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MEASURING
& IMPROVING QUALITY

STANDARD

Healthcare organisation certification for quality of care

2025 version

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Certification of quality of care: “Joint involvement of patients and healthcare professionals”

Certification – a mission entrusted to the HAS (the French National Authority for Health) by law since 1996 – is a procedure that evaluates the quality and safety of care in public and private healthcare organisations. It is carried out by HAS-mandated professionals (peers) known as surveyors. This procedure, independent of the organisation and its governing bodies, relates to the level of quality and safety of care delivered to patients. This is evaluated over the course of a survey of the organisation in relation to collectively defined national objectives set by healthcare professionals and service users.

- **Being certified for Quality of Care** means considering **the patients' point of view on their experience** in the healthcare organisation.
- **Being certified for Quality of Care** means **evaluating outcomes**, not only in terms of the patient's health but also in terms of their experience while in the organisation (reception, information provided, coordination of the teams in their care, their discharge, etc.).
- **Being certified for Quality of Care**, means **adopting a pragmatic approach** which empowers the teams to organise their practices to achieve the targeted results using the methods they deem most appropriate.
- **Being certified for Quality of Care** means being able to **call on the HAS for assistance** to perform self-assessment.
- **Being certified for Quality of Care** means asserting with pride that the teams provide patient-centred care. **For each of the professionals, it is recognition of their commitment to the continuous improvement of the quality and safety of care** (and that their individual work directly contributes to this).

However:

- **A certification is not an inspection.**
- **Certification is not a ranking of hospitals and clinics.**
- **Certification does not interfere with the other regulatory assessments applicable to healthcare organisations (COFRAC, ASN, DDPP, etc.).**

Among the methods used to measure quality of care in healthcare organisations, **certification is the only national mechanism in France that provides a comprehensive framework for the external analysis and assessment of quality of care.**

By stimulating a healthcare organisation's specific improvement pathways, it acts as a lever to mobilise healthcare professionals and user representatives.

The procedure is based on international standards: the HAS itself is assessed by the International Society for Quality in Health Care (ISQua) via the International Accreditation Program (IAP) for the accreditation of healthcare organisations. In February 2023, the HAS was accredited by ISQua for the quality and safety of care for the overall healthcare organisation certification procedure (standard, organisation for certification deployment, surveyor training programme). This international recognition is a guarantee of the rigour and quality of the HAS’ programme and is a mark of trust, leading other organisations in other French-speaking countries to voluntarily enter into agreements with the HAS to be assessed in accordance with the French method and standard. The French certification standard has been transposed to take into account the specific characteristics of these countries.

Evolving constantly for the past 25 years…

The healthcare organisation certification process began 25 years ago. It was part of a general aim – in France and internationally, in the health field and other sectors of activity – to make production processes as safe as possible. It was also in response to a legitimate expectation for greater transparency in relation to the quality of the service provided, for patients and their representatives, for public authorities and for healthcare professionals. It has helped drive a collective process aimed at improving quality and safety.

The process has evolved constantly over time, with each iteration building on the achievements of the previous one to introduce new objectives, methods, or requirements.

The first version of the procedure dates from June 1999. It helped to develop the culture of quality and safety of care and to engage healthcare organisations in a continuous improvement process.

The second iteration of the certification procedure, launched in 2005, introduced the assessment of professional practices in care units.

The third iteration (known as V2010) established greater rigour in terms of patient care and risk management and placed an emphasis on essential requirements, through priority required practices.

V2014 was developed to enhance the ability of healthcare organisations to identify and control their risks on an ongoing basis. It introduced the patient-centred assessment method, with the tracer patient method, and mobilised healthcare organisation managers around quality and safety of care issues.

Finally, quality and safety of care certification aims to assess the results of healthcare organisations' quality and safety of care process, and their capacity to improve while maintaining the progress made.

Moreover, the introduction of financial incentives to improve quality in the financing arrangements of healthcare organisations in 2017, and the incorporation of certification results within this framework, give financial recognition to certification decision levels.

… since 2021, healthcare organisation certification has been undergoing significant transformation...

The HAS Board has set out three aims for the continuous development of the new certification.

Medicalise certification and take better account of patient care outcomes

Providing patients with quality care is the prime objective of healthcare personnel. The certification process must therefore be relevant for care teams. This means that the process must focus on aspects that are meaningful for them: their practices and patient outcomes in terms of effectiveness, safety and satisfaction.

