



Non-hospital Medical and Surgical
Facilities Accreditation Program

ACCREDITATION STANDARDS

Governance and
Leadership

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Non-hospital Medical and Surgical Facilities Accreditation Program
College of Physicians and Surgeons of British Columbia
300-669 Howe Street
Vancouver BC V6C 0B4

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Introduction

Patient safety relies on good governance and management processes. Organizational (corporate) governance of health-care organizations is comprised of the four integrated components of clinical, financial, risk and other business governance. The governing body (board/ownership) is responsible for good organizational (corporate) governance.

Clinical governance is the set of relationships and responsibilities that a health-care organization establishes with its governing body (board, owners), executive leadership, health-care providers, patients and other stakeholders to ensure the delivery of high quality, safe health care. Good clinical governance ensures that everyone from the frontline care providers, to the leadership to the governing body (board) are accountable to patients and other stakeholders for assuring the delivery of high quality, safe health care.

The governing body (board, ownership) sets the strategic focus of the organization, delegates the day-to-day operations to the executive leadership who in turn delegates specific responsibilities to other leaders and staff, supervises the performance of the executive leadership, ensures the appropriate risk management and accountability structures are in place and monitors the performance of the organization. Good clinical governance relies on having the resources necessary to provide safe and quality care.

Governance and leadership

No.	Description	Reference	Risk	Change	Asmt.
GVL1.0	GOVERNANCE AND LEADERSHIP				
GVL1.1	<p>The governing body sets and communicates the organization’s commitment to a safety and quality culture and a person-centred approach care.</p> <p>Guidance: A governing body may be a board, owner or chief executive officer.</p>				
GVL1.1.1	<p>B The mission of the organization is defined.</p> <p>Guidance: The governing body is responsible for defining the mission and values of the organization. A mission statement defines what the organization does, for whom and why. It should reflect a commitment to the delivery of high quality, safe care and a person-centred approach.</p>	1, 12, 20, 22	B		F
GVL1.1.2	<p>B The values of the organization are defined.</p> <p>Guidance: The governing body is responsible for defining the mission and values of the organization. They should reflect a commitment to the delivery of high quality, safe care and a person-centred approach.</p>	1, 12, 20, 26	B		F
GVL1.1.3	<p>B The ethics of the organization are defined.</p> <p>Guidance: The governing body is responsible for defining the ethics or code of behaviour of the organization. Organizational ethics outline the culture, attitudes, beliefs and behaviours that govern the organization’s conduct such as openness, integrity and trust. The ethics of the organization should reflect a commitment to a culture of safety and quality improvement.</p>	1, 12, 20, 26	B		F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.1.4	<p>B The organization’s commitment to a culture of safety is documented.</p> <p>Guidance: The governing body’s written commitment to safety and quality is key to the development of a safety and quality culture within an organization and guides the organization’s priorities, resource allocation, policies and procedures. This may be an organizational guiding principle.</p>	24, 26	B	New	F
GVL1.1.5	<p>B The organization’s commitment to active patient engagement and a person-centred approach is documented.</p> <p>Guidance: The governing body’s written commitment sets the expectation for active patient engagement and health-care professionals’ partnership with patients in the continuum of care. This may be an organizational guiding principle.</p>	1, 21	B	New	F
GVL1.1.6	<p>B There is a strategic plan.</p> <p>Guidance: The governing body is responsible for developing a strategic plan which sets the strategic priorities and direction of the organization.</p>	1	B	New	F
GVL1.1.7	<p>B The strategic plan defines the strategic objectives of the organization.</p> <p>Guidance: The strategic objectives should support the governing body’s commitment to the delivery of high quality, safe and person-centred care and achieving a ‘blame-free,’ accountable and learning culture. The organization’s risk management framework should be used to inform strategic and operational planning activities.</p>	1, 11, 12, 20	B	New	F
GVL1.2	The operational plan guides the organization in achieving its strategic goals and objectives and overall mission and values.				

No.	Description	Reference	Risk	Change	Asmt.
GVL1.2.1	<p>B There is an operational plan.</p> <p>Guidance: The operational plan is typically developed by the executive leadership (e.g. medical director) in consultation with other organizational leaders. The operational plan guides the organization in achieving its strategic goals and objectives. Operational plan template https://www.health.qld.gov.au/_data/assets/word_doc/0023/444353/hf-operational-plan-template.docx</p>	1, 25	B	New	F
GVL1.2.2	<p>B The operational plan defines the service objectives of the organization.</p> <p>Guidance: Service objectives may outline what services and/or service volumes are available now and what services and service volume the organization is working to provide in future or others related to human resources, risk or communication etc.</p>	1	B	New	F
GVL1.2.3	<p>B The operational plan is updated to demonstrate progress towards achieving the objectives and goals.</p> <p>Guidance: The operational plan is a live document. The operational plan is reviewed and updated regularly (such as quarterly) with progress and performance data.</p>	1	B	New	F
GVL1.3	The governing body ensures that the organization has a defined process to develop, review, update and approve the organization's strategic, operational, risk management and quality improvement plans.				
GVL1.3.1	<p>B There is a documented process for developing, monitoring and revising the organization's plans.</p> <p>Guidance: The organization's plans should include a strategic plan, an operational plan, a risk management plan and a quality improvement plan.</p>	1, 12, 15	B	New	F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.3.2	<p>B The organization’s plans are reviewed within defined timeframes.</p> <p>Guidance: The defined timeframes for review should be specified in the documented process for developing, monitoring and revising the organization’s plans.</p>	1, 12, 15	B	New	F
GVL1.3.3	<p>B The organization’s plans are identified with a title.</p> <p>Guidance: The title identified the subject and type of document, e.g. strategic plan.</p>		B	New	F
GVL1.3.4	<p>B The organization’s plans are identified with their approval date.</p>		B	New	F
GVL1.3.5	<p>B The organization’s plans are updated with their progress/review date(s).</p>		B	New	F
Strategic plan					
GVL1.3.6	<p>B Responsibility for developing, reviewing and revising the organization’s strategic plan is clearly assigned.</p> <p>Guidance: This should be a responsibility of the governing body in collaboration with the organization’s governance leadership.</p>	1, 12	B	New	F
GVL1.3.7	<p>B Responsibility for approving the organization’s strategic plan is clearly assigned.</p> <p>Guidance: This is typically a responsibility of the governing body in collaboration with the executive leadership and should be outlined in the documented process.</p>	1, 12	B	New	F
Operational plan					

