

Hospital Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 143 criteria.

17 standards · 143 criteria · Version 4.0

Standard 15 — Psychiatry & Mental Health

6 criteria · 3 non-negotiable · 2 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

- 15.1 — Suicide Risk Screening and Continuous Observation for High-Risk Patients
- 15.2 — Environmental Ligature Risk Is Identified and Mitigated
- 15.3 — Restraint and Seclusion Used as Genuine Last Resort, With Strict Documentation
- 15.4 — Psychiatric Medication Management Follows a Defined Interaction and Monitoring Protocol
- 15.5 — Staff Are Trained and Drilled in De-escalation, Not Only Briefed
- 15.6 — Discharge Safety Planning With Follow-Up Care Genuinely Arranged

15.1 Suicide Risk Screening and Continuous Observation for High-Risk Patients

NON-NEGOTIABLE

Every psychiatric admission undergoes suicide risk screening using a validated tool, with a patient identified as high-risk placed on a genuinely continuous, documented observation level — not a screening completed once at

admission with no follow-through into the observation practice that should result.

In plain terms: Every patient is genuinely screened with a real tool, and a high-risk patient is actually, continuously watched at the level their risk requires — not a form completed at intake that doesn’t translate into real observation practice.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A validated screening tool catches risk considerably more reliably than clinical impression alone, particularly since a patient at genuine risk may not spontaneously disclose it, and a structured tool prompts specific questions an informal conversation might miss. A screening result that identifies high risk but doesn’t translate into genuinely continuous observation — nominally ordered but with real gaps in actual practice — provides no real protection; the entire protective value lies in the observation genuinely happening, not merely being documented as ordered.

WHAT GOOD LOOKS LIKE

- Screening uses a validated tool, applied consistently to every admission.
- A high-risk observation level is genuinely continuous with real documented intervals.
- Observation level is reassessed as risk changes during the admission.

COMMON FAILURE MODES

- Screening relies on clinical impression rather than a consistent validated tool.
- An ordered observation level has gaps in actual documented checks.
- Observation level is set at admission and never reassessed as risk changes.

WORKED EXAMPLE

IN PRACTICE

A patient admitted and identified as high suicide risk.

BEFORE	The patient was correctly screened as high-risk and ordered for continuous observation, but a review of actual observation logs found gaps of up to forty-five minutes during busy shift periods, considerably longer than the continuous standard the order specified.
ACTION	The unit built a dedicated staffing allocation specifically for continuous observation patients, separate from general ward duties, ensuring the observing staff member has no competing responsibility that could create a gap.
AFTER	The Monitor reviewed subsequent observation logs for a high-risk patient and found genuinely continuous, gap-free documentation. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Adopt a validated suicide risk screening tool if not already in use.
2. Review actual observation logs for gaps against the ordered level.
3. Build dedicated staffing allocation for continuous observation, separate from competing duties.

The most common mistake: A continuous observation order that's correctly placed but, in actual practice, has real gaps because the observing staff member also carries other ward responsibilities that compete for their attention.

SELF-ASSESSMENT QUESTIONS

1. Is screening performed using a validated tool, applied consistently to every admission, not left to clinical impression alone? — *A structured tool catches risk more reliably than impression alone, particularly for a patient who may not spontaneously disclose risk. Evidence: Screening record*

2. Is a high-risk observation level genuinely continuous and documented at real intervals, not nominal with gaps in practice? — *A documented observation level that isn't actually maintained in practice provides no real protection.*

Evidence: Observation log review

3. Is observation level reassessed as risk changes during the admission, not fixed at the initial screening? — *Risk can genuinely change during an admission; a level set once at intake may no longer reflect current status.*

Evidence: Reassessment documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Observation is ordered correctly but actual logs show gaps during busy periods.**
- **Risk level is set at admission but rarely formally reassessed.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm a validated screening tool is in consistent use.
Week 2	Audit actual observation logs for gaps against ordered levels.
Week 3	Build dedicated staffing allocation for continuous observation.
Ongoing	Review observation log completeness periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Observation log review	Reviews actual observation logs for a high-risk patient against the ordered observation level for real gaps.

EVIDENCE BASE

World Health Organization. Preventing Suicide: A Global Imperative. Geneva: WHO; 2014.

15.2

Environmental Ligature Risk Is Identified and Mitigated

NON-NEGOTIABLE

The psychiatric unit’s physical environment is systematically assessed for ligature and other self-harm risk points, with identified hazards genuinely mitigated through environmental design or removal — not a one-time assessment that’s never revisited as fixtures and furnishings change.

In plain terms: The unit’s physical space is genuinely assessed for self-harm risk points, and what’s found is actually fixed — not an assumption based on general psychiatric unit design standards, and not a one-time check that’s never repeated as things change.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Assuming a unit is safe because it follows general psychiatric unit design principles, without a specific, documented assessment of this particular environment’s actual fixtures and furnishings, overlooks the reality that risk points can be genuinely specific to a given space and its particular contents. A hazard identified in an assessment but left unaddressed provides no real protection — the mitigation step is what actually matters, and a hazard that’s merely noted, without follow-through, represents a documented but unresolved risk.

WHAT GOOD LOOKS LIKE

- A systematic, documented ligature risk assessment has actually been performed.
- Identified hazards are genuinely mitigated, not

COMMON FAILURE MODES

- Safety is assumed from general design standards without a specific unit assessment.
- Hazards are identified in an assessment but not

merely noted.

- The assessment is repeated when the physical environment changes.

actually corrected.

- The assessment was performed once and never repeated as furnishings changed.

WORKED EXAMPLE

IN PRACTICE

A unit that replaced bathroom fixtures without reassessing ligature risk.

BEFORE

A thorough ligature risk assessment had been performed when the unit originally opened, but new bathroom fixtures installed during a later renovation were never reassessed against the same risk criteria, introducing an unaddressed hazard.

ACTION

The unit built a required ligature risk reassessment step triggered by any renovation or furnishing change, with a specific sign-off required before new fixtures go into clinical use.

AFTER

The Monitor reviewed the current assessment record and confirmed it reflected the actual current fixtures, with a documented reassessment following the recent renovation. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Perform or confirm a specific, documented ligature risk assessment for this actual unit.
2. Build a mitigation tracking process ensuring identified hazards are genuinely corrected.
3. Build a reassessment trigger for any future renovation or furnishing change.

The most common mistake: A thorough initial ligature risk assessment that's never repeated following a later renovation or

furnishing change, leaving newly introduced fixtures unassessed against the same risk criteria that governed the original design.

SELF-ASSESSMENT QUESTIONS

1. Has a systematic, documented ligature risk assessment actually been performed for the unit, not assumed from general psychiatric unit design standards? — *A specific, documented assessment of this unit's actual environment, not an assumption based on general design principles.*

Evidence: Ligature risk assessment report

2. Are identified hazards genuinely mitigated, not noted but left unaddressed? — *A hazard identified but not corrected provides no real protection.*

Evidence: Mitigation tracking record

3. Is the assessment repeated when the physical environment changes, not treated as a one-time exercise? — *New furnishings or fixtures can introduce new hazards not present at the original assessment.*

Evidence: Reassessment trigger log

COMMON REASONS FOR A PARTIAL ANSWER

- **An original assessment exists but hasn't been repeated after subsequent changes.**
- **Some identified hazards remain unaddressed in the mitigation tracking.**

IMPLEMENTATION PLAN

When	What
Week 1	Perform or confirm a current, specific ligature risk assessment.
Week 2	Build a mitigation tracking process for identified hazards.
Week 3	Build a reassessment trigger for future environmental changes.
Ongoing	Review mitigation completion periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Unit inspection	Inspects the unit directly against the documented ligature risk assessment for current accuracy.

EVIDENCE BASE

World Health Organization. Preventing Suicide: A Global Imperative. Geneva: WHO; 2014.

15.3 Restraint and Seclusion Used as Genuine Last Resort, With Strict Documentation

NON-NEGOTIABLE

Physical restraint or seclusion is used only after genuine, documented attempts at de-escalation have failed, for the minimum time necessary, with each episode individually justified, time-limited, and reviewed — not a default response to agitation or a measure extended past clinical necessity.

