See also* FMS.02.00, ME 1)
2. The hospital takes action based on its assessment to minimize risks during construction, renovation, and demolition projects, and maintenance activities that affect patient care.
3. Ⓓ The hospital ensures that contractor compliance is monitored, enforced, and documented.

Governance, Leadership, and Direction (GLD)

Overview

Providing excellent patient care requires effective leadership. Effective leadership begins with understanding the various responsibilities and authority of individuals in the organization and how these individuals work together. Those who govern, manage, and lead an organization have both authority and responsibility. Collectively and individually, they are responsible for complying with laws and regulations and for meeting the organization's responsibility to the patient population served.

Organization leaders promote safety culture across the organization. Over time, effective leadership helps overcome perceived barriers and communication problems between departments and services in the organization, and the organization becomes more efficient and effective. Services become increasingly integrated. In particular, the integration of all quality management and improvement activities throughout the organization results in improved patient outcomes.

Level I: GLD.01.00
Governance

Level II: GLD.02.00
Chief Executive

Level III: GLD.03.00 – GLD.05.03			
Hospital Leaders			
Medicine	Nursing	Administration	Others

Level IV: GLD.06.00 – GLD.06.02			
Department/Service Leaders			
Clinical Departments	Diagnostic Services	Pharmacy	Ancillary Service
Managers of Clinical and Nonclinical Services			

GLD.07.00 – GLD.09.00
Organization and Clinical Ethics Health Professional Education Human Subjects Research

Standards in this chapter are grouped using the following leadership hierarchy:

Level I: Governance

Governance refers to the governing entity of the hospital and can exist in many configurations. For example, the governing entity may be a group of individuals (such as a community board), one or more individual owners within a corporate structure, or in the case of public hospitals, the Ministry of Health. Any individual(s) or board member(s) responsible for the requirements found in GLD.01.00 is considered the governing entity of the hospital.

Level II: Chief Executive

The most senior hospital executive, commonly termed the *chief executive*, is a position occupied by one or more individuals selected by the governing entity to manage the organization on a day-to-day basis. In academic medical centers, the dean of the medical school may be at this executive level in the hospital. GLD.02.00 describes the accountabilities and expectations of the chief executive.

Level III: Hospital Leaders

The standards assign to hospital leaders a variety of responsibilities intended to collaboratively guide the hospital in meeting its mission. Most frequently, hospital leadership consists of a chief medical officer representing the medical staff of the hospital, a chief nursing officer representing all levels of nursing in the hospital, senior administrators, and any other individuals the hospital selects, such as a chief quality officer, chief information officer, or vice president of human resources. In larger hospitals with different organizational structures, such as divisions, hospital leadership may include the leaders of these divisions. Each hospital identifies hospital leadership, and standards GLD.03.00 through GLD.05.03 describe the accountabilities of this group.

Note: GLD.06.00 describes the responsibilities of leaders of clinical services; however, they may be formally or informally organized. In academic medical centers, the leader of medical education and leader of clinical research may be a part of hospital leadership.

Level IV: Department/Service Leaders

For effective and efficient daily delivery of clinical services and management of the organization, hospitals are most frequently divided into cohesive subgroups such as departments, services, or units, each under the direction of a department/service leader(s). Standards GLD.06.00 through GLD.06.02 describe the expectations of these department/service leaders. The subgroups consist of departments such as medicine, surgery, obstetrics, pediatrics, and others; one or more nursing subgroups; diagnostic services or departments such as quality and patient safety, radiology, and clinical laboratory; pharmacy services, both centralized and distributed throughout the hospital; and ancillary services such as transportation, social work, finance, purchasing, facility management, and human resources, among others. Most larger hospitals also have managers within these subgroups. For example, nursing may have a manager of the operating theatres and one for outpatient services, the department of medicine may have managers of each patient clinical unit, and the hospital business office may have managers for the different business functions such as bed control, billing, and purchasing, among others.

Finally, there are requirements in the GLD chapter that touch on all the levels described above. These requirements are found in GLD.07.00 through GLD.09.00 and include the organization and clinical ethics, health professional education, and human subjects research when present.

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Leadership Structure

GLD.01.00 The structure, authority, and responsibilities of the hospital's governing entity are described in bylaws, policies and procedures, or similar written documents.

Chief Executive(s) Accountabilities

GLD.02.00 A chief executive(s) is responsible for operating the hospital and complying with applicable laws and regulations.

Leader Accountabilities

GLD.03.00 Hospital leaders are identified and are collectively responsible for defining the hospital's mission and creating the programs and policies needed to fulfill the mission.

GLD.03.01 Hospital leaders identify, plan, and communicate the type of clinical services required to meet the needs of the patients served by the hospital.

GLD.03.02 Hospital leaders ensure effective communication throughout the hospital.

Leadership for Quality and Patient Safety

GLD.04.00 Hospital leaders plan, develop, and implement a quality and patient safety program.

GLD.04.01 Hospital leaders report quality improvement and patient safety information to the governing entity and hospital staff.

GLD.04.02 Hospital leaders collaborate to prioritize which hospitalwide processes will be measured, which hospitalwide improvement and patient safety activities will be implemented, and how success of these hospitalwide efforts will be measured.

Leadership for Contracts and Resources

GLD.05.00 Hospital leaders are accountable for the review, selection, and monitoring of clinical and nonclinical contracts and inspect compliance with contracted services as needed.

GLD.05.01 Hospital leaders ensure that health care practitioners and clinical staff not employed by the hospital have the right credentials and are competent and/or privileged for the services provided to the hospital's patients.

GLD.05.02 Hospital leaders use data and information in resource decision-making to understand its implications on patient safety and quality.

GLD.05.03 Hospital leaders establish a supply chain strategy that includes protection of patients and staff from unstable, contaminated, defective, and counterfeit supplies.

Direction of Hospital Departments and Services

GLD.06.00 The hospital identifies the scope of services and structure of each department or service.

GLD.06.01 Department/service leaders participate in hospitalwide improvement priorities and in monitoring and improving patient care specific to the department/service.

GLD.06.02 Department/service leaders select and implement clinical practice guidelines, clinical pathways, and clinical protocols when designing or improving processes.

Organizational and Clinical Ethics

GLD.07.00 Hospital leaders establish a framework for ethical management that promotes a culture of ethical practices and decision-making to ensure that patient care is provided within business, financial, ethical, and legal norms and protects patients and their rights.

GLD.07.01 Hospital leaders create and maintain a culture of safety and quality throughout the hospital.