No.	Description	Reference	Risk	Change	Asmt.
GVL1.3.8	<p>B Responsibility for developing, reviewing and revising the organization’s operational plan is clearly assigned.</p> <p>Guidance: This should be a responsibility of the medical director and may be delegated in collaboration with other governance leaders and should be outlined in the documented process.</p>	1, 12	B	New	F
GVL1.3.9	<p>B Responsibility for approving the organization’s operational plan is clearly assigned.</p> <p>Guidance: This is typically a responsibility of the governing body in collaboration with the executive leadership and should be outlined in the documented process.</p>	1, 12	B	New	F
Risk management plan					
GVL1.3.10	<p>B Responsibility for developing, reviewing and revising the organization’s risk management plan is clearly assigned.</p> <p>Guidance: This should be a responsibility of the medical director and may be delegated in collaboration with other governance leaders and should be outlined in the documented process.</p>	1, 12, 16	B	New	F
GVL1.3.11	<p>B Responsibility for approving the organization’s risk management plan is clearly assigned.</p> <p>Guidance: This is typically a responsibility of the governing body in collaboration with the executive leadership and should be outlined in the documented process.</p>	1, 12	B	New	F
Quality improvement plan					

No.	Description	Reference	Risk	Change	Asmt.
GVL1.3.12	<p>B Responsibility for developing, reviewing and revising the organization’s quality improvement plan is clearly assigned.</p> <p>Guidance: This should be a responsibility of the medical director and may be delegated in collaboration with other governance leaders and should be outlined in the documented process.</p>	1, 12	B	New	F
GVL1.3.13	<p>B Responsibility for approving the organization’s quality improvement plan is clearly assigned.</p> <p>Guidance: This is typically a responsibility of the governing body in collaboration with the executive leadership and should be outlined in the documented process.</p>	1, 12	B	New	F
GVL1.4	The governing body ensures that the organization has a defined process to develop, review, update and approve policies and procedures for its key functions.				
GVL1.4.1	<p>B There is a documented process for developing, monitoring and revising the organization’s policies and procedures.</p> <p>Guidance: This applies to policies and procedures required in accordance with the NHMSFAP accreditation standards and to other policies and procedures related to the organization’s key operational and clinical functions. The process should include circulating drafts and revisions for review to ensure it covers all relevant information and perspectives.</p>	1, 15	B	New	F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.4.2	<p>B Policies and procedures not related to clinical operations are reviewed within defined timeframes.</p> <p>Guidance: This pertains to policies and procedures developed by the organization which are above and beyond those required by the accreditation standards, policies, rules, procedures and guidelines for the NHMSFAP. Policies and procedures should be reviewed and updated on a regular basis and in response to identified risks or changes in legislation, regulation or organizational processes. The review timeframes are determined by the organization and specified in the process for developing, monitoring and revising policies and procedures which are not related to clinical operations.</p>	1, 15	B	New	F
GVL1.4.3	<p>B Responsibility for developing, reviewing and revising policies and procedures not related to clinical operations is clearly assigned.</p> <p>Guidance: This responsibility should be specified in the organization's governance policy. Policies and procedures may be reviewed and revised by different roles (e.g. nurse manager, MDRD lead) or departments (e.g. accounting, human resources) within an organization.</p>	1, 15	B	New	F
GVL1.4.4	<p>B Responsibility for approving policies and procedures not related to clinical operations is clearly assigned.</p> <p>Guidance: This responsibility should be specified in the organization's governance policy. Policies and procedures should be approved by an appropriate leader.</p>	1, 15	B	New	F
GVL1.4.5	<p>M Responsibility for developing, reviewing and revising the policies and procedures required in accordance with the NHMSFAP accreditation standards is clearly assigned.</p> <p>Guidance: Policies and procedures may be developed, reviewed and revised by different clinical leaders (e.g., nurse leader, MDRD lead) or departments (e.g. accounting, human resources) within the organization.</p>	1	L	New	P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.4.6	<p>M Clinical practice policies and procedures are developed using current standards, protocols and guidelines.</p> <p>Guidance: These policies and procedures list the reference standards, protocols and/or guidelines adopted and/or used to develop the organization's policies and procedures.</p>	1	M	New	P, F
GVL1.4.7	<p>M Policies and procedures required in accordance with the NHMSFAP accreditation standards are reviewed every two years.</p> <p>Guidance: These policies and procedures must be reviewed every two years at a minimum and should be reviewed more frequently to ensure their currency with changes in legislation, regulation and accreditation standards. These reviews are documented.</p>	1	M	REVISED Fr. 1 to 2 yrs.	F
GVL1.4.8	<p>M Policies and procedures required in accordance with the NHMSFAP accreditation standards are reviewed and updated in response to changes in legislation, regulation and accreditation standards.</p> <p>Guidance: Reviews and updates in response to changes in accreditation standards are documented and occur proximal to NHMSFAP notifications of updates.</p>	2	M		F
GVL1.4.9	<p>M The medical director is responsible for approving the policies and procedures. required in accordance with the NHMSFAP accreditation standards.</p>	1	L		P, F
GVL1.4.10	<p>M The medical director is responsible for the re-approval and any revisions to the policies and procedures required in accordance with the NHMSFAP accreditation standards.</p>	2	L		P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.4.11	<p>M New and revised policies and procedures are communicated to staff.</p> <p>Guidance: The organization has a process for communicating new and revised policies and procedures to staff such as a communication log, email broadcast or quality management system read and sign. Documentation of the notification is on file.</p>	15	M		P, F
GVL1.4.12	<p>M Outdated policies and procedures are retained for a minimum period of 16 years.</p> <p>Guidance: Outdated policies and procedures are retained for a minimum period of 16 years from the date they are replaced/retired. Organizations should also seek their own legal advice on retention periods for policies and procedures as they may recommend a longer retention period.</p>	9	L		F
GVL1.4.13	<p>M Policies and procedures documents are identified with a title.</p> <p>Guidance: The title identifies the subject and type of document, e.g. clinical governance policy, patient discharge procedure.</p>		M		P, F
GVL1.4.14	<p>B Policies and procedures are identified with a version number.</p> <p>Guidance: First edition documents are typically identified as version 1.0.</p>		B		F
GVL1.4.15	<p>M Policies and procedures are identified with a (revision) date.</p> <p>Guidance: First edition documents are typically dated with their original (effective) date and following revision, include a revision (second) date.</p>	15	M		P, F
GVL1.5	The organization has a clear and formal governance structure.				