In plain terms: Restraint or seclusion is genuinely the last resort, after real de-escalation attempts are tried and documented — each time individually justified and time-limited, not a default reaction or something that quietly extends past what’s actually needed.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Restraint used as a default or first response to agitation, rather than genuinely as a last resort after other approaches are tried, represents both a significant risk to the patient and a well-documented pattern this criterion exists specifically to prevent. A blanket or open-ended restraint order, applied without case-specific justification and active,

timely reassessment, can persist well past the point where it's actually still clinically necessary — the genuine safeguard lies in each episode being individually justified, time-limited, and genuinely reviewed.

WHAT GOOD LOOKS LIKE

- Documented evidence shows de-escalation was genuinely attempted first.
- Every episode is individually, specifically justified and time-limited.
- A genuine, timely review process checks whether restraint remains necessary.

COMMON FAILURE MODES

- Restraint is used as a first response rather than a documented last resort.
- A blanket order is applied without case-specific, time-limited justification.
- Restraint continues without active, timely reassessment of continued necessity.

WORKED EXAMPLE

IN PRACTICE

A unit reviewing a recent restraint episode.

BEFORE	A restraint episode record showed the restraint was applied but included no documentation of de-escalation attempts made beforehand, and the order was open-ended without a specific time limit or scheduled reassessment.
ACTION	The unit built a required de-escalation attempt log preceding any restraint order, with every restraint order required to specify a maximum duration and a mandatory reassessment point before any extension.
AFTER	The Monitor reviewed a subsequent restraint episode and found documented de-escalation attempts, a time-limited order, and a timely reassessment leading to early discontinuation. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a required de-escalation attempt documentation step preceding any restraint order.

2. Require every restraint order to specify a maximum duration.
3. Build a mandatory, timely reassessment point before any extension.

The most common mistake: A restraint order that’s open-ended rather than time-limited, with no documented evidence of de-escalation attempts beforehand and no mandatory reassessment point, which allows the restraint to continue well past genuine clinical necessity.

SELF-ASSESSMENT QUESTIONS

1. Is there documented evidence that de-escalation was genuinely attempted before restraint or seclusion, not restraint used as a first response? — *Restraint as a last resort, with real evidence of what was tried first, not the default response to agitation.*

Evidence: De-escalation attempt log

2. Is every episode individually, specifically justified and time-limited, not a blanket order applied without case-specific review? — *A blanket or open-ended restraint order is a specific, serious failure mode this criterion exists to prevent.*

Evidence: Episode-specific justification record

3. Is there a genuine, timely review process checking whether restraint remains necessary, not continued without active reassessment? — *Ongoing restraint without active, timely reassessment can persist well past genuine clinical need.*

Evidence: Reassessment schedule and record

COMMON REASONS FOR A PARTIAL ANSWER

- **Justification is documented but de-escalation attempts aren’t clearly logged beforehand.**
- **Orders are time-limited but reassessment at the limit isn’t consistently timely.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a de-escalation attempt documentation requirement.
Week 2	Require every restraint order to specify maximum duration.

When	What
Week 3	Build a mandatory, timely reassessment point.
Ongoing	Audit restraint episodes periodically for full compliance.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Restraint episode review	Reviews a specific restraint episode record for de-escalation evidence, time-limited order, and timely reassessment.

EVIDENCE BASE

World Health Organization. QualityRights Guidance and Training Tools. Geneva: WHO; 2019.

Psychiatric Medication Management

15.4 Follows a Defined Interaction and Monitoring Protocol

CORE

Psychiatric medications, including those with significant interaction risk or requiring specific monitoring, are managed through a defined protocol covering interaction screening and required laboratory or clinical monitoring — not prescribed and administered without this structured safeguard.

In plain terms: Psychiatric medications go through a real, systematic interaction check and genuinely scheduled monitoring — not just relying on the prescriber’s own memory for every possible interaction or required lab test.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Relying on an individual prescriber's memory for every known interaction, rather than a systematic screening step, is considerably less reliable than a structured check — particularly given the number of significant interactions relevant to psychiatric medications and the volume of patients a prescriber manages. Required monitoring that's left to chance, rather than genuinely scheduled and tracked, risks missing a clinically significant abnormal result that a defined protocol exists specifically to catch.

WHAT GOOD LOOKS LIKE

- Interaction screening is actually performed for every new medication order.
- Required monitoring is genuinely scheduled and tracked, not left to chance.
- A documented process exists for responding to an abnormal monitoring result.

COMMON FAILURE MODES

- Interaction screening relies on prescriber memory rather than a systematic check.
- Required monitoring is assumed to happen without active tracking.
- An abnormal result doesn't trigger a clear, documented clinical response.

WORKED EXAMPLE

IN PRACTICE

A patient started on a medication requiring regular specific lab monitoring.

BEFORE

The medication was correctly prescribed, but required monitoring was left to the prescriber's own memory to order at the appropriate intervals, resulting in a monitoring gap that went unnoticed for several weeks.

ACTION

The unit built an automated monitoring schedule tied to the specific medication, flagging the care team when a required test is due, with a documented escalation step for any result outside normal range.

AFTER

The Monitor reviewed a subsequent patient's record and found monitoring genuinely tracked

against the automated schedule, with no gaps.
Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a systematic interaction screening step for new psychiatric medication orders.
2. Build an automated or actively tracked monitoring schedule tied to specific medications.
3. Build a documented response process for an abnormal monitoring result.

The most common mistake: Required ongoing monitoring for a specific medication left to the individual prescriber's own memory to order at the correct intervals, rather than a systematic, tracked schedule that flags when a test is due.

SELF-ASSESSMENT QUESTIONS

1. Is interaction screening actually performed for every new psychiatric medication order, not assumed from the prescriber's general knowledge alone? — *A systematic check, not reliance on an individual prescriber's memory for every known interaction.*

Evidence: Interaction screening record

2. Is required monitoring, such as specific lab tests for certain medications, genuinely scheduled and tracked, not left to chance? — *Specific, required monitoring actually completed on schedule, not assumed to happen.*

Evidence: Monitoring schedule tracking

3. Is there a documented process for what happens when monitoring reveals an abnormal result? — *Detection without a genuine clinical response provides limited protective value.*

Evidence: Abnormal-result response protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Screening happens but isn't consistently systematic across all prescribers.**
- **Monitoring is scheduled but tracking has occasional gaps.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a systematic interaction screening step.
Week 2	Build a tracked monitoring schedule tied to specific medications.
Week 3	Build an abnormal-result response protocol.
Ongoing	Audit monitoring schedule adherence periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Monitoring schedule review	Checks a specific patient's required monitoring schedule against actual completed tests for gaps.

EVIDENCE BASE

World Health Organization. mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders. Geneva: WHO; 2016.

15.5 Staff Are Trained and Drilled in De-escalation, Not Only Briefed

CORE

Staff working on the psychiatric unit are trained and practically drilled in de-escalation technique, not only given a written policy to read, with training refreshed on a defined schedule, not completed once at hiring.

In plain terms: Staff genuinely practice de-escalation technique, not just read about it once — refreshed on a real schedule, not a single onboarding session years in the past.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A written de-escalation policy, however well-crafted, functions very differently under real stress than a technique that's genuinely been practiced through scenario-based drilling — the gap between reading about an approach and having actually rehearsed it is considerably more significant for a skill that needs to be applied calmly under genuine pressure. Training completed once at hiring, with no refresher, risks skill fade, particularly for staff who use de-escalation technique infrequently and may lack the ongoing reinforcement that regular use would otherwise provide.

WHAT GOOD LOOKS LIKE

- Training genuinely includes practical drilling, not only a written policy or lecture.
- Training is refreshed on a defined schedule, not completed once at hiring.
- Staff can describe their actual de-escalation approach confidently when asked.

COMMON FAILURE MODES

- Training is a written policy distributed with no practical, scenario-based component.
- Training happened once at hiring with no refresher since.
- Staff struggle to articulate a concrete de-escalation technique when asked.

WORKED EXAMPLE

IN PRACTICE

A unit reviewing its de-escalation training approach.

BEFORE	De-escalation training consisted of a written policy document reviewed during onboarding, with no practical scenario-based component and no refresher since initial hiring, in some cases years earlier.
ACTION	The unit built a scenario-based de-escalation training program with actual role-play practice, required for all staff with direct patient contact, refreshed on an annual schedule.
AFTER	The Monitor asked several staff members to describe their de-escalation approach and received confident, concrete answers, and

reviewed recent annual refresher completion records. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a scenario-based, practical de-escalation training program.
2. Set a defined annual or similar refresher schedule.
3. Ask several staff to describe their actual approach as a quick confidence check.