GLD.07.02 The hospital implements a workplace violence prevention program to provide a safe and secure workplace.

Health Professional Education

GLD.08.00 Health professional education, when provided within the hospital, is guided by the educational parameters defined by the sponsoring academic program and the hospital's leaders.

Human Subjects Research

GLD.09.00 Human subjects research, when provided within the hospital, is guided by laws, regulations, and hospital leaders.

Standards, Intents, and Measurable Elements

Leadership Structure

Standard GLD.01.00

The structure, authority, and responsibilities of the hospital's governing entity are described in bylaws, policies and procedures, or similar written documents.

Intent of GLD.01.00

There is a governing entity—for example, a group of individuals (such as a board of directors or a community board), one or more individual owners who are appointed by the corporate structure, or in the case of many public hospitals, the Ministry of Health—that is responsible for overseeing the hospital's provision of care, treatment, and services.

Every hospital has a leadership structure to support operations and the provision of care, treatment, and services. In many hospitals, this structure is formed by various leadership groups and includes the governing entity, executive leaders, and department or senior leaders.

Individual leaders may participate in more than one group and have several distinct roles. Many leadership responsibilities directly affect the provision of care, treatment, and services, as well as the day-to-day operations of the hospital. As such, it is important to identify the responsibilities of the various levels of hospital leadership.

Evaluation of the hospital's top leaders is critical to ensure strategic alignment and to monitor organizational and individual performance. These evaluations align the CEO's understanding of the governing entity's performance expectations and provide feedback on the governing entity's assessment of progress and improvement toward attaining the mission and vision of the organization as well as realigning the strategy, as necessary.

The hospital's governing entity is represented or displayed in an organizational chart or other document that shows lines of authority and accountability. The governing entity's responsibilities are described in a written document(s). These responsibilities are primarily at the approval level and include the following:

- Approving and periodically reviewing the hospital's mission and ensuring that the public is aware of the hospital's mission
- Approving the hospital's various strategic and operational plans and the policies and procedures needed to operate the hospital day to day
- Approving the hospital's participation in health care professional education and in research and the oversight of the quality of such programs
- Approving or providing a capital and operating budget(s) and other resources
- Appointing and evaluating the hospital's chief executive(s)

The governing entity oversees the effectiveness of strategic plans through periodic reports provided by the hospital leadership team.

Measurable Elements of GLD.01.00

1. Ⓓ The structure, authority, and responsibilities of the hospital's governing entity are described in a written document, bylaws, and/or policies and procedures, with those responsible for governance of the hospital identified.
2. The governing entity approves the hospital's capital and operating budget(s) that aligns with the hospital's services, and provides for the resources required to meet the hospital's mission.
3. The governing entity approves the hospital's participation in health care professional education and research and in the oversight of the quality of such programs.
4. Ⓓ The governing entity appoints, and annually evaluates, the hospital's chief executive(s), and the evaluation is documented.
5. Ⓓ The hospital has written policies that describe when and how the authority of the governing entity, and the chief executive(s), can be delegated.

Chief Executive(s) Accountabilities

Standard GLD.02.00

A chief executive(s) is responsible for operating the hospital and complying with applicable laws and regulations.

Intent of GLD.02.00

Effective leadership is essential for a hospital to be able to operate efficiently and to fulfill its mission. As the most senior hospital executive leader appointed by the governing entity, the chief executive(s) is ultimately responsible for the hospital's overall operations.

The chief executive(s) cooperates with hospital leaders to define the hospital's mission and to plan the policies, procedures, and clinical services related to that mission. When approved by the governing entity, the chief executive(s) is ultimately responsible for implementing all policies and ensuring that all staff comply with policies and all applicable laws and regulations.

Measurable Elements of GLD.02.00

1. The education and experience of the chief executive(s) match the requirements in the position description.
2. The chief executive(s) recommends policies, strategic plans, and budgets to the governing entity.
3. The chief executive(s) ensures consistent implementation of the hospital's approved policies.
4. The chief executive(s) ensures compliance with applicable laws and regulations.
5. The chief executive(s) responds to any reports from inspecting and regulatory agencies.

Leader Accountabilities

Standard GLD.03.00

Hospital leaders are identified and are collectively responsible for defining the hospital's mission and creating the programs and policies needed to fulfill the mission.

Intent of GLD.03.00

Although the governing entity names the chief executive(s), the chief executive(s) is responsible for the selection and appointment of other hospital leadership team members who are collectively responsible for fulfilling the organization's mission.

Hospital leaders may have formal titles, such as Medical Director or Director of Nursing; may be leaders of clinical or nonclinical departments or services; or may be informally recognized for their seniority, stature, or contribution to the hospital. It is important that hospital leaders are recognized and brought into the process of defining the hospital's values and mission. Hospital leaders work collectively and collaboratively to develop the programs, policies, and services needed to fulfill the mission. When the mission and policy framework are set by owners or agencies outside the hospital, hospital leaders work collaboratively to carry out the mission and policies.

Measurable Elements of GLD.03.00

1. Hospital leaders are responsible for defining the hospital's mission, vision, and goals.
2. Hospital leaders are responsible for creating the policies and procedures necessary to carry out the mission.
3. Hospital leaders ensure that policies and procedures are followed.

Standard GLD.03.01

Hospital leaders identify, plan, and communicate the type of clinical services required to meet the needs of the patients served by the hospital.

Intent of GLD.03.01

Hospital leaders determine essential services that meet the needs of the patient population and reflect the strategic direction of the hospital and the perspective of the patients cared for by the hospital.

Hospital leaders plan with the department/service leaders the scope and intensity of the various services to be provided by the hospital directly or indirectly. When applicable to the mission, hospital leaders plan and participate with the community, local hospitals, and others in meeting community health care needs.

Part of the planning is providing uniform services to similar patient populations in multiple departments. Services are guided by policies and procedures that result in their uniform delivery of care. Department/service leaders ensure that the same level of care is available each day of the week, and all work shifts each day.

Those policies and procedures adhere to applicable laws and regulations that are best developed collaboratively. Uniform patient care results in the efficient use of resources and permits the evaluation of outcomes of similar care throughout the hospital.

Planning patient care services involves hospital leaders defining its communities and patient populations, identifying community needs for services, and planning ongoing communication with those key community stakeholder groups. The communications may be directly to individuals or through public media and through agencies within the community or third parties. The types of information communicated include information on services, hours of operation, and the process to obtain care and on the quality of services, which is provided to the public and to referral sources.