No.	Description	Reference	Risk	Change	Asmt.
GVL1.5.1	<p>M The governing body is responsible for establishing an effective governance structure.</p> <p>Guidance: The governing body (or ownership) ensures an effective governance structure and resources are in place to provide safe and quality medical-surgical services.</p>	1, 12	M		P, F
GVL1.5.2	<p>M The governance structure is appropriate for the organization’s size, scope and complexity of operations.</p> <p>Guidance: As a general principle, governing bodies (board, owner) govern and management manages. However, the roles and responsibilities of governing bodies may be different depending upon the organization’s size, scope and complexity of operations. The continuum of governing bodies ranges from a working board (part oversight, part management), to a management board (less doing but highly involved in operational decisions), to a policy board which sets the organization’s strategic direction and then assigns the operations/management to an executive leader.</p>	1, 22	M		P, F
GVL1.5.3	<p>M The governance structure of the organization is documented.</p> <p>Guidance: There is an organizational diagram, chart, plan, report or other document that outlines the components of the organization’s governance structure, the leader/position/body responsible (e.g., board, owner, executive officer, committee) for each area/component of the governance structure and lines of authority. Governance structure components may include strategic and service planning, clinical governance, risk management, finance, quality improvement, human resource management, infrastructure management and partner engagement. The corporate governance structure should identify the organization’s regulatory relationship with the NHMSFAP.</p>	1, 12	M		P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.5.4	<p>M The governing body is identified on the organizational chart.</p> <p>Guidance: Governing bodies may include an owner, ownership/shareholder group or board.</p>	1	L		P, F
GVL1.5.5	<p>M The senior executive officer is identified on the organizational chart.</p> <p>Guidance: In small organizations with a working or management board, the senior executive officer and governing body may be the same person.</p>	1	L		P, F
GVL1.5.6	<p>M The medical director is identified on the organizational chart as responsible and accountable for the clinical governance and clinical operations of the organization.</p> <p>Guidance: Clinical governance includes clinical risk management and safety and quality of care including quality improvement. In small organizations with a working or management board, the governing body, senior executive officer, and medical director may be the same person.</p>	1, 2	M		P, F
GVL1.5.7	<p>M The leadership position responsible and accountable for financial management is identified on the organizational chart.</p> <p>Guidance: Good clinical governance relies on having the resources necessary to provide safe and quality care.</p>	1	L	New	P, F
GVL1.5.8	<p>M The leadership positions responsible and accountable for other components of the governance structure are identified on the organizational chart.</p> <p>Guidance: These may include strategic and service planning, human resource management, infrastructure management and partner engagement.</p>	1	L	New	P, F
GVL1.5.9	<p>M Lines of accountability are clearly indicated on the organizational chart.</p>	1	M		P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.5.10	<p>M The medical director is responsible and accountable to the governing body.</p> <p>Guidance: This accountability is clearly indicated on the organizational chart.</p>	1	M		P, F
GVL1.5.11	<p>M The medical director is responsible and accountable to the organization’s senior executive officer.</p> <p>Guidance: This accountability is clearly indicated on the organizational chart.</p>	1	M		P, F
GVL1.5.12	<p>M The medical director is responsible and accountable to the NHMSFAP Committee.</p> <p>Guidance: This accountability is clearly indicated on the organizational chart.</p>	1, 2	M		P, F
GVL1.5.13	<p>M The organizational chart reflects the current governance structure.</p> <p>Guidance: The organizational chart is reviewed and updated as changes occur.</p>		L		P, F
GVL1.5.14	<p>M The organizational chart is dated.</p>		L		P, F
GVL1.6	The roles and responsibilities of the governing body and the governance leaders are clearly defined.				