The most common mistake: Treating a written de-escalation policy, reviewed once during onboarding, as sufficient training, without the practical, scenario-based drilling that actually prepares staff to apply the technique confidently under real pressure.

SELF-ASSESSMENT QUESTIONS

1. Has de-escalation training genuinely included practical drilling, not only a written policy or lecture-style session? — *Practical, scenario-based training functions differently under real stress than a document only read.*

Evidence: Training curriculum content

2. Is training refreshed on a defined schedule, not completed once at hiring and never revisited? — *Skills can fade without periodic reinforcement, particularly for a skill used infrequently by some staff.*

Evidence: Refresher completion record

3. Can staff describe their actual de-escalation approach confidently when asked, not struggle to articulate a concrete technique? — *Confident, concrete description suggests the training genuinely embedded, not just technically completed.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Training includes some practical component but isn't consistently scenario-based.**
- **A refresher schedule exists but completion isn't consistently tracked.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current training content for practical, scenario-based components.
Week 2	Build or source scenario-based training with role-play practice.
Week 3	Set a defined refresher schedule.
Ongoing	Spot-check staff confidence periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff directly to describe their de-escalation approach, checking for confident, concrete answers.

EVIDENCE BASE

World Health Organization. QualityRights Guidance and Training Tools. Geneva: WHO; 2019.

15.6 Discharge Safety Planning With Follow-Up Care Genuinely Arranged

STANDARD

Before discharge, every psychiatric patient has a documented safety plan and a genuinely arranged, confirmed follow-up appointment — not a verbal recommendation to “follow up with your provider” with no actual appointment secured, given the specific, well-documented elevated risk in the period immediately following psychiatric discharge.

In plain terms: Every patient leaves with a real, individualized safety plan and a genuinely confirmed follow-up appointment — not a vague suggestion to “follow up,” during the exact window when risk is known to be highest.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

The period immediately following psychiatric discharge carries a specific, well-documented elevated risk, which is precisely why a verbal recommendation to seek follow-up care, without an actual confirmed appointment, leaves the patient to navigate this high-risk window largely on their own. A generic safety plan handout, given regardless of the patient's specific situation, provides considerably less genuine protective value than an individualized plan built around that patient's own actual risk factors, supports, and circumstances.

WHAT GOOD LOOKS LIKE

- Every discharge includes a documented, individualized safety plan.
- Follow-up care is genuinely arranged and confirmed before discharge.
- A documented process exists for following up if the first appointment is missed.

COMMON FAILURE MODES

- A generic safety plan handout is given regardless of individual situation.
- Follow-up care is suggested verbally with no actual appointment secured.
- A missed first follow-up appointment triggers no active re-engagement.

WORKED EXAMPLE

IN PRACTICE

A patient discharged after a psychiatric admission.

BEFORE

The patient was given a generic printed safety plan and told to "follow up with your outpatient provider within a week," with no actual appointment scheduled before discharge and no process to check whether the patient followed through.

ACTION

The unit built a required step confirming an actual, scheduled outpatient appointment before

discharge is finalized, with an individualized safety plan built from a structured conversation covering the patient's specific risk factors and supports, and an active re-engagement call if the first appointment is missed.

AFTER

The Monitor reviewed a recent discharge record and found a confirmed, scheduled outpatient appointment, an individualized safety plan, and a documented re-engagement call for a patient who had missed the first appointment. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a required step confirming a scheduled outpatient appointment before discharge.
2. Build an individualized safety plan process, not a generic handout.
3. Build an active re-engagement process for a missed first follow-up appointment.

The most common mistake: Discharging a patient with a verbal recommendation to seek follow-up care, rather than an actually confirmed, scheduled appointment, leaving the patient to navigate the known highest-risk post-discharge period largely on their own.

SELF-ASSESSMENT QUESTIONS

1. Does every discharge include a documented, individualized safety plan, not a generic handout given regardless of the patient's specific situation? — *A genuinely individualized plan, not a standard form applied identically to every patient.*

Evidence: Safety plan record

2. Is follow-up care genuinely arranged and confirmed before discharge, not a verbal suggestion with no actual appointment secured? — *A confirmed appointment, not a recommendation the patient must arrange themselves during a known high-risk period.*

Evidence: Confirmed appointment record

3. Is there a documented process for following up if the patient misses their first post-discharge appointment? — *A specific, active*

process for re-engagement during the known highest-risk window, not simply noting the missed appointment.
Evidence: Re-engagement protocol

COMMON REASONS FOR A PARTIAL ANSWER

- Appointments are usually confirmed but occasionally remain a verbal suggestion.
- No active re-engagement process exists for a missed first appointment.

IMPLEMENTATION PLAN

When	What
Week 1	Review current discharge follow-up confirmation practice.
Week 2	Build a required confirmed-appointment step before discharge.
Week 3	Build an individualized safety plan process and re-engagement protocol.
Ongoing	Track missed-appointment re-engagement outcomes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Discharge record review	Checks recent discharge records for individualized safety plans and confirmed, scheduled follow-up appointments.

EVIDENCE BASE

World Health Organization. Preventing Suicide: A Global Imperative.
Geneva: WHO; 2014.

← Hospital Standards — all standards

Self-assess against these criteria →

← Standard 14 — Oncology & Cancer Care

**Standard 16 — Academic
Medical Center →**

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Standard 16 — Academic Medical Center: Teaching & Research Governance

6 criteria · 2 non-negotiable · 3 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

- 16.1 — Resident and Trainee Supervision With Verified, Graduated Autonomy
- 16.2 — Patients Are Genuinely Informed of Trainee Involvement in Their Care
- 16.3 — Research Activity Operates Under Independent Ethics Review Before Enrollment
- 16.4 — Clinical Care and Research Participation Are Clearly Separated in Consent
- 16.5 — Conflicts of Interest Between Research and Clinical Care Are Disclosed and Managed
- 16.6 — Teaching Faculty Maintain Verified, Current Clinical Competency

16.1 Resident and Trainee Supervision With Verified, Graduated Autonomy

NON-NEGOTIABLE

Each resident or trainee’s current scope of independent practice is explicitly defined and documented, matched to their verified competency progression, with supervising

physician involvement genuinely available at the level that scope requires — not assumed from training year or general program level alone.

In plain terms: Exactly what each trainee can do on their own is written down and based on what they’ve actually demonstrated — not guessed from what year of training they’re in — and real backup is actually available at the level their current scope requires.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Training year is a genuinely weak proxy for actual independent competency — two residents at the identical point in a program can have meaningfully different demonstrated ability, and treating training year as a reliable stand-in for verified competency risks granting independence beyond what a given trainee has actually shown they can safely handle. Supervising physician availability that’s generically described as “on call,” rather than genuinely matched to the specific scope a trainee is currently exercising, can leave a real gap exactly where backup is most likely to be needed.

WHAT GOOD LOOKS LIKE

- Each trainee’s current scope of independent practice is explicitly documented.
- Supervising physician availability is genuinely matched to the trainee’s actual scope.
- Scope of practice is reassessed and updated as competency genuinely progresses.

COMMON FAILURE MODES

- Independent scope is inferred from training year rather than documented and verified.
- Supervision is a generic on-call arrangement, not matched to actual current scope.
- Scope is fixed at program entry and never formally reassessed.

WORKED EXAMPLE

IN PRACTICE

A hospital reviewing its trainee supervision structure.

BEFORE	A resident's independent scope was assumed from their training year alone, with no documented, individualized record of what specific procedures or decisions they had actually demonstrated competency to perform independently.
ACTION	The hospital built an individualized, documented competency progression record for each trainee, updated as specific skills were verified, with supervising physician availability explicitly tied to each trainee's current documented scope.
AFTER	The Monitor reviewed a sample trainee's record and found a specific, individualized documented scope matched to verified competency, not training year alone. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build an individualized, documented scope-of-practice record for each trainee.
2. Tie supervising physician availability explicitly to each trainee's current scope.
3. Build a reassessment process that updates scope as competency is verified.

The most common mistake: Treating training year as a reliable proxy for independent competency, rather than maintaining an individualized, documented record of what each specific trainee has actually demonstrated.