Measurable Elements of GLD.03.01

1. Hospital leaders determine and plan with department/service leaders the type of care, treatment, and services to be provided by the hospital that are consistent with the hospital's mission and needs of the patients served. (*See also* SQE.01.05, ME 1)
2. Hospital leaders communicate with key stakeholders in the hospital's community to facilitate access to care and access to information about its patient care services. (*See also* MOI.01.00, ME 1)
3. Hospital leaders provide data and communicate information related to safety and quality of the hospital's services to stakeholders, which include nursing staff, nonclinical and management staff, patients, families, and external interested parties.
4. Ⓓ Hospital leaders implement written policies to provide uniform care in the following ways:
   - The hospital provides care and treatment for the patient's immediate needs and refers them to the appropriate level of care.
   - Access to immediate care and treatment by qualified practitioners does not depend on the day of the week or time of day.
   - Acuity of the patient's condition determines the resources allocated to meet the patient's needs.
   - The scope, level of care, treatments, and services available and provided to patients are comparable throughout the hospital.

Standard GLD.03.02

Hospital leaders ensure effective communication throughout the hospital.

Intent of GLD.03.02

Effective communication within a hospital is the responsibility of hospital leaders. Hospital leaders not only set the parameters of communication, but leaders also serve as role models with the effective communication of the hospital's mission, strategies, plans, and other relevant information. Hospital leaders pay attention to the accuracy and timeliness of information shared and communicated throughout the hospital.

Hospital leaders understand the dynamics of communication between professional groups; between structural units, such as departments; between professional and nonprofessional groups; between health care practitioners and management; between health care practitioners and families; and between health care practitioners and outside organizations.

To coordinate and to integrate patient care, hospital leaders develop a culture that emphasizes cooperation and communication. Formal (for example, standing committees, joint teams) and informal (for example, newsletters and posters) methods for promoting communication among services and individual staff members are used. Coordination of clinical services comes from an understanding of each department's mission and services and collaboration in developing common policies and procedures.

Measurable Elements of GLD.03.02

1. Hospital leaders ensure that processes are in place for communicating relevant information throughout the hospital in a timely manner. (*See also* MOI.01.00, ME 1)
2. Hospital leaders ensure effective communication among clinical and nonclinical departments, services, and individual staff members. (*See also* MOI.01.00, ME 1)
3. Hospital leaders communicate the hospital's vision, mission, goals, policies, and plans to staff.

Leadership for Quality and Patient Safety

Standard GLD.04.00

Hospital leaders plan, develop, and implement a quality and patient safety program.

Intent of GLD.04.00

Hospital leaders are responsible for establishing and providing ongoing support for an organizational commitment to quality. Hospital leaders develop the quality and patient safety program for approval by the governing entity, and through its vision and support, shapes the quality culture of the hospital.

Leadership and planning are essential to successfully initiate and maintain improvement and reduce risks to patients and staff. Leadership and planning begin with the governing entity of the hospital and those who manage and lead the daily clinical and managerial activities of the hospital. These individuals represent the leaders of the departments and services of the hospital. Hospital leaders select the method to measure, assess, and improve quality and patient safety. Hospital leaders also determine how the program will be directed and managed daily, such as through a quality department, and ensure that the program has adequate resources to be effective.

Hospital leaders implement a structure and process for the overall monitoring and coordination of the program throughout the hospital. These actions ensure coordination among all the departments and services in measurement and improvement efforts. Coordination can be achieved through a quality management council, committee, department, or other structure. Coordination encourages a systemwide approach to quality monitoring and improvement activities while reducing duplication of effort; for example, two departments independently measuring similar processes or outcomes.

Careful identification, investigation, and analysis of serious patient safety events, as well as strong corrective actions that provide effective and sustained system improvement, is essential to reduce risk and prevent patient harm (*see also* Sentinel Event Policy at https://www.jointcommissioninternational.org/contact-us/sentinel-event-policy/ and Standards QPS.04.00 and QPS.04.01). Although organizations are not required to report sentinel events to Joint Commission International, accredited organizations must have a policy defining sentinel events and describing how the organization addresses sentinel events.

Measurable Elements of GLD.04.00

1. Ⓓ Hospital leaders participate in developing and implementing a hospitalwide quality and patient safety program. (*See also* PCI.08.00, ME 1; QPS.01.00, ME 3; QPS.03.03, ME 1)
2. Hospital leaders select and implement a hospitalwide process to measure, assess data, plan change, and sustain improvements in quality and patient safety, and provide staff education on this quality improvement process. (*See also* QPS.02.00, ME 2; QPS.04.00, ME 4)
3. Hospital leaders determine how the program will be directed and managed daily and ensure that the program has adequate resources to be effective. (*See also* QPS.01.00, ME 1)
4. Hospital leaders implement a structure and process for the overall monitoring and coordination of the quality and patient safety program. (*See also* PCI.08.00, ME 3)
5. Ⓓ Hospital leaders define, in writing, patient safety events, including sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual, and encourage voluntary external reporting to programs such as the Joint Commission International Sentinel Event Database in addition to mandatory programs in accordance with laws and regulations when applicable.
6. The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual.
7. Hospital leaders establish a process to actively provide support systems for staff who have been involved in an adverse event or a sentinel event. (*See also* FMS.07.01, ME 2)

Standard GLD.04.01

Hospital leaders report quality improvement and patient safety information to the governing entity and hospital staff.

Intent of GLD.04.01

Communication of quality improvement and patient safety information promotes a proactive identification of potential system failures. Hospital leaders analyze and act on problems that have occurred, and they encourage the reporting of adverse events and close calls ("near misses"), both internally and externally.

Establishing a safety program that integrates safety priorities into all processes, functions, and services within the hospital is part of leadership responsibilities. Hospital leaders are also responsible for providing periodic quality reports for review by the governing entity and for seeing that the actions and directives of the governing entity related to the quality and patient safety program reports are carried out.

The governing entity approves the quality and patient safety program on an annual basis, and on a quarterly basis receives quality reports. The reports can be global in nature or focus on a particular clinical service, a patient group, or some operational aspect. Therefore, over a period of time, all aspects of the quality and patient safety program, including adverse events and sentinel events, are presented to the governing entity for their information and discussion. When the discussion results in actions, such as allocation of additional resources, those actions are recorded in minutes and are reexamined at a future meeting(s).