No.	Description	Reference	Risk	Change	Asmt.
GVL1.6.1	<p>M The role and responsibilities of the governing body are clearly defined.</p> <p>Guidance: The roles and responsibilities of the governing body are documented in governance policy, terms of reference and/or letter of appointment and should include setting the organization’s strategic direction and establishing a strong safety and quality culture, endorsing the organization’s governance structure, overseeing management/leadership performance, monitoring organizational performance and ensuring organizational accountability.</p>	1, 13	M	New	P, F
GVL1.6.2	<p>M The roles and responsibilities of the medical director are clearly defined.</p> <p>Guidance: The roles and responsibilities of the medical director are documented in governance policy, job description or letter of appointment. These include clinical governance responsibilities such as evidence-informed treatments and care, policies and procedures, risk management, quality improvement, credentialing and privileging, education and training, patient safety incident review and clinical operation responsibilities.</p>	1, 2	M		P, F
GVL1.6.3	<p>M The role and responsibilities of the leadership position accountable for the financial management of the organization is clearly defined.</p> <p>Guidance: Financial management includes the planning, monitoring, organizing and controlling of the monetary resources of the organization.</p>	1	L	New	P, F
GVL1.6.4	<p>B Financial management decisions of the organization consider the safety and quality of care.</p>	13, 14	B	New	F
GVL1.6.5	<p>M The roles and responsibilities for other components of the governance structure are clearly defined.</p> <p>Guidance: Other components of the governance structure may include strategic and service planning, human resource management, infrastructure management and partner engagement.</p>	1	L	New	P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.7	The organization has a clear and formal clinical leadership structure.				
GVL1.7.1	<p>M The clinical leadership structure is appropriate to the organization's size, scope and complexity of operations.</p> <p>Guidance: The clinical leadership structure must be comprised of at minimum a medical director. Organizations with an anesthesiologist(s) on staff will also have a head of anesthesia as part of their clinical leadership team. A nurse leader to lead the nursing team is also strongly recommended for all organizations.</p>	1	H		P, F
GVL1.7.2	<p>M The clinical operations leadership structure of the organization is documented.</p> <p>Guidance: There is a diagram, chart, plan, report or other document that outlines the clinical operations leadership roles of the organization.</p>	1, 12	H		P, F
GVL1.7.3	<p>M There is a head of anesthesia to organize and direct the anesthesia services.</p> <p>Guidance: Organizations with an anesthesiologist(s) on staff must identify a head of anesthesia as part of their clinical operations leadership team. It is recognized that in smaller organizations, individuals can fulfil more than one role (e.g. if the medical director is an anesthesiologist, they may also be the head of anesthesia).</p>	1, 8	H		P, F
GVL1.7.4	<p>M There is a nurse leader to lead the nursing team of the organization.</p> <p>Guidance: Nursing teams may span many areas or departments such as pre-admission, admission, procedural/surgical rooms and post- anesthesia care.</p>	1	H	New	P, F
GVL1.7.5	<p>M Lines of accountability of the clinical operations leaders are clearly indicated on the organizational chart.</p>	1	M		P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.7.6	<p>M The head of anesthesia is responsible and accountable to the medical director.</p> <p>Guidance: This accountability is clearly indicated on the organizational chart.</p>	1	M		P, F
GVL1.7.7	<p>M The nurse leader is responsible and accountable to the medical director.</p> <p>Guidance: This accountability is clearly indicated on the organizational chart.</p>	1	M		P, F
GVL1.7.8	<p>M Interrelationships between clinical operations leaders and departments are clearly indicated on the organizational chart.</p>	1	M		P, F
GVL1.7.9	<p>M The lines of accountability are appropriate to the organization's size, scope and complexity of operations.</p>	1	H		P, F
GVL1.7.10	<p>M The organizational chart reflects the current clinical operations leadership structure.</p> <p>Guidance: The organizational chart is reviewed and updated as changes occur.</p>		L		P, F
GVL1.7.11	<p>M The organizational chart is dated.</p>		L		P, F
GVL1.7.12	<p>B The governing body endorses the clinical leadership structure of the organization.</p> <p>Guidance: This could be documented in the organization's governance policies or the header/footer of the organizational diagram.</p>	12	B	New	F
GVL1.8	<p>Clinical operations leadership roles and responsibilities are clearly defined.</p>				