The objectives of the standard and its quality-of-care criteria are defined by consensus, are easy to share, and are in line with the requirements of day-to-day good practice.

Simplify all aspects of the certification process

To facilitate the adoption of the process, the certification is being simplified by:

- giving greater **autonomy** to healthcare organisations in terms of their organisational methods;
- putting the priority on **outcomes** rather than the ability to comply with processes.

Pragmatic assessment methods close to the experience on the ground:

- providing healthcare organisations with methods and tools to enable them to carry out a self-assessment under survey-like conditions if they so wish;
- summary assessment reports;
- a standard that can be adapted to the specificities of each healthcare organisation;
- certification **results** that are clear for everyone.

Recognise local integration of healthcare organisations and care pathway construction.

The certification should recognise the efforts made by an organisation to improve the quality and safety of the patient care pathway within its local area, close to where the patients live, with greater attention paid to their needs and choices. The quality of the patient pathway requires coordinated action on the part of numerous players (those involved in prevention, health promotion, healthcare, medico-social care, and social care) and covers the key health factors.

… in keeping with today's challenges in terms of quality

Developing patient engagement

There has been a complete change in patient positioning. **While exercising patients' fundamental rights remains a critical prerequisite for the quality and safety of care, the positioning of patients as stakeholders in their own care must be widely promoted as a factor in the effectiveness of the care. It is a question of fostering the emergence of the patient as a:**

- partner of healthcare professionals in their individual care. Shared decision-making in terms of the patient's care pathway, their role in their care and expression of their point of view in terms of patient experience and outcomes are crucial for the quality of patient care and represent key factors for their successful recovery, remission, or cure;

- partner of healthcare organisations on a collective level. Patient engagement via an array of initiatives (expert patient, peer, etc.) in professional training, and patient and carer information and training supplement the action and role of user representatives in organisations.

Developing a culture focused on evaluating the appropriateness of the care and its outcome

To accompany the gradual adoption of the quality approach culture by healthcare organisations, it has been structured in several stages and initially focused on the establishment of quality procedures and processes. This necessary step represents a means and not an end in itself. It is now necessary to move away from a means-based approach to a results-based approach, maximising the appropriateness and quality of the care delivered. The appropriateness issue is important, since – according to experts – some 25 to 30% of examinations or procedures are estimated to be unnecessary, leading to many avoidable risks or adverse events. **The process of analysis of the relevance (i.e. examining the appropriateness of prescriptions of procedures, medicinal products, medical devices, hospital stays) and outcomes of their practices by care teams is central to this new certification process.** Teams' commitment to analysing their practices in order to improve appropriateness and outcomes will be assessed.

Developing teamwork, a driving force for improving practices

Patient care is now largely carried out in a multidisciplinary, multiprofessional framework, linked to the chronicity, complexity and increasingly technical nature of care. Therefore, it is rare for a professional to act alone in a patient's care. Coordination between the various players during treatment is a key aspect in the quality of care and in reducing risks. Analysis of serious adverse event reports reveals that a lack of teamwork is a factor in the occurrence of one in four events. The new certification process takes this factor into account, with respect to both teams within the healthcare organisation and the other players involved in the patient care pathway.

Adapting to changes in the healthcare system

Changes in the healthcare system, whether medical, economic, social, or linked to health crises, lead to a greater need for local structuring: the healthcare chain is becoming increasingly interdependent and requires careful coordination between all the players involved to ensure effective and cost-efficient care for patients throughout their pathway. Local coordination between the players involved in care provision in the health and medical-social sectors, in non-hospital settings, in the home and in healthcare organisations is encouraged through public policies as a guarantee of healthcare system quality. On a healthcare organisation scale, this involves ensuring local coordination between the organisation's roles, the population's needs and local healthcare provision, and promoting a smoother flow in care and health pathways.

These new challenges can only be met if the resources in terms of technical facilities and professional expertise are aligned with the roles of each healthcare organisation within the local care provision.

The standard

The standard is the cornerstone of the certification procedure. It lists the criteria to be met by the healthcare organisation and all the details required for their proper understanding and assessment. This approach facilitates the adoption of the standard:

- by professionals as well as user representatives, who can refer to the standard to carry out their own assessment in an autonomous way and use it as a tool for the continuous improvement of quality;
- by surveyors, as a reference document for conduct of the survey.

This standard is the result of concerted development and co-construction between the HAS and healthcare professionals, supervisory bodies and user representatives.