Obtaining review and action on reports of the quality and patient safety program from the governing entity may be a challenge for some hospitals, particularly those that are one of many organizations reporting to a governing entity, such as a Ministry of Health (MOH). If the governing entity continues to be unresponsive, the hospital makes a credible effort to contact them. A credible effort includes contacting the governing entity multiple times by various methods and documenting the attempts/outcomes of the communications.

It is essential that hospital leaders also communicate information about the quality and patient safety program to staff. This flow of quality communications is through effective channels, such as newsletters, storyboards, staff meetings, and human resources processes.

The information can be about new or recently completed improvement projects, including the following:

- Progress in meeting the International Patient Safety Goals
- Results of the analysis of sentinel events and other adverse events
- Recent research or benchmark programs

Measurable Elements of GLD.04.01

1. The governing entity annually reviews and approves the hospital's program for quality and patient safety. (*See also* FMS.02.00, ME 4)
2. Ⓓ At least quarterly, hospital leaders provide the governing entity with written reports on quality and patient safety that, at minimum, include the following:
   - All system or process failures (*See also* QPS.02.00, ME 3)
   - The number and type of sentinel events (*See also* Sentinel Event Policy)
   - Whether the patients and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences
   - Follow-up of actions taken, when necessary
3. Hospital leaders regularly communicate information on quality improvement and the patient safety program to staff.

Standard GLD.04.02

Hospital leaders collaborate to prioritize which hospitalwide processes will be measured, which hospitalwide improvement and patient safety activities will be implemented, and how success of these hospitalwide efforts will be measured.

Intent of GLD.04.02

Due to staff and resource limitations, not every process within a hospital can be measured and improved at the same time. Thus, a primary responsibility of hospital leaders is to work with the chief executive(s) in prioritizing hospitalwide measurement and improvement activities.

Measurement and improvement efforts impact activities in multiple departments and services. Hospital leaders provide focus for the hospital's quality measurement and improvement activities, including measurement and activities regarding compliance with the International Patient Safety Goals; for example, measuring the effectiveness of the patient identification process for IPSG.01.00 or monitoring the process for reporting critical results of diagnostic tests as noted in IPSG.02.00.

Priorities may focus on the achievement of strategic objectives; for example, to become the leading regional referral center for cancer patients. Similarly, hospital leaders may give priority to other projects, including those that do the following:

- Increase efficiency.
- Reduce readmission rates.
- Eliminate patient flow problems in the emergency department.
- Create a monitoring process for the quality of services provided by contractors.

Understanding both the impact of an improvement on patient outcomes and the relative cost and resulting process efficiency contributes to improved priority-setting in the future, both at an organizational level and at a departmental/service level. When this information is combined hospitalwide, hospital leaders can better understand how to allocate available quality and patient safety resources.

Hospital leaders collectively work to consider priorities at a system level to spread the impact of improvements broadly throughout the hospital; for example, improving the hospital's medication management system. The priority-setting process includes the consideration of available data on which systems and processes demonstrate the most variation in implementation and outcomes.

Using available data, hospital leaders assess the impact of hospitalwide improvements. Measuring improvement in efficiency of a complex clinical process, and/or identifying reductions in cost and resource use following improvement in a process, are examples. Measuring the impact of an improvement supports an understanding of the relative costs for investing in quality and the human, financial, and other returns on that investment. Hospital leaders support the creation of simple tools to quantify resource use of the old process and for assessing a new process.

It is also important to collect and analyze data on diagnostic errors, and hospital leaders should include this in their data-driven decision-making. *Diagnostic errors* are diagnoses that are missed, wrong, or delayed, as detected by subsequent definitive test findings, according to the Society to Improve Diagnosis in Medicine. Diagnostic errors were found to make up 17% of preventable errors in patients in one study (Harvard). Another study (Johns Hopkins) found that the most common diagnostic errors were related to vascular events, cancer, and infections. These are also the largest causes of medical malpractice claims.

Causes of diagnostic errors are complex, and rarely the fault of an individual clinician or staff member. Factors leading to diagnostic errors include diagnostic complexity, breakdowns in communication or care coordination, lost test results, equipment malfunctions, availability of specialty clinicians, and cognitive errors or bias. Closed-loop communication is an essential method to reduce diagnostic errors, and it means every test result is always sent, received, acknowledged, and acted on.

Often, following up on actions taken is a necessary step, and can even be critical, for patient care. This requires care coordination throughout the continuum to hand off test results, interpret the results, and communicate them in language patients can understand. Implementing a closed-loop communication process requires a number of interventions, such as redesigning communication processes, improving patient engagement, establishing data-driven measures to monitor and act on diagnostic results communication on an ongoing basis, and evaluating patient outcomes.

Measurable Elements of GLD.04.02

1. Ⓓ Hospital leaders use available data to set collective priorities for hospitalwide measurement and improvement activities and consider potential system improvements. (*See also* QPS.04.00, ME 1)
2. Hospital leaders set priorities for compliance with the International Patient Safety Goals.
3. Ⓓ Hospital leaders conduct a data-driven, risk-focused assessment of data annually for diagnostic errors that focuses on at least one of the following areas:
   - Radiology
   - Pathology
   - Laboratory/microbiology
   - Care coordination
4. Hospital leaders implement evidence-based interventions based on the diagnostic error risk assessment and data analysis with the intent to improve the diagnostic area(s) of focus and evaluate the effectiveness of the interventions on an ongoing basis, reevaluating when indicated.

Leadership for Contracts and Resources

Standard GLD.05.00

Hospital leaders are accountable for the review, selection, and monitoring of clinical and nonclinical contracts and inspect compliance with contracted services as needed.

Intent of GLD.05.00

Evaluation of all services provided through contracted services impacts the quality and safety of patient care. To provide and maintain continuity of patient services, hospital leaders describe and monitor the scope of services provided through contractual agreements.

The patient care processes in hospitals are supported by a range of operational activities that includes distribution of supplies and services throughout the organizations. Health care logistics encompasses the process of handling services (for example, radiology and diagnostic imaging services, financial accounting services, housekeeping, food, linens) and physical goods (for example, pharmaceuticals, surgical medical products, medical equipment, sterile items, linens, food). Hospitals frequently have the option to either provide clinical and management services directly or to arrange for such services through referral, consultation, contractual arrangements, or other agreements.

The COVID-19 pandemic highlighted the need to increase the capacity of hospitals to respond to and maintain access to essential health services. The World Health Organization identifies *contracting* as an important tool for increasing capacity and maintaining critical resources for patient care. Reviewing and monitoring contracts also allows the hospital to prepare for continuity of services during an emergency. The World Health Organization guidance for contracting services recommends that hospital leaders do the following:

- Define the purpose and structure of the contract.
- Plan the procurement process.
- Procure and sign the contract.
- Monitor the contractual relationship.