SELF-ASSESSMENT QUESTIONS

1. Is each trainee's current scope of independent practice explicitly documented, not inferred from training year alone? — *A specific, verified scope, not an assumption that a given training year implies a*

given level of independence.
Evidence: Trainee scope-of-practice record

2. Is supervising physician availability genuinely matched to the trainee’s actual current scope, not a generic on-call arrangement?
— *Real, appropriate availability for the specific procedure or decision a trainee is performing, not a general backup presence.*

Evidence: Supervision assignment record

3. Is scope of practice reassessed and updated as competency genuinely progresses, not fixed at program entry? — *A trainee’s verified competency can change meaningfully during training; scope should track actual demonstrated ability.*

Evidence: Reassessment schedule and record

COMMON REASONS FOR A PARTIAL ANSWER

- **Scope is documented at program entry but rarely formally updated.**
- **Supervision is generally matched to scope but not consistently documented as such.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for documenting trainee scope of independent practice.
Week 2	Build individualized, documented scope records tied to verified competency.
Week 3	Tie supervising physician availability explicitly to documented scope.
Ongoing	Reassess and update scope as competency progresses.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Trainee record review	Reviews a sample trainee’s documented scope-of-practice record against actual training year to confirm individualized, verified assignment.

EVIDENCE BASE

Accreditation Council for Graduate Medical Education. Common Program Requirements. Chicago: ACGME; 2023.

16.2 Patients Are Genuinely Informed of Trainee Involvement in Their Care

CORE

Patients are clearly, genuinely informed before or at admission that a teaching hospital's care model involves residents and trainees, with a real opportunity to ask questions about who is involved in their care — not a line buried in general admission paperwork that provides no genuine understanding.

In plain terms: Patients genuinely know, and actually understand, that trainees are part of their care team — not a line they signed among many pages of paperwork without really registering it.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A disclosure line embedded among many pages of general admission paperwork provides very different genuine understanding than a clear, specific communication a patient actually registers — the distinction matters because patients have a legitimate interest in knowing who is involved in decisions about their care, and a technically-present disclosure that doesn't achieve genuine understanding falls short of what this criterion is designed to ensure. Identifying the attending physician of record, distinct from any trainee, gives the patient clarity about who holds ultimate responsibility, which matters for both trust and practical communication.

WHAT GOOD LOOKS LIKE

- Trainee involvement is disclosed clearly and specifically, not buried in general paperwork.
- The patient has a genuine, practical opportunity to ask who is involved in their care.

COMMON FAILURE MODES

- Disclosure is a single clause within lengthy general admission paperwork.
- No genuine, practical opportunity exists for the patient to ask questions.

- The attending physician of record is clearly identified, distinct from any trainee.

- The attending physician of record isn't clearly distinguished from trainees involved.

WORKED EXAMPLE

IN PRACTICE

A hospital reviewing its admission disclosure practice.

BEFORE

Trainee involvement was disclosed only as one clause within a lengthy general consent-to-treatment form, with no separate, specific communication and no structured opportunity for the patient to ask who specifically would be involved in their care.

ACTION

The hospital built a separate, clear admission communication specifically about the teaching care model, delivered verbally at admission with a structured opportunity to ask questions, alongside clear identification of the attending physician of record.

AFTER

The Monitor spoke with several recently admitted patients, who could confirm they understood trainees were involved in their care and knew who their attending physician was. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a separate, clear communication specifically about trainee involvement.
2. Build a structured opportunity for patients to ask who is involved in their care.
3. Ensure the attending physician of record is clearly identified to each patient.

The most common mistake: Relying on a single clause within general admission paperwork as sufficient disclosure, rather than

a separate, clear communication a patient actually registers and understands.

SELF-ASSESSMENT QUESTIONS

1. Is trainee involvement disclosed clearly and specifically, not buried in general admission paperwork a patient is unlikely to genuinely read or absorb? — *Clear, specific disclosure the patient actually registers, not a clause among many in a signed form.*

Evidence: Admission disclosure process

2. Does the patient have a genuine, practical opportunity to ask who specifically is involved in their care? — *A real opportunity to ask, not merely a theoretical right buried in policy.*

Evidence: Patient interview

3. Is the attending physician of record, distinct from any trainee, clearly identified to the patient? — *The patient should know who holds ultimate responsibility for their care, separate from any trainee involved.*

Evidence: Attending identification record

COMMON REASONS FOR A PARTIAL ANSWER

- **Disclosure happens but isn't consistently delivered in a way patients clearly register.**
- **The attending physician is documented but not consistently communicated to the patient.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current admission disclosure content and delivery.
Week 2	Build a separate, clear verbal communication about trainee involvement.
Week 3	Build consistent attending-physician identification practice.
Ongoing	Spot-check patient understanding periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient interview	Speaks directly with recently admitted patients to confirm genuine understanding of trainee involvement and attending identification.

EVIDENCE BASE

Association of American Medical Colleges. Optimal Resuscitation Training and Patient Disclosure in Teaching Hospitals. Washington, DC: AAMC; 2021.

16.3 Research Activity Operates Under Independent Ethics Review Before Enrollment

NON-NEGOTIABLE

No patient is enrolled in a research study until that study has received approval from an independent ethics review board (IRB or equivalent), with the approval current and the enrolled patient’s participation genuinely falling within the approved protocol — not research activity proceeding ahead of, or outside the scope of, that approval.

In plain terms: No patient goes into a research study until a genuinely independent ethics board has actually approved it, and what happens to that patient genuinely matches what was approved — not research moving ahead of approval, and not drifting outside what was specifically approved.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Independent ethics review exists specifically to provide a check on research design and patient protection separate from the research team’s own judgment, however well-intentioned that team may be — a

board with significant overlap with the research team under review doesn't provide that genuine independent check. Enrollment proceeding ahead of actual approval, or a patient's real participation drifting outside the specific scope the board approved, represents a serious breach of the protective structure this criterion exists to maintain.

WHAT GOOD LOOKS LIKE	COMMON FAILURE MODES
• Independent ethics board approval is genuinely obtained and current before enrollment. • The ethics board is genuinely independent of the research team being reviewed. • Each enrolled patient's actual participation genuinely falls within the approved protocol.	• Enrollment proceeds while ethics approval is still pending, not yet granted. • The reviewing board has significant overlap with the research team under review. • A patient's actual participation drifts outside the approved protocol's specific scope.

WORKED EXAMPLE

IN PRACTICE	
<i>A hospital reviewing its research enrollment process.</i>	
BEFORE	A review of research enrollment records found one instance where patient screening and preliminary enrollment steps had begun before the ethics board's formal approval was actually finalized.
ACTION	The hospital built a hard enrollment gate requiring documented, current ethics board approval before any enrollment step can begin, verified through the hospital's research administration office rather than left to individual research teams to confirm.

AFTER

The Monitor reviewed subsequent enrollment records and confirmed each had documented, current ethics approval genuinely in place before enrollment began. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Confirm the ethics review board is genuinely independent of research teams it reviews.
2. Build a hard enrollment gate requiring documented, current approval before enrollment.
3. Build a verification step independent of individual research teams.

The most common mistake: Allowing preliminary screening or enrollment steps to begin while ethics board approval is still pending, rather than treating approval as a hard gate that must be genuinely in place first.

SELF-ASSESSMENT QUESTIONS

1. Is independent ethics board approval genuinely obtained and current before any patient enrollment, not assumed pending or informally proceeding? — *Approval that's actually in place, not an application submitted with enrollment proceeding regardless.*

Evidence: Ethics approval record

2. Is the ethics board genuinely independent of the research team being reviewed, not effectively self-reviewing? — *Real independence from the team whose research is under review, not a board with significant overlap or conflict.*

Evidence: Ethics board composition record

3. Does each enrolled patient's actual participation genuinely fall within the approved protocol's scope? — *A protocol deviation, even well-intentioned, falls outside the specific approval granted.*

Evidence: Protocol compliance review

COMMON REASONS FOR A PARTIAL ANSWER

- **Approval is generally obtained first but the enrollment gate isn't consistently enforced.**

- **Protocol compliance isn't actively monitored after initial enrollment.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm genuine independence of the ethics review board.
Week 2	Build a hard enrollment gate requiring documented current approval.
Week 3	Build independent verification of the gate, separate from research teams.
Ongoing	Monitor protocol compliance of enrolled patients.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Enrollment record review	Checks enrollment dates against ethics approval dates for a sample of research studies to confirm approval preceded enrollment.

EVIDENCE BASE

World Medical Association. Declaration of Helsinki — Ethical Principles for Medical Research Involving Human Subjects. Fortaleza: WMA; 2013 (current revision).