In accordance with the provisions of the certification procedure published in the French Official Journal, this standard describes the various aspects of the certification system:

- the requirements, divided into chapters, objectives and assessment criteria;
- the assessment methods used;
- the decision-making process.

To take into account changes in the healthcare system and feedback from healthcare organisations, and in consultation with all the stakeholders, this standard is updated every year.

A standard built around 12 objectives divided into three chapters: the patient, the care teams, and the healthcare organisation

To fulfil the goals and requirements, the certification standard is structured into three chapters: the patient, the care teams, and the healthcare organisation. Each chapter consists of a limited number of objectives, in turn broken down into criteria.

Chapters	Objectives
Chapter 1 The patient	**1.1 –** Respecting patient rights
	1.2 – Patient information
	1.3 – Patient engagement in their care plan
	1.4 – Involvement of patients and their representatives in the life of the healthcare organisation

The first chapter pertains directly to the outcome for the **patient**. Throughout their care, their rights are respected and their specific needs are taken into account, along with their expectations and preferences. Beyond this, the patient's engagement is sought. Their involvement as a partner in their care, and that of their relatives and carers, is fostered by enabling them to express their point of view on their experience and care outcome.

Chapters	Objectives
Chapter 2 The care teams	**2.1 –** Coordination of patient care teams
	2.2 – Control of practice-associated risks
	2.3 – Safety in units with major risks (emergency departments, surgical and interventional sectors, maternity units, critical care, emergency medical services and mobile emergency units, mental health and psychiatry, etc.)

	2.4 – The culture of appropriateness and assessment

The second chapter focuses on the **care teams,** at all levels. The goal of the certification is to assess their ability to strive for appropriateness, effectiveness and safety of care, and to consult and coordinate throughout the patient's pathway. It also places an emphasis on care-related risk control.

Chapters	Objectives
Chapter 3 The healthcare organisation	**3.1 –** Global management through the quality and safety of care
	3.2 – Proficient use of professional resources and skills
	3.3 – Local positioning
	3.4 – Adaptation to eco-responsible care and digital innovations

The third chapter concerns the **healthcare organisation** and its governance (facility management and medical board/committee). The organisation promotes local integration in liaison with the other players involved in health and medical-social care provision. It leads a strong drive to improve the quality and safety of care, uniting and supporting teams, as well as patients, user representatives and patient associations.

This structuring allows cross-analysis between the outcome for the patient, the practices implemented by the care teams and the impetus given by governance. The objective is to build an integrated vision of the level of quality of care within a healthcare organisation.

A modular standard that can be adapted based on the healthcare organisation's activities

The standard contains 86 generic criteria applicable to all healthcare organisations, and 32 specific criteria linked to fields of application relating to:

- populations: children and adolescents, elderly patients;
- care methods: hospitalisation at home (HAH)
- sectors of activity: emergency medical services and mobile emergency units, surgery and interventional procedures, maternity care, critical care (category encompassing adult and paediatric general and specialised intensive care), mental health and psychiatry, electroconvulsive therapy, medical and convalescence care), long-term care (LTC) units, radiotherapy.

Each healthcare organisation is assessed on generic criteria, applicable to the entire organisation, and on the specific criteria applicable to it.

A standard comprising criteria with three requirement levels:

- 92 **standard** criteria that correspond to the expectations of the certification;
- 21 **essential** criteria that correspond to fundamental requirements in any healthcare organisation. If the assessment of one of these criteria is negative, the HAS reserves the right to refuse to grant certification to the organisation; this could have an impact on the decision level.
- 5 **advanced** criteria that correspond to desirable situations, but which are not currently enforceable. They correspond to potential future standard criteria.

Practical steps of the certification procedure

For each organisation, the procedure involves four stages.

1	2	3	4
Engagement in the procedure	**Assessment and dissemination of results**	**Decision**	**Publication**

① **Engagement in the certification procedure**	**INITIALLY**		**ANNUALLY**
	HCO Engagement	**HAS** Integration of healthcare organisation data	**HCO** Validation of updated HCO data
② **Assessment**	**BETWEEN 2 SURVEYS**		
	HCO Internal assessment(s)		
	YEAR OF THE SURVEY		
	HAS – HCO Ongoing preparatory HAS <-> HCO discussions	**HAS** Communication of expert team 3 months before the survey	**HAS** Survey
③ **Decision**	**HAS** Transmission of the survey report to the HCO 15 days after the survey	**HCO** Transmission of observations 1 month following receipt of the report	**CCES** Certification decision After observations
④ **Publication and dissemination of results**	**HAS** Notification and dissemination of the report decision		**HCO** Possibility of formulating an appeal 2 months following receipt of the decision
	CERTIFIED With or without distinction	**CONDITIONAL CERTIFICATION**	**NOT CERTIFIED**

Joining the programme and personalising the approach

Except in the case of a specific agreement with the HAS, the procedure is initiated by the legal entity.