The hospital needs to receive, analyze, and act on quality information and performance data from outside sources. The contract with the outside source of service includes quality and patient safety expectations and the data that are to be provided to the hospital, their frequency, and their format. Department/service leaders receive and act on quality reports from contracting agencies that relate to the scope of services provided within their department/service and ensure that the reports are integrated into the hospital's quality measurement process.

Hospital leaders are accountable for such contracts or other arrangements to ensure that the services meet patient needs and are included as part of the hospital's quality management and improvement activities. Department/service leaders participate in the review and selection of all clinical and nonclinical contracts and are accountable for monitoring those contracts.

Measurable Elements of GLD.05.00

1. Hospital leaders identify an individua(s) with oversight responsibility for contracts to meet patient and management needs. (*See also* AOP.03.00, ME 3)
2. Ⓓ The hospital has a written description of the nature and scope of those services to be provided through contractual agreements.
3. Department/service leaders participate in the review, selection, and monitoring of clinical and nonclinical contracts. (*See also* ASC.01.00, ME 6)
4. Hospital leaders monitor compliance with contracted services and take actions to maintain continuity of services when contracts are renegotiated or terminated. (*See also* AOP.03.09, MEs 3 and 4; AOP.05.06, MEs 3 and 4)
5. Ⓓ All contracts stipulate the quality and performance data that are to be reported to the hospital, the reporting frequency and mechanism, and how the hospital will respond when quality requirements or expectations are not met. (*See also* AOP.03.09, MEs 3 and 4; AOP.05.06, MEs 3 and 4)
6. Ⓓ Quality data reported under contracts are integrated into the hospital's quality monitoring program.

Standard GLD.05.01

Hospital leaders ensure that health care practitioners and clinical staff not employed by the hospital have the right credentials and are competent and/or privileged for the services provided to the hospital's patients.

Intent of GLD.05.01

Hospital leaders have the responsibility to confirm that health care practitioners and clinical staff are competent and/or privileged to provide the services to their patients.

Contracts with independent health care practitioners and other clinical staff may include preventive, curative, restorative, surgical, rehabilitative, or other medical or dental services for patients; or interpretative services for patients, such as pathology, radiology, or laboratory services. The services provided by independent health care practitioners may also include telehealth or teleradiology. In some cases, these individuals may be located outside the region or country of the hospital. The contracts stipulate that the clinical staff provided meet the patient needs and the hospital's requirement for similar staff.

Independent health care practitioners may be accompanied by staff reporting to them and who are not part of the hospital (for example, surgical assistant accompanying a surgeon). Any support staff accompanying independent health care practitioners and providing care and services in the hospital are compliant with requirements for primary source verification.

Measurable Elements of GLD.05.01

1. Ⓓ All diagnostic, consultative, and treatment services provided by independent health care practitioners outside the hospital are credentialed and privileged by the hospital to provide such services.
2. Ⓓ Independent health care practitioners who provide patient care services on the premises of the hospital but are not employees or members of the clinical staff are credentialed, privileged, and evaluated as required in SQE.05.00 through SQE.07.01.
3. Any support staff accompanying independent health care practitioners and providing care and services in the hospital are compliant with requirements for primary source verification.
4. The quality of services by independent practitioners outside the hospital is monitored as a component of the hospital's quality improvement program.

Standard GLD.05.02

Hospital leaders use data and information in resource decision-making to understand its implications on patient safety and quality.

Intent of GLD.05.02

Hospital leaders use data and information to appropriately guide their decisions regarding the purchase and use of human and technical resources to better understand its impact on overall hospital operation.

Hospital leaders improve decision-making when they have data, information, and tools to support decisions. For example, when the hospital needs to replace or add infusion pumps: Information on maintenance requirements, staff training or retraining requirements, information on previous failure rates and patient safety incidents, preferences of staff, and alarm issues will result in decisions based more on quality and patient safety than on cost alone. Similarly, when making decisions regarding the reduction or reassignment of nursing staff, consideration of the implications for patient care quality and patient safety needs to be brought forward to inform the decision. The COVID-19 pandemic placed unprecedented demands on entire health systems and drove them to full capacity. Hospitals were confronted with the difficult problem of ensuring appropriate staffing and resources to a high number of critically ill patients. Hospitals are better prepared when leaders

develop a process to gather data and information for resource decisions that will ensure patient safety and quality of care

One component of data gathering related to resource decisions is to understand the required or recommended staffing, medical equipment, supplies, and medications necessary to continuously provide service. Recommendations on medical equipment, supplies, and medication can come from a government agency, national or international professional organizations, or other authoritative sources. It is also important to gather input from clinicians, clinical engineers, and frontline staff. When resource decisions are made by a third party—for example, a Ministry of Health—hospital leaders provide data and information to the third party on their experiences and preferences to better inform future resource choices.

Measurable Elements of GLD.05.02

1. Hospital leaders use data and information when making decisions on purchasing, replacing, or retiring medical equipment. (*See also* FMS.07.00, ME 1)
2. Hospital leaders use data and information when making decisions on staffing needs to continuously support patient safety and quality.
3. Hospital leaders use the recommendations of professional organizations and other authoritative sources in making resource decisions. (*See also* GHI.04.00, MEs 1 and 2)
4. Hospital leaders monitor the results of their decisions and use the data to evaluate and improve the quality of their resource purchasing and allocation decisions.

Standard GLD.05.03

Hospital leaders establish a supply chain strategy that includes protection of patients and staff from unstable, contaminated, defective, and counterfeit supplies.

Intent of GLD.05.03

Hospitals require a variety of items, and the issues of storing and distributing these items throughout the hospital are important to providing high-quality patient service. Hospital leaders need to understand the flow of all supplies to continuously provide safe and high-quality patient care services.

Supply chain management is key to ensuring the safety and quality of the hospital's supplies. The supply chain includes the steps from origination to delivery of supplies to the hospital. Due to staff and resource limitations, not every supply chain can be tracked and evaluated at the same time. Therefore, hospitals identify the most critical and highest-risk supplies that impact hospitalwide patient care services. These most critical and highest-risk supplies vary in each organization depending on the hospital's scope of services, settings, and local laws and regulations. As part of the supply chain strategy, hospital leaders define the most at-risk supplies and outline mitigating steps that will ensure continuity of services.