No.	Description	Reference	Risk	Change	Asmt.
GVL1.8.1	<p>M The role and responsibilities of the head of anesthesia are clearly defined.</p> <p>Guidance: In collaboration with the medical director, the head of anesthesia ensures that anesthesia services are provided by qualified and competent physicians, that the anesthesia services are organized, that anesthetic-related policy and procedures are established and followed and monitors the professional performance of anesthesia staff as well as the quality of anesthetic care provided at the facility. The head of anesthesia also has medical administrative responsibility for the post-anesthesia care unit. This may be documented in a clinical governance policy, job description or letter of appointment.</p>	1, 8	M		P, F
GVL1.8.2	<p>M The role and responsibilities of the nurse leader are clearly defined.</p> <p>Guidance: The roles and responsibilities of the nurse leader are documented in governance policy, job description or letter of appointment.</p>	1, 10	M		P, F
GVL1.8.3	<p>M The medical director (or delegated clinical operations leader) ensures that each patient is evaluated before the day of the procedure to allow for the appropriate work-up and ensure the patient is appropriate for the non-hospital setting</p> <p>Guidance: Conformance with the NHMSFAP Pre-admission Evaluation and Selection standard is demonstrated.</p>	1	H		P, F
GVL1.8.4	<p>M The medical director (or delegated clinical operations leader) ensures appropriate operating/procedure room management including scheduling, efficiency and post-operative stay needs.</p> <p>Guidance: This includes the date and time slot for the procedure, the required procedure/operating room, surgeon, anesthesiologist, perioperative nurses and post-anesthesia care.</p>	1, 27	H		P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.8.5	M The medical director (or delegated clinical operations leader) ensures continuity of care for all patients following a procedure at the facility.	1, 2	H		P, F
GVL1.8.6	M The medical director (or delegated clinical operations leader) ensures appropriate staffing qualifications for the safe delivery of care.	1	H		P, F
GVL1.8.7	M The medical director (or delegated clinical operations leader) ensures the appropriate staffing levels for the safe delivery of care.	1	H		P, F
GVL1.8.8	M The medical director (or delegated clinical operations leader) ensures appropriate materials and equipment management to meet the needs of the scheduled procedures.	1	H		P, F
GVL1.8.9	B The medical director (or delegated clinical operations leader) ensures staff are provided with appropriate supervision, support and guidance. Guidance: This is also evidenced by a clinical leadership structure that is appropriate to the organization’s size, scope and complexity of operations.	1	B	New	F
GVL1.8.10	B The medical director (or delegated clinical operations leader) monitors and resolves workload issues. Guidance: Workload monitoring measures may include volume of patients, length/type of surgery, patient turnover, nurse-to-patient ratios and direct care time and should monitor workload at the unit/department level and individual health-care provider level.	1	B	New	F
GVL1.9	Clinical governance promotes high-quality and safe care by requiring staff to use current accepted evidence-based standards, protocols and guidelines in their clinical practice.				

No.	Description	Reference	Risk	Change	Asmt.
GVL1.9.1	<p>M The organization provides staff with access to current clinical practice guidelines.</p> <p>Guidance: Clinical guidelines may include decision support tools, pathways and clinical care standards and guidelines such as the Operating Room Nurses Association of Canada (ORNAC), the association of perioperative Registered Nurses (AORN), National Association of PeriAnesthesia Nurses of Canada (NAPAN), Canadian Anesthesiologists' Society (CAS), Choosing Wisely Canada etc. Access may be through electronic or paper copies or outlined in a policy document with web-addresses and online subscription access information.</p>	1, 12, 19	M	New	P, F
GVL1.9.2	<p>M Clinical practice policies and procedures have been developed using or are adopted from textbooks, peer-reviewed literature or standards, guidelines and best-practices by international, national or provincial bodies.</p> <p>Guidance: Clinical practice policies and procedures need to list the references used or adopted in their development. This requirement should be outlined in the process for developing, monitoring and revising the organization's policies and procedures for clinical practice.</p>	1, 12, 19	M		P, F
GVL1.10	Service planning provides direction for human resource planning, capital expenditure planning and service continuity and expansion.				
GVL1.10.1	<p>B The organization has a planning process for the provision of services which is informed by patients, medical staff, clinical operations leaders and other external health partners.</p> <p>Guidance: The planning process may relate to the scope of services, volume of services and/or desired patient experience. The planning process should consider what is needed to deliver and maintain that scope and/or volume of services and/or patient experience. Other external health partners may include CPSBC, health authorities or other service users/contract partners.</p>	1	B		F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.10.2	B The services planning process considers the professional practice recommendations, staff levels and skill mix required to meet the needs of the services provided.	1	B	New	F
GVL1.10.3	B Information on the range of services offered by the organization is publicly available. Guidance: The organization should have established arrangements for communicating with patients and external health partners about the services offered. This information could be posted on the organization's website.	1	B	New	F
GVL1.10.4	M Information made publicly available on the range of services offered by the organization is congruent with the organization's scope of accreditation. Guidance: The organization's scope of accreditation is set out on its NHMSFAP certificate of accreditation.	1	M	New	P, F
GVL1.10.5	B Information on how to access the services offered by the organization is publicly available. Guidance: This information could be posted on the organization's website.	1	B	New	F
GVL1.10.6	B There is policy and procedures for notifying the NHMSFAP of changes to the provision of services. Guidance: The medical director is required to notify the NHMSFAP of changes to the provision of services as outlined in the NHMSFAP Addition of New Programs, Additional Procedures or New Contract policy and other changes such as to the level of anesthesia, medical director appointment, facility ownership, discontinuing accredited services and/or facility closure.	2, 6	B	New	F
GVL1.11	Effective patient care coordination is essential to safe and quality care.				