16.4 **Clinical Care and Research Participation Are Clearly Separated in Consent** CORE

A patient genuinely understands which elements of their care are standard clinical treatment and which are research participation, with declining research participation never affecting the standard care they receive — not a blurred consent process that leaves a patient unclear what they're actually agreeing to.

In plain terms: Patients genuinely know what part of their care is standard treatment and what part is research — and saying no to the research part never changes the

standard care they get, which they can always genuinely withdraw from.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A consent process that presents standard care and research participation as a single blended decision, rather than clearly distinguishing them, can leave a patient genuinely unclear about what they’re actually agreeing to — and risks a patient feeling pressured toward research participation out of concern it might affect their standard treatment, when genuinely it should not. Ongoing voluntariness, meaning a patient who initially consented can genuinely withdraw at any point with that withdrawal actually honored, is a core protection this criterion exists to maintain, distinct from a one-time consent treated as binding regardless of a patient's later wishes.

WHAT GOOD LOOKS LIKE

- Informed consent genuinely distinguishes standard clinical care from research participation.
- It's genuinely, explicitly clear that declining research won't affect standard care.
- A patient who initially consented can genuinely withdraw at any point.

COMMON FAILURE MODES

- Standard care and research participation are presented as one blended decision.
- It's not genuinely, explicitly clear that declining research won't affect standard care.
- Withdrawal from research is treated as difficult or discouraged in practice.

WORKED EXAMPLE

IN PRACTICE

A patient eligible for a research study alongside standard treatment.

BEFORE	The consent form presented standard treatment and research participation as a single combined decision, without clearly, explicitly stating that declining the research component would not affect the standard care the patient received.
ACTION	The hospital built a separated consent structure with a distinct section explicitly, clearly stating that standard care continues unaffected regardless of the research decision, plus a simple, genuinely accessible withdrawal process described upfront.
AFTER	The Monitor reviewed the consent documentation and spoke with an enrolled patient, confirming genuine understanding that standard care was unaffected by the research decision. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a consent structure that clearly separates standard care from research participation.
2. Add an explicit statement that declining research won't affect standard care.
3. Build a genuinely accessible withdrawal process, described clearly upfront.

The most common mistake: Presenting standard treatment and research participation as a single, blended consent decision, which can leave a patient genuinely unclear whether declining the research component carries any effect on the care they receive.

SELF-ASSESSMENT QUESTIONS

1. Does informed consent genuinely distinguish standard clinical care from research participation, not present them as a single blended decision? — *Genuine clarity about which parts are standard treatment versus which are research, not a combined consent that obscures the distinction.*

Evidence: Consent form structure

2. Is it genuinely, explicitly clear to the patient that declining research participation will not affect the standard care they receive?
— *A patient should never feel their standard treatment is contingent on research participation.*

Evidence: Consent language review

3. Can a patient who initially consented genuinely withdraw from research participation at any point, with that withdrawal actually honored? — *Genuine ongoing voluntariness, not a one-time consent treated as irrevocable.*

Evidence: Withdrawal process documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Separation exists in the consent form but isn't reinforced verbally at the time of consent.**
- **A withdrawal process exists but isn't clearly communicated upfront.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current consent form structure for clarity of separation.
Week 2	Build a clearly separated consent structure with explicit non-contingency language.
Week 3	Build and clearly communicate a genuinely accessible withdrawal process.
Ongoing	Spot-check enrolled patient understanding periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient interview	Speaks with an enrolled research patient to confirm genuine understanding that standard care is unaffected by the research decision.

EVIDENCE BASE

World Medical Association. Declaration of Helsinki — Ethical Principles for Medical Research Involving Human Subjects. Fortaleza: WMA; 2013 (current revision).

16.5

Conflicts of Interest Between Research
and Clinical Care Are Disclosed and
Managed

CORE

A clinician’s financial or other significant interest connected to a research study is disclosed through a defined process and genuinely managed — such as separating the clinician’s research role from their direct clinical decision-making for enrolled patients — not left undisclosed or disclosed without any real management action following.

In plain terms: When a clinician has a financial or other real stake in a research study, that’s actually disclosed through a working process and actually managed — not just noted somewhere with nothing done about it.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A financial or other significant interest connected to a research study can genuinely influence a clinician’s judgment, even with the best of intentions, which is precisely why disclosure alone, without a genuine management action following it, provides limited real protective value. Separating a clinician’s research role from their direct clinical decision-making for enrolled patients is one concrete way to manage a disclosed conflict, and the specific management action matters considerably more than the disclosure record alone.

WHAT GOOD LOOKS LIKE

- A defined, actually-used disclosure process exists for financial or other interests.
- Once disclosed, the conflict is genuinely managed through a concrete action.

COMMON FAILURE MODES

- A disclosure policy exists on paper but isn’t actually used in practice.
- A disclosed conflict is logged with no genuine management action following.
- Disclosure happens once and is never revisited as

- Disclosure is reviewed and refreshed periodically, not captured once only.

circumstances change.

WORKED EXAMPLE

IN PRACTICE

A clinician with a financial interest connected to a research study they're also involved in clinically.

BEFORE	The clinician's financial interest was disclosed and logged in an annual conflict-of-interest form, but no actual management step separated their research role from their direct clinical decision-making for patients enrolled in that same study.
ACTION	The hospital built a concrete management step requiring a separate, uninvolved clinician to handle direct clinical decisions for patients enrolled in a study where the treating clinician has a disclosed financial interest.
AFTER	The Monitor reviewed a disclosed conflict case and confirmed a genuine management action — a separate clinician handling direct clinical decisions — was actually in place. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a defined, actually-used disclosure process for financial and other interests.
2. Build a concrete management action for a disclosed conflict, not disclosure alone.
3. Build a periodic refresh cycle for disclosure, not a one-time capture.

The most common mistake: Treating disclosure alone as sufficient, with a conflict logged on an annual form but no actual, concrete management action — such as separating research and clinical decision-making roles — genuinely following.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined, actually-used process for a clinician to disclose a financial or other significant interest connected to a research study? — *A real, functioning disclosure process, not a policy that exists on paper but isn't actually used.*

Evidence: Disclosure process documentation

2. Once disclosed, is the conflict genuinely managed through a concrete action, not merely logged with no follow-through? — *Disclosure alone provides limited protective value without a genuine management step following it.*

Evidence: Conflict management record

3. Is disclosure reviewed and refreshed periodically, not captured once and never revisited as circumstances change? — *A conflict of interest can emerge or change after the original disclosure point.*

Evidence: Disclosure refresh schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **Disclosure happens but management actions aren't consistently applied to every case.**
- **Disclosure is annual but doesn't capture a conflict that arises mid-cycle.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current disclosure process for actual use, not just existence.
Week 2	Build a concrete management action protocol for disclosed conflicts.
Week 3	Build a periodic disclosure refresh cycle.
Ongoing	Audit conflict management follow-through periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Conflict management record review	Reviews a disclosed conflict case for the specific, concrete management action that was actually taken.

EVIDENCE BASE

Institute of Medicine. Conflict of Interest in Medical Research, Education, and Practice. Washington, DC: National Academies Press; 2009.

16.6

Teaching Faculty Maintain Verified,
Current Clinical Competency

STANDARD

Faculty teaching clinical skills maintain active, verified clinical competency in the skill being taught, confirmed through a defined process — not a teaching role assumed to carry current clinical competency simply from past experience or academic seniority.

In plain terms: Faculty teaching a clinical skill are genuinely, currently good at that skill themselves, checked through a real process — not assumed to be competent just because of years of experience or academic rank.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Past experience and academic seniority are genuinely weak proxies for current clinical competency in a specific skill — a faculty member’s hands-on competency in a given procedure can meaningfully diminish over time, particularly if their current role has shifted considerably toward teaching and administration with reduced direct practice. Relying on seniority alone, without a genuine current verification process, risks a trainee learning a skill from faculty whose own current competency in that specific skill hasn’t actually been confirmed.

WHAT GOOD LOOKS LIKE

- Current clinical competency, not past experience alone, is genuinely verified.

COMMON FAILURE MODES

- Teaching competency is assumed from years of past experience or academic rank.

- Competency verification is repeated on a defined schedule, not confirmed once.
- A defined process exists for addressing an identified competency gap.

- Competency was verified once at initial appointment and never revisited.
- An identified gap has no defined process for being addressed.

WORKED EXAMPLE

IN PRACTICE

A hospital reviewing its teaching faculty competency process.