Supply chain strategy is not only about a prospective evaluation of supplies that are at high risk, it also includes retrospective tracing of supplies after they have entered the hospital. The hospital has a process to identify medications, medical supplies, and medical devices that are unstable, contaminated, defective, or counterfeit and trace them back through the hospital to determine the source or cause of the problem, if possible. When applicable, the hospital notifies the manufacturer and/or distributor when unstable, contaminated, defective, or counterfeit supplies are identified through retrospective tracing. Supply chain strategy must outline recommendations that will ensure continuity of safe and high-quality patient care services. For example, the supply chain strategy recommends that the hospital not only maintain inventory of masks and disinfectants but also include two backup suppliers who can provide these critical supplies in an event of COVID-19 resurgence.

When hospital supplies are purchased, stored, and distributed by a governmental authority, the hospital participates in programs to detect and report suspected unstable, contaminated, defective, and counterfeit

supplies and takes measures to prevent potential patient harm. Although a public hospital may not know the integrity of each supplier in the chain, it can become aware of how supplies are purchased and managed by the governmental or nongovernmental agency.

Measurable Elements of GLD.05.03

1. Ⓓ Hospital leaders establish a written supply chain strategy that does the following:
   - Defines the steps in the supply chain.
   - Identifies risk within the steps of the supply chain.
   - Defines supplies at most risk.
   - Outlines recommendations on mitigating risks that will ensure continuity of safe and high-quality patient care services.
2. The hospital has a process for performing retrospective tracing of supplies found to be unstable, contaminated, defective, or counterfeit.
3. The hospital notifies the manufacturer and/or distributor when unstable, contaminated, defective, or counterfeit supplies are identified.

Direction of Hospital Departments and Services

Standard GLD.06.00

The hospital identifies the scope of services and structure of each department or service.

Intent of GLD.06.00

The clinical care, patient outcomes, and overall management of a hospital are only as good as the clinical, managerial, and operational activities of each individual department or service. Good departmental or service performance requires clear leadership from qualified individuals.

Hospital leaders provide for the coordination of care, treatment, and services among the hospital's different programs, services, sites, or departments. In larger departments or services, there may be multiple leaders. The responsibility of each role is defined in writing.

Each department/service leader reports their resource requirements to hospital leaders. This helps ensure that adequate staff, space, medical equipment, technology, and other resources are available to meet patients' needs at all times.

Department/service leaders consider the services provided and planned by the department or service and the education, skills, knowledge, and experience needed by the department's professional staff to provide those services. Department/service leaders develop criteria reflecting this consideration and then select staff. Department/service leaders may also work with human resources or other departments in the selection process based on their recommendations.

Department/service leaders ensure that all staff in the department or service understand their responsibilities and establish the orientation and training for new staff. The orientation includes the hospital's mission, the department's or service's mission, the scope of services provided, and the policies and procedures related to providing services. For example, all staff understand the infection prevention and control procedures within the hospital and within the department or service. When new or revised policies or procedures are implemented, staff are trained.

Clinical services provided to patients are coordinated and integrated within each department or service. Also, each department or service coordinates and integrates its services with other departments and services. Unnecessary duplication of services is avoided or eliminated to conserve resources. Although the department/service leaders make recommendations regarding human and other resource needs, those needs sometimes

change or are not fully met. Thus, department/service leaders have a process to respond to resource shortages to ensure safe and effective care for all patients.

Each department/service leader identifies, in writing, the services to be provided by the department, and integrates or coordinates those services with the services of other departments. The department/service leaders collaborate to determine the uniform format and content of the department-specific planning documents. In general, the documents prepared by each clinical department define its goals, as well as identify current and planned services.

Department policies and procedures reflect the department's goals and services as well as the knowledge, skills, and availability of staff required to assess and to meet patient care needs.

Measurable Elements of GLD.06.00

1. Each department or service in the hospital is directed by an individual with the qualification, training, education, and experience comparable to the services provided. (*See also* AOP.03.01, ME 1; AOP.04.00, ME 1; AOP.05.01, ME 1; MMU.01.00, MEs 1 and 5; FMS.01.01, ME 1; HCT.01.00, ME 2; PCI.01.00, ME 1; QPS.01.00, ME 1; GHI.01.00, ME 3)
2. Department/service leaders recommend space, medical equipment, staffing, technology, and other resources needed by the department or service and have a process in place to respond to shortages. (*See also* SQE.01.00, ME 1)
3. Ⓓ The departmental or service documents describe the current and planned services provided by each department or service. (*See also* ACC.02.02, ME 3)
4. There is coordination and/or integration of services within and among other departments and services. (*See also* ACC.02.02, ME 4; ACC.03.00, ME 1; ACC.05.00, ME 1)

Standard GLD.06.01

Department/service leaders participate in hospitalwide improvement priorities and in monitoring and improving patient care specific to the department/service.

Intent of GLD.06.01

Each department participates in improvement activities that reflect and contribute to the hospitalwide priorities to establish an integrated quality and patient safety program.

Department leaders are responsible for ensuring the quality of care and services provided by their department/service. Department/service leaders identify improvement priorities that address clinical or nonclinical activities specific to the department or service. For example, a clinical department or service would participate in the hospitalwide effort to improve handover communications and may monitor and reduce variation in an internal process such as the ordering of diagnostic tests for patients with the same condition. Similarly, a managerial department may be involved in automation projects to improve handover communications and may monitor and improve the accuracy of patient bills.

Quality measurement activities can be important to ensuring that the department/service leader has objective information to support improvement activities. Over time, quality measurement includes all the services provided by the department or service and includes the clinical privileges of all the physicians. In some cases, the measures will be linked to the clinical practice guidelines, clinical pathways, and clinical protocols implemented in the department or service. Data are needed to support the evaluation of the nurses and other health care practitioners in the department. Although these individuals have job descriptions rather than clinical privileges, the department/service leader is still accountable for evaluating their work. In many cases, the clinical practice guidelines implemented in the department or service will have associated pathways and protocols that will support the collection of measurement data for nursing staff and other health care practitioners.

Leaders of the department or service implement the selection and monitoring of measures or indicators specific to the department or service that include the following:

- Those hospitalwide measurement and improvement priorities set by hospital leaders that relate to their specific department or service
- The measures associated with specific department/service priorities to reduce variation, improve the safety of high-risk procedures/treatments, improve patient satisfaction, or improve efficiency

Selection of measures should be based on those activities and processes that need improvement in the department or service. For each measure, a target should be set. It is expected that initial measurement will not reach the target; however, when strategies for improvement are implemented, department/service leaders should expect to see improvement toward the target. When the target has been met and sustained for at least four measurement periods, a new measure is selected.