No.	Description	Reference	Risk	Change	Asmt.
GVL1.11.1	<p>B The organization has a process to support the coordination of services within and between departments.</p> <p>Guidance: This process should support a smooth, safe and efficient patient journey from pre-admission right through post-discharge follow-up as well as the coordination necessary within and between departments for the delivery of safe and quality care.</p>	1	B		F
GVL1.11.2	<p>B The organization has a process to support the coordination of services with external health partners.</p> <p>Guidance: External health partners may include patients, medical staff with privileges at the facility, medical staff with designate/continuity of care responsibilities, health authorities and other service users/contract partners.</p>	1	B		F
GVL1.11.3	<p>B There is policy and procedures for the intake and processing of procedure bookings.</p> <p>Guidance: Procedure bookings may come in from various external health partners such as from the offices of medical staff with privileges at the facility, the health authority or other service users/contract partners. A standardized process for the transfer of patient information between the organization and its external health partners promotes optimal communication, patient safety and efficiency.</p>	1, 23	B	New	F
GVL1.11.4	<p>B There is policy and procedures for preparing, editing and communicating the operating/procedure room slate.</p> <p>Guidance: A standardized process for the preparation, editing and communication of the slate between the organization and its external health partners and within and between departments of the organization promotes optimal communication, patient safety and efficiency.</p>	1	B	New	F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.11.5	B There is policy and procedures for determining and scheduling the appropriate staffing and staffing levels for the safe delivery of care.	1	B	New	F
GVL1.11.6	B There is policy and procedures for determining and ensuring the appropriate materials and equipment are available for the scheduled procedures.	1	B	New	F
GVL1.12	<p>Risk is managed through a risk management framework that includes both reactive and proactive processes.</p> <p>Guidance: A risk management framework is the high-level overview or foundation for designing, implementing, monitoring, reviewing and continually improving risk management within an organization.</p>				
GVL1.12.1	<p>B The organization uses a risk management framework to identify and manage major and significant clinical and non-clinical risks.</p> <p>Guidance: Major risks are those which have more than minor consequences should they occur and have a moderate or higher chance of occurring. Significant risks are those which are sufficiently important and therefore warrant attention. The risk management framework should include the scope, objectives and criteria for assessing risk, the identification of risk management responsibilities and functions, staff training, a list of identified strategic, operational and financial risks, processes for reporting risks to the governing body, a summary of risk plans for major risks to the organization and processes for communicating with stakeholders.</p>	1, 20	B	New	F
GVL1.12.2	<p>M There is a risk management plan.</p> <p>Guidance: The risk management plan outlines the organizations risk management process and approach to handling risk such as the methods used to identify, analyze and prioritize risk, roles and responsibilities in monitoring and managing risk, what to do if a risk materializes and how risks should be communicated with key stakeholders.</p>	1, 20	M	New	P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.12.3	<p>M There is a risk management policy.</p> <p>Guidance: The policy should outline the vision, principles and objectives of the risk management system and the processes for implementing and monitoring the risk management system such as responsibilities, resources, outcomes and how outcomes will be measured.</p>	1, 16, 20	M	New	P, F
GVL1.12.4	<p>M There is a risk register.</p> <p>Guidance: The risk register is a live document that lists all identified risks (clinical and non-clinical) to the organization and the organization’s analysis of those risks (i.e. risk assessment). Key risk areas to consider include clinical care, leadership, facility infrastructure, finances, information management, external relations and regulatory compliance. Each risk is assigned a likelihood of the risk occurring and impact if the risk was to occur which determines the severity of the risk. Each risk should be assigned a ‘risk owner’ who is responsible for managing, monitoring and ensuring that the appropriate accountability arrangements are in place. The risk register is reviewed regularly (such as quarterly) and updated as risks change.</p>	1, 16, 20	M	New	P, F
GVL1.12.5	<p>B A senior leader is assigned accountability for each risk.</p> <p>Guidance: Members of the governing body and clinical governance team, such as the medical director, are considered senior leaders.</p>	20	B	New	F
GVL1.13	Groups of patients and procedures that have a high risk of harm are identified and processes are in place to mitigate these risks.				