BEFORE	Faculty teaching status for a given clinical skill was assumed to continue indefinitely from initial appointment, with no periodic reverification of current, active competency in that specific skill.
ACTION	The hospital built a periodic competency reverification process for teaching faculty, with a defined process for addressing an identified gap through supervised practice or, where necessary, reassignment of teaching responsibility.
AFTER	The Monitor reviewed teaching faculty records and confirmed periodic competency reverification was genuinely in place, with a documented process for addressing an identified gap. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a current competency verification process for teaching faculty, not reliance on seniority.
2. Set a defined schedule for periodic reverification.
3. Build a defined process for addressing an identified competency gap.

The most common mistake: Assuming teaching competency continues indefinitely from an initial appointment based on

seniority, without a genuine periodic process to reverify current, active competency in the specific skill being taught.

SELF-ASSESSMENT QUESTIONS

1. Is current clinical competency, not past experience alone, genuinely verified for faculty teaching a given clinical skill? — *Current, active competency verified through a real process, not assumed from years of past experience or academic rank.*
Evidence: Competency verification record

2. Is competency verification repeated on a defined schedule, not confirmed once at initial faculty appointment? — *Clinical competency in a given skill can change over time; a one-time check at appointment doesn't reflect current status.*
Evidence: Reverification schedule

3. Is there a defined process for addressing an identified competency gap in a teaching faculty member? — *Identifying a gap without a genuine response process provides limited protective value.*
Evidence: Gap-remediation protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification exists at appointment but a periodic reverification schedule isn't fully built.**
- **A gap-remediation process exists on paper but hasn't been genuinely applied.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for verifying teaching faculty clinical competency.
Week 2	Build a periodic reverification schedule and process.
Week 3	Build a defined gap-remediation process.
Ongoing	Apply and document reverification on schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Faculty competency record review	Reviews teaching faculty records for current, periodic competency verification distinct from a one-time appointment check.

EVIDENCE BASE

Accreditation Council for Graduate Medical Education. Common Program Requirements. Chicago: ACGME; 2023.

- ← Hospital Standards — all standards
- Self-assess against these criteria →
- ← Standard 15 — Psychiatry & Mental Health
- Standard 17 — Enterprise & Multi-Site Governance →

ASF STANDARDS · HOSPITAL · STANDARD 17

Standard 17 — Enterprise & Multi-Site Governance

6 criteria · 2 non-negotiable · 3 core · 1 standard-level · Version 1.0 · For organizations operating multiple hospital sites under shared governance

CRITERIA IN THIS STANDARD

- 17.1 — Governance Structure Defines Authority Between Central and Site-Level Leadership
- 17.2 — Incident Learning Is Genuinely Shared Across Sites, Not Siloed
- 17.3 — Clinical Policy Is Standardized Across Sites, With Any Local Variation Explicitly Justified
- 17.4 — Credentialing and Privileging Are Centrally Verified and Consistently Recognized
- 17.5 — Central Resource and Staffing Decisions Are Evaluated for Site-Level Patient Safety Impact
- 17.6 — Site-Level Quality Data Is Genuinely Reviewed by Central Governance

17.1 Governance Structure Defines Authority Between Central and Site-Level Leadership

NON-NEGOTIABLE

For an organization operating multiple sites, explicit, documented governance defines which decisions belong to central/corporate leadership and which belong to site-level

leadership, with no genuine ambiguity about who holds authority for a given decision — not an informal or assumed division that leaves real gaps when a decision actually needs to be made.

In plain terms: It's written down, clearly, who decides what between the head office and each hospital — not an unwritten understanding that falls apart the moment a real decision needs making quickly.

Applicability	Scope
Applies to	Organizations operating two or more hospital sites under shared governance

WHY THIS MATTERS

An informal or assumed division of authority between central and site-level leadership can function adequately during routine operations, but genuinely breaks down exactly when it matters most — during an urgent decision where different people hold different assumptions about who actually has the authority to decide. A documented structure that site leadership can articulate clearly, rather than one that exists only as a policy document rarely consulted, provides considerably more real protection against the specific risk of a decision stalling, or being made by the wrong party, during a genuine time-sensitive situation.

WHAT GOOD LOOKS LIKE

- The division of authority is explicitly documented, not assumed or informal.
- Site leadership can clearly identify who holds authority for a specific decision type.
- A defined escalation path exists for genuinely unclear decision ownership.

COMMON FAILURE MODES

- Authority division exists informally, understood differently by different people.
- Site leadership can't confidently identify decision ownership when asked directly.
- No defined escalation path exists for a genuinely ambiguous decision.

WORKED EXAMPLE

IN PRACTICE

A multi-site hospital network reviewing its governance clarity.

BEFORE	Site leadership generally understood that major capital decisions sat with central leadership, but the actual boundary — what counted as “major” versus a decision site leadership could make independently — existed only as an informal shared understanding, interpreted differently across sites.
ACTION	The network built an explicit, documented decision-rights matrix specifying exactly which decision types sit with central leadership, which sit with site leadership, and a defined escalation path for genuinely unclear cases.
AFTER	The Monitor asked site leadership at two different locations to describe who held authority for a specific decision type, and received consistent, confident answers matching the documented matrix. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Document an explicit decision-rights matrix between central and site-level leadership.
2. Test whether site leadership can confidently articulate the division when asked.
3. Build a defined escalation path for genuinely ambiguous decision ownership.

The most common mistake: Relying on an informal, shared understanding of decision authority that's actually interpreted differently across different sites, rather than an explicit, documented structure everyone can consistently reference.

SELF-ASSESSMENT QUESTIONS

1. Is the division of authority between central and site-level leadership explicitly documented, not assumed or informal? — A

written, specific division, not an unwritten understanding that can be interpreted differently by different people.

Evidence: Decision-rights matrix

2. Can site leadership clearly identify who holds authority for a specific type of decision when asked? — *A genuine test of whether the documented structure actually translates into practical clarity for the people who need it.*

Evidence: Site leadership interview

3. Is there a defined escalation path when a decision's ownership is genuinely unclear? — *Even a well-documented structure can encounter an edge case; a defined path for resolving ambiguity matters.*

Evidence: Escalation path documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **A matrix exists but hasn't been actively communicated to all site leadership.**
- **Most decision types are covered but an escalation path for edge cases is missing.**

IMPLEMENTATION PLAN

When	What
Week 1	Draft an explicit decision-rights matrix across major decision categories.
Week 2	Communicate and verify understanding with site leadership.
Week 3	Build a defined escalation path for ambiguous cases.
Ongoing	Review and update the matrix as the organization evolves.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Site leadership interview	Asks site leadership at more than one location to describe who holds authority for a specific decision type, checking for consistent answers.

EVIDENCE BASE

Institute for Healthcare Improvement. Framework for Effective Board Governance of Health System Quality. Boston: IHI; 2018.

17.2

Incident Learning Is Genuinely Shared Across Sites, Not Siloed

CORE

A serious incident identified at one site triggers a genuine review and dissemination process reaching every other site under the same governance structure, with lessons learned actually reaching relevant staff elsewhere in the network — not confined to the originating site as though it carries no relevance to the rest of the organization.

In plain terms: When something serious goes wrong at one hospital, the lesson genuinely reaches the other hospitals too — not stuck at the site where it happened as if the rest of the network has nothing to learn from it.

Applicability	Scope
Applies to	Organizations operating two or more hospital sites under shared governance

WHY THIS MATTERS

A multi-site network’s genuine advantage lies partly in the ability to learn once and apply that learning everywhere — an incident confined to the originating site, with no real process for reaching other locations, forfeits that advantage and leaves other sites exposed to a risk already identified and understood elsewhere in the same organization. A pattern that’s invisible when each site’s incidents are viewed in isolation can become genuinely visible once incidents are actually aggregated and reviewed at the network level, which is a distinct and additional value beyond single-site incident review.

WHAT GOOD LOOKS LIKE

- A defined process genuinely moves a serious incident’s lessons to other sites.
- Staff at other sites actually receive and register relevant incident learning.
- A pattern across multiple sites’ incidents gets

COMMON FAILURE MODES

- Incident review and learning stay confined to the originating site.
- Learning is technically distributed but not genuinely received or absorbed elsewhere.
- Cross-site patterns go unidentified because

identified and addressed
network-wide.

incidents are reviewed
only in isolation.

WORKED EXAMPLE

IN PRACTICE

A network reviewing its cross-site incident learning process.

BEFORE

A serious medication error at one site triggered a thorough root-cause review at that location, but the findings and resulting process change were never actually communicated to the other sites in the network, which continued operating under the same vulnerable process.