The leader of the clinical department or service is responsible for ensuring that the measurement activities provide the opportunity for the evaluation of staff as well as the processes of care. Thus, measurement includes, over time, all the services provided. The resulting data and information are important to the department's or service's improvement efforts but are also important to the hospital's quality and patient safety program.

Measurement activities provide the opportunity for evaluation of services. Department/service leaders are involved in the appointment, privilege delineation, ongoing professional practice evaluation, and reappointment of the physicians within the department or service.

Some departments, such as infection prevention and control, facility management, radiology, and the clinical laboratory, have ongoing quality monitoring or control programs that are included in the measurement priorities and are described in the standards related to those services.

Measurable Elements of GLD.06.01

1. Ⓓ Department/service leaders implement hospitalwide quality measures that relate to the services provided by their department or service, including any contracted services for which they are responsible. (*See also* FMS.02.00, ME 2)
2. Ⓓ Department/service leaders implement quality measures to reduce variation and improve processes within the department or service. (*See also* FMS.02.00, ME 3)
3. Ⓓ Department/service leaders select measures based on the need for improvement, and when improvement has been sustained, select a new measure. (*See also* QPS.04.00, ME 2)
4. When applicable, assessment of participation in quality activities and the results of measurement activities are included in the evaluation of the department's staff.

Standard GLD.06.02

Department/service leaders select and implement clinical practice guidelines, clinical pathways, and clinical protocols when designing or improving processes.

Intent of GLD.06.02

Clinical practice guidelines, clinical pathways, and clinical protocols are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

Clinical guidelines are issued by the scientific sources (for example, medical associations and societies) or governmental authorities (outside sources). Pathways and protocols may be used interchangeably and are used to implement and streamline the requirements of the "clinical pathways."

The goals of hospitals include the following:

- Standardizing clinical care processes
- Reducing risks within care processes, particularly those associated with critical decision steps

- Providing clinical care in a timely, effective manner using available resources efficiently
- Consistently delivering high-quality care using evidence-based practices

Hospitals use a variety of tools to reach these and other goals. For example, health care practitioners seek to develop clinical care processes and make clinical care decisions based on the best available scientific evidence. Clinical practice guidelines, clinical pathways, and clinical protocols are useful tools in this effort to understand and to apply the best science to a particular diagnosis or condition. The hospital uses only those clinical practice guidelines, clinical pathways, and clinical protocols that have been reviewed and endorsed by relevant authoritative sources; for example, a national professional association or council, or an international organization that publishes approved guidelines. If the clinical practice guidelines, clinical pathways, and clinical protocols were developed by the hospital, they would be submitted to an authoritative source (for example, Ministry of Health or professional organizations) for endorsement.

Frequently, the effective implementation of clinical practice guidelines, clinical pathways, and clinical protocols will require clinical pathways and clinical protocols to be adapted or developed. Pathways and protocols are useful tools in this effort to ensure effective sequencing, integration, and coordination of care and efficient use of available resources.

Clinical practice guidelines, clinical pathways, and clinical protocols relevant to the hospital's patient population and mission meet the following criteria:

- Are selected from among those applicable to the services and patients of the hospital (mandatory national guidelines are included in this process, if present).
- Are evaluated for their relevance to identified patient populations.
- Are adapted when needed to the technology, drugs, and other resources of the hospital or to accepted national professional norms.
- Are assessed for their scientific evidence and endorsement by an authoritative source.
- Are formally approved or adopted by the hospital.
- Are implemented and measured for consistent use and effectiveness.
- Are supported by staff trained to apply the guidelines or pathways.
- Are periodically updated based on changes in the evidence and evaluation of processes and outcomes.

As many guidelines, and related protocols and pathways, impact multiple clinical departments or services, the leaders are expected to collectively determine at least five priority areas on which to focus—for which guidelines would impact the quality and safety of patient care and reduce unwanted variation in outcomes.

This collective selection process does not prohibit an individual department or service from selecting additional guidelines, nor any associated protocols or pathways, more specific to the services provided in that department or service.

Measurable Elements of GLD.06.02

1. On an annual basis, department/service leaders collectively determine at least five priority areas on which to focus the use of clinical practice guidelines.
2. Department/service leaders collaborate with appropriate clinical staff to select, review, approve, and modify the clinical practice guidelines, clinical pathways, and clinical protocols as needed.
3. Department/service leaders implement clinical practice guidelines, clinical pathways, and clinical protocols for each identified priority area as relevant to the department/service.
4. Department/service leaders demonstrate how the implementation of the clinical practice guidelines, clinical pathways, and clinical protocols supports the reduction of variation in the process and improved outcomes.

Organizational and Clinical Ethics

Standard GLD.07.00

Hospital leaders establish a framework for ethical management that promotes a culture of ethical practices and decision-making to ensure that patient care is provided within business, financial, ethical, and legal norms and protects patients and their rights.

Intent of GLD.07.00

Hospitals face many challenges in providing safe, high-quality health care. With advances in medical technology, financial constraints, and increasing expectations, ethical dilemmas and controversies are much more common. Hospital leaders have a professional and legal responsibility to create and promote an environment and culture that operates within an ethical framework.

The ethical framework must apply to both the hospital's business and clinical activities. Hospital leaders must demonstrate ethical behaviors and develop guidelines for organizational performance and conduct. Hospital leaders' actions and the hospital's guidelines for ethical behavior must be aligned with organizational policies and the hospital's vision, mission, and value statements.

The framework supports the hospital's health care practitioners, other staff, and patients and family when confronted by ethical dilemmas in patient care, such as interprofessional disagreements, disagreements between patients and their health care practitioners, and disagreements among family members about their relative who lacks decision-making capacity. Support is readily available and includes ethics resources and training for all staff. In addition, national and international norms related to human rights and professional ethics must be taken into consideration when creating an ethical framework and guiding documents.

The hospital operates within this framework to do the following:

- Disclose ownership and any conflicts of interest (for example, relationships between the referring physician and outside sources of laboratory or diagnostic imaging services).
- Honestly portray its services to patients.
- Protect confidentiality of patient information.
- Provide clear admission, transfer, and discharge policies.
- Bill accurately for its services and ensure that financial incentives and payment arrangements do not compromise patient care.
- Establish a mechanism by which health care practitioners and other staff may report clinical errors and raise ethical concerns with impunity, including disruptive staff behavior related to clinical and/or operational issues.
- Support an environment that allows free discussion of ethical concerns without fear of retribution.
- Provide an effective resolution to ethical conflicts within a clearly defined time frame.
- Ensure nondiscrimination in employment practices and provision of patient care in the context of the cultural and regulatory norms of the country.
- Reduce disparities in health care access and clinical outcomes by identifying vulnerable populations.