No.	Description	Reference	Risk	Change	Asmt.
GVL1.13.1	<p>M The organization has conducted a risk assessment to identify characteristics that define groups of patients that are known to be high-risk.</p> <p>Guidance: The organization needs to identify groups of patients that may be at greater risk of harm, or who are more likely to have a poor health-care experience such as because of their condition, age, gender identity, socio-economic circumstances, cultural background, religion, preferred language spoken or sexuality.</p>	1, 18	M	New	P, F
GVL1.13.2	<p>M The risk register lists the groups of patients that are known to be high-risk and the processes to mitigate this risk.</p>	1, 18	M	New	P, F
GVL1.13.3	<p>M The risk register outlines the processes in place to mitigate the risks to the groups of patients that are known to be high-risk.</p> <p>Guidance: The mitigation processes on the risk register should be supported through policies and procedures.</p>	1, 18	M	New	P, F
GVL1.13.4	<p>M The organization has conducted a risk assessment to identify procedures that are known to be high-risk.</p> <p>Guidance: Factors to consider in identifying high-risk procedures may include but are not limited to the type of anesthesia, malignant hyperthermia susceptibility, length of procedure, procedure and/or equipment complexity (i.e. x-ray imaging, laser), need for prolonged recovery stay, procedures involving specimens or implants and seriousness of post-operative infection should it occur.</p>	1, 18	M	New	P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.13.5	<p>M The risk register lists the procedures that are known to be high-risk.</p> <p>Guidance: Procedures listed may be a named procedure (e.g. abdominoplasty) or may be a group of procedures or processes such as medical device reprocessing, procedures involving specimens, procedures involving implants, medication administration that utilizes multi-dose vials etc.</p>	1, 18	M	New	P, F
GVL1.13.6	<p>M The risk register outlines the processes in place to mitigate the risks of the procedures that are known to be high-risk.</p> <p>Guidance: The mitigation processes on the risk register should be supported through policies and procedures.</p>	1, 18	M	New	P, F
GVL1.14	Patient safety and quality incidents are recognized, reported, investigated and this information used to improve safety and quality systems.				
GVL1.14.1	<p>M There is policy and procedures for patient safety incident and near miss management.</p> <p>Guidance: The policy and procedures for patient safety incident and near miss management outline the process for reporting, investigating, analyzing what happened, implementing recommended actions and monitoring their effectiveness and sharing what was learned. Adoption of the Canadian Incident Analysis Framework is recommended.</p>	1, 4, 7	M		P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.14.2	<p>M Patient safety incidents and near misses are investigated and analyzed.</p> <p>Guidance: The medical director along with the analysis team shares responsibility for conducting, coordinating and reporting on each patient safety incident or near miss investigation and analysis. The investigation, including interviews, should begin as soon as reasonably possible after the incident or near miss. The analysis should include a description of the incident or near miss, how and why it happened to determine contributing factors and recommended actions for improvement in processes or systems. A comprehensive analysis should be completed for incidents that result in or near misses that could have resulted in major harm and/or significant risk of harm. A brief analysis should be reasonable for incidents with a low risk of harm. Adoption of the Canadian Incident Analysis Framework is recommended.</p>	1, 2, 4, 7, 17, 26	H		P, F
GVL1.14.3	<p>M Recommended actions for improvement arising from the patient safety incident and near miss analysis are implemented and their effectiveness monitored.</p> <p>Guidance: Effective recommended actions address the risk associated with the finding identified during the analysis and utilize the most effective solution that is reasonable given the circumstances (i.e. high leverage vs. low leverage options for change). Adoption of the Canadian Incident Analysis Framework is recommended.</p>	1, 4, 17	H		F
GVL1.14.4	<p>M There is a patient safety incident and near miss reporting framework.</p> <p>Guidance: The reporting framework clearly identifies the data to be reported at each level of the organization and timelines for reporting.</p>	7, 17, 26	H		P, F
GVL1.14.5	<p>M Patient safety incidents and near misses are reported to the medical director.</p>	7	H		P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.14.6	<p>M Patient safety incidents and near misses requiring mandatory reporting are reported to the NHMSFAP on a form approved by the NHMSFAP committee.</p> <p>Guidance: The NHMSFAP Patient Safety Incidents Reporting Policy lists the patient safety incidents requiring mandatory reporting. The organization’s policy and procedures for patient safety incident and near miss management include reference to PSI requiring mandatory reporting and the required reporting form.</p>	1, 2, 7	H		F
GVL1.14.7	<p>M Patient safety incidents requiring mandatory reporting are documented in a log.</p> <p>Guidance: The PSI mandatory reporting log includes the name of the patient, the licensee(s) who performed the procedure, the date of the incident, the nature of the incident and the outcome. The log should also include the date the PSI report was submitted to the NHMSFAP and the date the PSI file was closed by the NHMSFAP (i.e. date of NHMSFAP PSI Panel Letter stating no further action is required).</p>	1, 2, 7	L		P, F
GVL1.14.8	<p>M There is policy and procedures for disclosing a patient safety incident to the patient.</p> <p>Guidance: The policy and procedures for patient disclosure should outline the circumstances for when disclosure should take place, how to prepare for disclosure, what to disclose and when, roles and responsibilities in disclosure, documentation and follow-up. The most responsible physician should be the one to lead the disclosure discussion. Adoption of the Canadian Disclosure Guidelines: Being Open with Patients and families is recommended.</p>	1, 3, 5, 26	M	New	P, F

No.	Description	Reference	Risk	Change	Asmt.
GVL1.14.9	<p>M Patients are informed about safety incidents that they are affected by.</p> <p>Guidance: The organization should have a disclosure policy or process. The disclosure policy or process should outline when disclosure should take place, who should participate in the disclosure and what should be disclosed. Further disclosure discussions may be necessary as the reasons for the incident are better understood or questions arise.</p>	1, 3, 5, 26	M	New	P, F

References

1. International Society for Quality in Health Care External Evaluation Association. Guidelines and principles for the development of health and social care standards [Internet]. Version 1.1. Geneva (CH): International Society for Quality in Health Care External Evaluation Association; 2022 Mar [cited 2023 Mar 21]. 60 p.
2. College of Physicians and Surgeons of British Columbia. Bylaws [Internet]. Vancouver: College of Physicians and Surgeons of British Columbia; 2009 [revised 2023 Jan 13; cited 2023 Mar 21]. 109 p.
3. College of Physicians and Surgeons of British Columbia. Practice standard: disclosure of adverse or harmful events [Internet]. Version 2.0. Vancouver: College of Physicians and Surgeons of British Columbia; 2014 May 1 [revised 2022 June 23; cited 2023 Mar 21]. 4 p.
4. Incident Analysis Collaborating Parties. Canadian incident analysis framework. Edmonton (AB): Canadian Patient Safety Institute; 2012 [cited 2023 Mar 21]. 148 p.
5. Canadian Patient Safety Institute, Disclosure Working Group. Canadian disclosure guidelines: being open with patients and families [Internet]. Edmonton (AB): Canadian Patient Safety Institute; 2011 [cited 2023 Mar 21]. 52 p.
6. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Policy: addition of new programs, additional procedures or new contracts [Internet]. Version 1.1. Vancouver: College of Physicians and Surgeons of British Columbia; 2023 Mar 25 [cited 2023 Mar 25]. 2 p. Document No.: 10786.
7. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Policy: patient safety incidents reporting [Internet]. Version 4.1. Vancouver: College of Physicians and Surgeons of British Columbia; 2023 Mar 25 [cited 2023 Mar 25]. 3 p. Document No.: 11098.
8. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: anesthesia [Internet]. Version 1.2. Vancouver: College of Physicians and Surgeons of British Columbia; 2023 Mar 24 [cited 2023 Mar 25]. 20 p. Document No.: 10785.
9. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: medical records and documentation [Internet]. Version 4.1 Vancouver: College of Physicians and Surgeons of British Columbia; 2023 Mar 24 [cited 2023 Mar 25]. 27 p. Document No.: 10829.
10. College of Physicians and Surgeons of British Columbia, Non-Hospital Medical and Surgical Facilities Accreditation Program. Accreditation standards: human resources [Internet]. Version 5.1. Vancouver: College of Physicians and Surgeons of British Columbia; 2023 Mar 24 [cited 2023 Mar 25]. 52 p. Document No.: 10820.