ACTION

The network built a defined cross-site incident learning process, with serious incidents reviewed at the network level and relevant findings actively disseminated to clinical leadership at every other site, with confirmation of receipt tracked.

AFTER

The Monitor asked clinical leadership at a different site about a recent serious incident elsewhere in the network, and received a genuine, specific description of the learning that had reached them. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a defined process for a serious incident to trigger network-wide review.
2. Build an active dissemination step with confirmation of receipt at other sites.
3. Build a periodic cross-site pattern review at the network level.

The most common mistake: Treating incident review and learning as a single-site activity, with findings and process changes never actually reaching other sites that face the identical underlying risk.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined process for a serious incident at one site to genuinely reach other sites in the network? — *A real, functioning cross-site process, not an assumption that lessons will somehow travel informally.*

Evidence: Cross-site incident learning process documentation

2. Do staff at other sites actually receive and register relevant incident learning, not merely have it technically distributed? — *Genuine receipt and understanding, not just an email sent with no confirmation it was read or absorbed.*

Evidence: Site leadership interview

3. Does a pattern across multiple sites' incidents get identified and addressed at the network level? — *A pattern invisible at any single site may only become visible when incidents are genuinely aggregated across the network.*

Evidence: Network-level pattern review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Dissemination happens but receipt confirmation isn't consistently tracked.**
- **Individual incidents are shared but a genuine pattern-level review doesn't happen regularly.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for cross-site incident communication.
Week 2	Build a defined network-wide dissemination process with receipt tracking.
Week 3	Build a periodic cross-site pattern review.
Ongoing	Apply the process to each new serious incident.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Cross-site interview	Asks clinical leadership at a site other than where an incident occurred to describe the learning that reached them, checking for genuine specificity.

EVIDENCE BASE

World Health Organization. Patient Safety Incident Reporting and Learning Systems. Geneva: WHO; 2020.

Clinical Policy Is Standardized Across
17.3 Sites, With Any Local Variation Explicitly Justified

CORE

Core clinical policies are standardized across every site in the network, with any permitted local variation explicitly documented and specifically justified — not silent, unexplained drift between sites that leaves patients receiving genuinely different standards of care depending on which site they visit.

In plain terms: The core rules for clinical care are genuinely the same across every hospital in the network — and if one site genuinely needs to do something differently, that’s written down and explained, not a quiet, unexplained gap from what the policy actually says.

Applicability	Scope
Applies to	Organizations operating two or more hospital sites under shared governance

WHY THIS MATTERS

A patient’s standard of care shouldn’t genuinely depend on which site within the same organization they happen to visit — unexplained drift between sites, where core clinical policy is nominally shared but actually followed differently at different locations, undermines the basic premise that a network provides a consistent standard. Permitted local variation can be entirely legitimate, reflecting genuine differences in site capability or patient population, but the critical distinction is between a documented, justified variation and silent, unexplained drift that nobody has actually examined or approved.

WHAT GOOD LOOKS LIKE

- Core clinical policies are genuinely standardized

COMMON FAILURE MODES

- Sites independently drift from shared policy without

across sites.

- Any permitted local variation is explicitly documented and specifically justified.
- A periodic process checks that sites genuinely still follow the standardized policy.

documentation or review.

- Variation exists but isn't explicitly justified or formally approved.
- Standardization is assumed to persist without any periodic verification.

WORKED EXAMPLE

IN PRACTICE

A network reviewing clinical policy consistency across sites.

BEFORE

A core infection control policy was nominally shared network-wide, but an audit found one site had quietly modified its actual practice over time in response to local supply constraints, with the variation never documented, reviewed, or approved at the network level.

ACTION

The network built a formal variation-request process requiring any site-level deviation from core policy to be explicitly documented and approved, alongside a periodic audit comparing actual practice at each site against the standardized policy.

AFTER

The Monitor reviewed the periodic audit findings and confirmed any variation found was documented and formally approved, with no unexplained drift remaining. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Confirm core clinical policies are genuinely shared and current across sites.
2. Build a formal variation-request process for any site-level deviation.
3. Build a periodic audit comparing actual site practice against standardized policy.

The most common mistake: Assuming that a policy shared on paper across the network is actually being followed identically at every site, without a periodic audit that would reveal quiet, unexplained drift that's crept in over time.

SELF-ASSESSMENT QUESTIONS

1. Are core clinical policies genuinely standardized across sites, not left to independently drift at each location? — *A shared baseline, not each site quietly developing its own version over time.*

Evidence: Policy comparison across sites

2. Is any permitted local variation explicitly documented and specifically justified, not simply tolerated without explanation? — *A genuine, documented reason for variation, not an unexplained gap between what's written and what's actually practiced at a given site.*

Evidence: Variation-request record

3. Is there a periodic process for checking that sites genuinely still follow the standardized policy, not assumed to remain aligned indefinitely? — *Standardization can erode over time without active checking.*

Evidence: Periodic audit record

COMMON REASONS FOR A PARTIAL ANSWER

- **A variation process exists but isn't consistently used by every site.**
- **Periodic audits happen but aren't consistently followed up when drift is found.**

IMPLEMENTATION PLAN

When	What
Week 1	Compare current practice across sites for core clinical policies.
Week 2	Build a formal variation-request and approval process.
Week 3	Build a periodic cross-site policy adherence audit.
Ongoing	Apply the audit on a defined schedule and follow up on findings.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Cross-site policy comparison	Compares actual clinical practice at two or more sites against the standardized core policy for unexplained variation.

EVIDENCE BASE

Institute for Healthcare Improvement. Framework for Effective Board Governance of Health System Quality. Boston: IHI; 2018.

17.4 **Credentialing and Privileging Are Centrally Verified and Consistently Recognized**

NON-NEGOTIABLE

A clinician’s credentials and clinical privileges are verified through a single, central process and consistently recognized across every site where that clinician practices, with no site allowing a clinician to practice without their current credentials and privileges actually being confirmed for that specific site.

In plain terms: A clinician’s credentials are checked once, centrally, done properly — and every site actually confirms, before that clinician practices there, that their credentials and privileges are current, rather than just assuming the central check automatically covers everywhere.

Applicability	Scope
Applies to	Organizations operating two or more hospital sites under shared governance

WHY THIS MATTERS

A single, centralized credentialing process, done properly, is considerably more reliable than independent, inconsistent verification repeated differently at each site — but centralization alone isn’t sufficient without each specific site also confirming current privileges

before a clinician practices there, closing the real gap that can otherwise occur between central records and what's actually happening at a given location. A privilege suspension at one site that fails to genuinely propagate to every other site where that clinician practices represents a serious, specific risk this criterion exists to prevent.

WHAT GOOD LOOKS LIKE	COMMON FAILURE MODES
• Credentialing verification is genuinely centralized, not inconsistently repeated. • Every site confirms a clinician's current privileges before they practice there. • A privilege change or suspension at one site genuinely propagates to all sites.	• Credentialing is inconsistently verified or skipped at some sites. • A site assumes central verification automatically covers their specific location. • A privilege suspension at one site fails to reach other sites where the clinician practices.

WORKED EXAMPLE

IN PRACTICE	
<i>A network reviewing its credentialing process across sites.</i>	
BEFORE	A clinician's privileges were suspended at one site following a disciplinary review, but no reliable process existed to propagate that suspension to other sites where the clinician also practiced, creating a genuine gap.
ACTION	The network built a centralized credentialing database with real-time visibility across all sites, requiring every site to confirm current status against that central record before a clinician practices, with any status change automatically flagged network-wide.

AFTER

The Monitor tested the system by checking whether a simulated status change at one site was genuinely visible and actionable at another site. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build or confirm a single, centralized credentialing verification process.
2. Require every site to confirm current status before a clinician practices there.
3. Build a real-time propagation mechanism for any privilege status change.

The most common mistake: Assuming a centralized credentialing process automatically covers every site, without a specific, confirmed mechanism ensuring a status change — particularly a suspension — genuinely reaches and is acted upon at every site where that clinician practices.