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

common problem in health care organizations. Staff shortages, increased patient acuity, and the misconception that violence does not occur in health care organizations—or if violence does occur, it is part of the job—are just a few of the barriers to acknowledging that workplace violence exists and to developing violence prevention programs.

Designating a leader to be accountable for the hospital's workplace violence prevention program establishes clear lines of accountability. In addition, establishing policies and standardized processes to prevent, respond to, report, and follow up on events or near misses decreases variation in the program. Data collection and simple, accessible reporting structures show commitment to providing a safe and secure work environment. Regularly reporting incidents and trends to the governing body promotes transparency and further establishes accountability for the program. Examples of outcomes that measure a program's success include the following:

- Decrease of incidence of harm from violent behavior
- Employee Engagement Survey results and organizationwide staff reports indicate staff feeling "very safe."
- Patients and families report feeling safe in the health care setting.
- Staff feel comfortable reporting incidents and involving persons of authority.

Measurable Elements of GLD.07.02

1. The workplace violence prevention program is led by a designated individual and developed by an interdisciplinary team.
2. Ⓓ The hospital develops and implements written policies and procedures to prevent and respond to workplace violence. (*See also* FMS.03.00, ME 1; FMS.04.00, ME 7; SQE.02.02, MEs 1 and 3)
3. The hospital implements a process to report incidents in order to analyze incidents and trends. (*See also* FMS.03.00, MEs 3 and 5; FMS.04.00, ME 9)
4. The hospital implements a process for follow-up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary.
5. The hospital implements a process for the reporting of workplace violence incidents to the governing body. (*See also* SQE.02.02, ME 3)

Health Professional Education

Note: For hospitals that meet the eligibility criteria for academic medical center hospital accreditation, GLD.08.00 applies to education provided to nursing students and/or other nonmedical, health professional students. For hospitals that are not academic medical centers, GLD.08.00 applies to education provided to medical students and trainees, nursing students, and/or other health professional students.

Standard GLD.08.00

Health professional education, when provided within the hospital, is guided by the educational parameters defined by the sponsoring academic program and the hospital's leaders.

Intent of GLD.08.00

Frequently, hospitals incorporate a teaching role in their mission and are the clinical setting for portions of medical, nursing, other health care practitioners, and other student training. For example, students and trainees in medicine may spend a few months gaining clinical experience in a community teaching hospital, or a nursing program may be based in the hospital. These hospitals serve an important role; however, they are not considered academic medical centers for the purposes of these standards.

Hospital leaders liaise with the training institution for proper oversight when the hospital participates in any type of training program. As part of this coordination, the hospital does the following:

- Obtains and accepts the parameters of the sponsoring academic program.
- Obtains the complete record of all students and trainees within the hospital.
- Understands and provides the level of supervision for all trainees.
- Integrates students and trainees into the hospital's orientation, quality and patient safety, infection prevention and control, and other programs.

Measurable Elements of GLD.08.00

1. The hospital provides a mechanism(s) for oversight of the training program(s).
2. Ⓓ The hospital has a complete record of all students and trainees within the hospital.
3. Ⓓ The hospital has documentation of the enrollment status, licensure or certifications achieved, and academic classification of the students and trainees.
4. The hospital provides the required level of supervision for each type and level of student and trainee.
5. The hospital provides an opportunity for students and trainees to evaluate the education program and to receive feedback.

Human Subjects Research

Note: Academic medical centers are required to meet these requirements in addition to the "Human Subjects Research Programs" (HRP) chapter.

Standard GLD.09.00

Human subjects research, when provided within the hospital, is guided by laws, regulations, and hospital leaders.

Intent of GLD.09.00

Human subjects research is a complex and significant endeavor for a hospital. Hospital leaders recognize the required level of commitment and personal involvement required to advance scientific inquiry. With differing local regulations, hospital leaders must protect the patient and respect their rights during research, investigation, and clinical trials.

A hospital's commitment to human subjects research is not separate from its commitment to patient care—commitment is integrated at all levels. Thus, ethical considerations, effective communication, responsible leaders, regulatory compliance, and financial and nonfinancial resources are components of this commitment. One such resource is indemnity insurance to compensate patients for adverse events due to the research protocol. Hospital leaders recognize the obligation to protect patients irrespective of the sponsor of the research.

Individuals from the research or other programs are involved in developing the criteria or protocol. Admission to such programs is documented in the patient's medical record and includes the criteria or protocol conditions under which the patient was admitted.

To comply with local laws and regulations, the hospital establishes a committee or identifies a qualified individual(s) to oversee all research in the hospital involving human subjects. A committee or other mechanism such as a hospital-specific or shared Institutional Review Board (IRB) to provide oversight for all such activities in the hospital is established. The hospital develops a statement of purpose for the oversight activities. Oversight activities include the review process for all research protocols, a process to weigh the relative risks and benefits to the subjects, and processes related to the confidentiality and security of the research information.

Measurable Elements of GLD.09.00

1. Hospital leaders identify the official(s) responsible for the development and compliance with human subjects research policies aligned with regulatory and professional requirements.
2. Ⓓ To help the patient determine whether to participate in research, investigation, or clinical trials, the hospital provides the patient with all the following information:
   - An explanation of the purpose and scope of the research
   - The expected duration of the patient's participation
   - A clear description of the procedures to be followed
   - A statement of the potential benefits, risks, discomforts, and side effects
   - Alternative care, treatment, and services available to the patient that might prove advantageous to the patient
3. Ⓓ The hospital documents the following in the research consent form:
   - That the patient received information to help determine whether to participate in the research, investigation, or clinical trial
   - That the patient was informed that refusing to participate in the research, investigation, or clinical trial or discontinuing participation at any time will not jeopardize their access to care, treatment, and services unrelated to the research
   - The name of the person who provided the information and the date the form was signed
   - The patient's right to privacy, confidentiality, and safety (*See also* PCC.01.02, ME 1)
4. Hospital leaders ensure that there is a source of indemnity insurance to compensate patients participating in clinical research who experience an adverse event.
5. Oversight of human subjects research activities includes processes to provide confidentiality and security of research information.