11. Australian Commission on Safety and Quality in Health Care. National model clinical governance framework [Internet]. Sydney (AU): Australian Commission on Safety and Quality in Health Care; 2017 Nov [cited 2023 Mar 21]. 44 p.
12. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service standards: user guide for governing bodies [Internet]. 2nd ed. Sydney (AU): Australian Commission on Safety and Quality in Health Care; 2019 Mar [cited 2023 Mar 21]. 67 p.
13. Australian Commission on Safety and Quality in Health Care. Clinical governance standard: governance, leadership and culture [Internet]. Sydney (AU): Australian Commission on Safety and Quality in Health Care; c2023. Governance, leadership and culture: Action 1.01; c2023 [cited 2023 Mar 21].
14. Australian Commission on Safety and Quality in Health Care. Clinical governance standard: governance, leadership and culture [Internet]. Sydney (AU): Australian Commission on Safety and Quality in Health Care; c2023. Organisational leadership - action 1.05; c2023 [cited 2023 Mar 21].
15. Australian Commission on Safety and Quality in Health Care. Clinical governance standard: patient safety and quality systems [Internet]. Sydney (AU): Australian Commission on Safety and Quality in Health Care; c2023. Policies and procedures - action 1.07; c2023 [cited 2023 Mar 21].
16. Australian Commission on Safety and Quality in Health Care. Clinical governance standard: patient safety and quality systems [Internet]. Sydney (AU): Australian Commission on Safety and Quality in Health Care; c2023. Risk management - action 1.10; c2023 [cited 2023 Mar 21].
17. Australian Commission on Safety and Quality in Health Care. Clinical governance standard: patient safety and quality systems [Internet]. Sydney (AU): Australian Commission on Safety and Quality in Health Care; c2023. Incident management systems and open disclosure - action 1.11; c2023 [cited 2023 Mar 21].
18. Australian Commission on Safety and Quality in Health Care. Clinical governance standard: patient safety and quality systems [Internet]. Sydney (AU): Australian Commission on Safety and Quality in Health Care; c2023. Diversity and highrisk groups - action 1.15; c2023 [cited 2023 Mar 21].
19. Australian Commission on Safety and Quality in Health Care. Clinical governance standard: clinical performance and effectiveness [Internet]. Sydney (AU): Australian Commission on Safety and Quality in Health Care; c2023. Evidence-based care - action 1.27; c2023 [cited 2023 Mar 21].
20. Health Insurance Reciprocal of Canada (HIROC). 21 questions: guidance for healthcare boards on what they should ask senior leaders about risk [Internet]. Toronto (ON): HIROC; 2018 Apr [cited 2023 Mar 23].
21. Health Standards Organization (HSO); Canadian Patient Safety Institute. The Canadian quality & patient safety framework for health services [Internet]. Ottawa (ON): HSO; c2020 [cited 2023 Mar 21].

22. Ontario Hospital Association, Governance Centre of Excellence. Guide to good governance [Internet]. 3rd ed. Toronto (ON): Ontario Hospital Association; [cited 2023 Mar 21].
23. Association of periOperative Registered Nurses (AORN). Guidelines for perioperative practice. 2021 ed. Denver, CO: AORN; 2021 Feb 4. Team communication; 35 p.
24. Association of periOperative Registered Nurses (AORN). Guidelines for perioperative practice. 2021 ed. Denver, CO: AORN; 2021 Feb 4. Safe patient handling and movement; 98 p.
25. Hospital foundation operational plan template [Internet]. Brisbane (AU): Queensland Government; c1995-2023 [cited 2023 Mar 21]. 4 p.
26. Canadian Patient Safety Institute. Patient safety culture 'bundle' for CEO's/senior leaders [Internet]. Edmonton (AB): Canadian Patient Safety Institute; 2018 Jan [cited 2023 Mar 21]. 1 p. 27. Denton BT, editor. Handbook of healthcare operations management: methods and applications [Internet]. New York: Springer; 2013 [cited 2023 Mar 23]. 541 p.

Revision history

Date	Revisions
March 21, 2013	<ul style="list-style-type: none"> NHMSFAP Governance and Leadership standard approved (version 1.0)
September 14, 2023	<ul style="list-style-type: none"> Substantial content revisions to reflect governance and leadership best practices (version 2.0) New standards template
November 27, 2024	ISQuaEEA Logo (no content changes) (version 2.1)
April 1, 2026	Transcribed to new template (no content changes) (version 2.2)