SELF-ASSESSMENT QUESTIONS

1. Is credentialing verification genuinely centralized, not independently and inconsistently repeated or skipped at each site? — *A single, reliable verification process, not a patchwork where sites verify differently or not at all.*

Evidence: Credentialing process documentation

2. Does every site confirm a clinician's current privileges before they practice there, not assume central verification covers every site automatically? — *A specific, site-level confirmation step, even within a centralized system, closes a genuine potential gap.*

Evidence: Site-level confirmation record

3. Is there a reliable process for a privilege change or suspension at one site to genuinely propagate to all sites where that clinician practices? — *A suspension that doesn't actually reach every site where the clinician practices creates a real, serious gap.*

Evidence: Propagation test record

COMMON REASONS FOR A PARTIAL ANSWER

- **Centralized verification exists but site-level confirmation isn't consistently performed.**

- **Propagation of a status change relies on manual notification rather than a reliable system.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current credentialing consistency across all sites.
Week 2	Build or confirm a centralized credentialing verification process.
Week 3	Build a site-level confirmation requirement and propagation mechanism.
Ongoing	Test propagation periodically to confirm genuine function.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Credentialing system test	Tests whether a status change at one site is genuinely visible and actionable at another site in the network.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Hospitals. 7th ed. Oak Brook, IL: JCI; 2020.

17.5	Central Resource and Staffing Decisions Are Evaluated for Site-Level Patient Safety Impact	CORE
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A central decision affecting staffing, equipment, or resource allocation at a specific site is evaluated for its patient safety impact at that site before being finalized, with a documented process for that evaluation — not a purely network-level financial or operational decision made without genuine consideration of site-level patient safety consequences.

In plain terms: Before the head office makes a decision affecting staffing or resources at a specific hospital, the actual patient safety impact at that hospital is genuinely considered — not a purely financial or operational decision made with no real input from the people who’d see the consequences.

Applicability	Scope
Applies to	Organizations operating two or more hospital sites under shared governance

WHY THIS MATTERS

A central resource decision made purely on network-level financial or operational grounds, without genuine consideration of the specific patient safety impact at an individual site, risks optimizing for the network as a whole while creating a real, serious gap at a specific location. Site-level clinical leadership holds genuine, specific knowledge about what a given resource reduction or reallocation would actually mean for patient safety at their site — knowledge that’s lost if that leadership is only informed after the decision has already been finalized, rather than having a real voice before it’s made.

WHAT GOOD LOOKS LIKE

- A documented process evaluates patient safety impact before a central decision is finalized.
- Site-level clinical leadership has a genuine voice in that evaluation beforehand.
- A real mechanism exists for a site to flag a concern and have it genuinely reconsidered.

COMMON FAILURE MODES

- Resource decisions are made on purely financial or operational grounds.
- Site leadership is informed of a decision only after it’s already finalized.
- A site’s flagged safety concern has no real avenue for reconsideration.

WORKED EXAMPLE

IN PRACTICE

A network considering a staffing reduction at one site.

BEFORE	A staffing reduction at one site was decided centrally based on network-level financial targets, with site clinical leadership notified of the decision after it had already been finalized, with no genuine opportunity to flag a specific patient safety concern beforehand.
ACTION	The network built a required patient safety impact evaluation step, genuinely completed before a central resource decision affecting a specific site is finalized, with site clinical leadership formally consulted as part of that evaluation.
AFTER	The Monitor reviewed a recent resource decision and found a documented patient safety evaluation genuinely completed beforehand, with site leadership input recorded. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a required patient safety impact evaluation step for central resource decisions.
2. Build a formal site clinical leadership consultation step before finalization.
3. Build a real escalation mechanism for a flagged safety concern.

The most common mistake: Making a central resource decision on purely financial or operational grounds, notifying site leadership only after the decision is already finalized, rather than genuinely consulting them and evaluating patient safety impact beforehand.

SELF-ASSESSMENT QUESTIONS

1. Is there a documented process for evaluating patient safety impact before a central resource decision affecting a specific site is finalized? — *A genuine evaluation step, not a decision made purely on network-level financial or operational grounds.*

Evidence: Patient safety impact evaluation record

2. Does site-level clinical leadership have a genuine voice in that evaluation, not merely informed after the decision is already made? — *Real input before the decision, not notification after the fact.*

Evidence: Consultation record

3. Is there a mechanism for a site to flag a safety concern about a central resource decision and have it genuinely reconsidered? — *A real, functioning escalation path, not a theoretical right with no actual avenue for reconsideration.*

Evidence: Escalation record

COMMON REASONS FOR A PARTIAL ANSWER

- An evaluation process exists but isn't consistently applied to every central decision.
- Site leadership is consulted but the consultation often happens too late to genuinely influence the outcome.

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for site input on central resource decisions.
Week 2	Build a required patient safety impact evaluation step.
Week 3	Build a formal, timely site consultation and escalation mechanism.
Ongoing	Apply the evaluation to every central resource decision affecting a site.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Resource decision review	Reviews a recent central resource decision affecting a site for documented patient safety evaluation and site consultation before finalization.

EVIDENCE BASE

World Health Organization. Global Patient Safety Action Plan 2021–2030. Geneva: WHO; 2021.

17.6

Site-Level Quality Data Is Genuinely Reviewed by Central Governance

STANDARD

Quality and safety metrics reported upward from each site are genuinely reviewed by central governance, with real follow-through action when a metric indicates a problem — not merely collected and filed as a reporting formality with no actual review or consequence.

In plain terms: Quality data from each hospital genuinely gets looked at by the people running the network, and when something looks wrong, something actually happens about it — not data flowing upward into a file nobody really examines.

Applicability	Scope
Applies to	Organizations operating two or more hospital sites under shared governance

WHY THIS MATTERS

Site-level quality data that flows upward into a central repository, but isn't genuinely reviewed by anyone with authority to act on it, provides the appearance of oversight without the substance — the reporting requirement is technically satisfied, but the protective value central governance oversight is meant to provide doesn't actually materialize. A concerning metric that goes unaddressed, because the review that would have caught it never genuinely happened, represents a specific, serious gap between what a network's governance structure claims to provide and what it actually delivers for patients at an individual site.

WHAT GOOD LOOKS LIKE

- Site-level quality data is genuinely reviewed by central governance, not just archived.
- A concerning metric from a specific site triggers a genuine follow-through action.

COMMON FAILURE MODES

- Quality data is collected and filed without a genuine review process.
- A concerning metric is noted but no actual follow-through action occurs.
- Central governance can't cite a concrete, recent

- Central governance can cite a specific, recent example of acting on site-level data.

example of acting on site data.

WORKED EXAMPLE

IN PRACTICE

A network reviewing how central governance engages with site-level quality data.

BEFORE	Each site submitted monthly quality metrics to a central dashboard, but review of the dashboard by central governance was inconsistent, and a sustained decline in one metric at a specific site had gone unaddressed for several reporting cycles.
ACTION	The network built a defined, scheduled central governance review of site-level quality data, with a required documented action for any metric crossing a defined concerning threshold, tracked to resolution.
AFTER	The Monitor asked central governance for a specific, recent example of acting on site-level quality data and received a concrete, documented example. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a defined, scheduled central governance review of site-level quality data.
2. Set defined thresholds that require a documented follow-through action.
3. Track follow-through actions to resolution, not just to initial acknowledgment.

The most common mistake: Treating a central quality dashboard as oversight in itself, without a genuine, scheduled review process and a required follow-through action when a metric actually indicates a problem.

SELF-ASSESSMENT QUESTIONS

1. Is site-level quality data genuinely reviewed by central governance, not simply collected and archived? — *A real review process, not data flowing upward into a repository nobody actually examines.*

Evidence: Governance review schedule and minutes

2. Does a concerning metric from a specific site trigger a genuine follow-through action, not go unaddressed? — *Detection without a real response provides limited protective value for patients at that site.*

Evidence: Follow-through action record

3. Can central governance identify, when asked, a specific recent example of acting on site-level quality data? — *A concrete, recent example suggests genuine, ongoing practice rather than a theoretical process.*

Evidence: Governance interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A review schedule exists but isn't consistently followed in practice.**
- **Follow-through actions are initiated but not consistently tracked to resolution.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current central governance engagement with site-level quality data.
Week 2	Build a defined, scheduled review process with concerning-metric thresholds.
Week 3	Build a follow-through action tracking process through to resolution.
Ongoing	Apply the review on schedule and track outcomes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Governance interview	Asks central governance for a specific, recent example of reviewing and acting on site-level quality data.

EVIDENCE BASE

Institute for Healthcare Improvement. Framework for Effective Board Governance of Health System Quality. Boston: IHI; 2018.

← **Hospital Standards — all standards**

Self-assess against these criteria →

← **Standard 16 — Academic Medical Center**

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