The healthcare organisation will then receive its user ID and password. It will have access to all the tools required to perform its own self-assessment (optional), track its procedure, and view the results of its assessments and certification reports.

The entity's legal representative designates the administrator of the procedure in Calista. Under the authority of the head of the healthcare organisation, the administrator:

- validates the organisation's data on the required dates;
- gives access rights to selected professionals and patient representatives.

This initial stage also involves identifying the healthcare organisation's profile, which makes it possible to define:

A standard that adapts to the specificities of each organisation

- the standard's specific criteria applicable to the healthcare organisation. In fact, the generic criteria are applicable to all organisations, while the specific criteria depend on their activities, the types of care they provide, or the type of population cared for;
- the number and methods of assessment that will be performed during the survey (number and profiles of tracer patients, tracer pathways, etc.).

The healthcare organisation's profile includes data for each of its geographical sites.

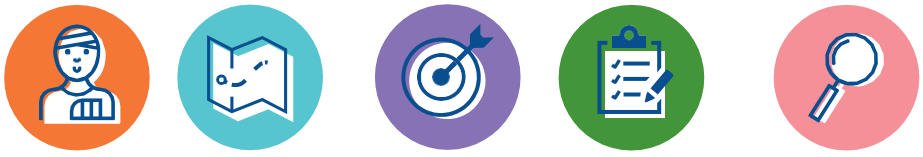
Calista: a collaborative platform

Healthcare organisations, as well as all their designated professionals and user representatives, have access, via CALISTA, to all the tools and information they need for their procedures:

- their customised standard;
- certification-related news;
- documents to be shared (organisation project, organisation chart, etc.);
- the results of their internal assessments;
- their survey schedule;
- their certification reports;
- etc.

Assessment methods close to the reality on the ground

Each criterion is assessed using one or more of the following five methods:



The tracer patient | The tracer pathway | The targeted tracer method | The system audit | Observation

These methods are used by the HAS surveyors during the certification survey. They may also be used by the healthcare organisation's assessors, if they so wish, for their own internal assessment. In the following paragraphs, the term assessor refers to surveyors as well as to the healthcare organisation's internal assessor.

Tracer patient

Meeting involving the patient and the care team

The tracer patient method assesses the quality and safety of the care provided to a patient in the healthcare organisation. It records the experience of the patient and/or that of their family, subject to the patient's prior consent.

The assessor meets the patient. The assessor then talks with the team in charge of the patient's care.

For external assessments, this method is only used by surveyors who are also physicians.

Tracer pathway

Assessment of the coordination of departments

The tracer pathway method assesses the continuity and coordination of patient care, as well as teamwork. It also assesses the quality and safety of care culture. The assessor meets the care teams involved in the care.

Supported by a professional, the assessor then goes through the patient's physical care pathway. Hence, to complete the assessment, the assessor meets the teams involved in the selected pathway, and patients.

Targeted tracer

Assessment on the ground of implementation of a process

The targeted tracer method consists in the on-the-ground assessment of the actual implementation of a process. The assessment starts at ground level and works its way up to the process, if malfunctions are observed. To do this, the assessor meets the teams, examines the required documents and conducts the relevant observations.

During a survey, the surveyors assess several targeted tracers: medicinal and healthcare product circuit, prevention of healthcare-associated infections, management of adverse events, emergency medical services and mobile emergency units, isolation and restraint, electroconvulsive therapy, interventional sectors and transfusion.

System audit

Strategy assessment all the way to ground level

A system audit consists in assessing a process to ensure it is under control and able to fulfil the objectives. The assessment starts with the process and works its way down to on-the-ground verification of its actual implementation by professionals. To do this, the assessor first examines all the components making up the process. Then, the assessor meets with management, the chairperson of the Medical Committee, the Head of Care, or equivalent, the persons in charge of a specific unit, and user representatives. Finally, the third and last step consists in assessing, with professionals and their medical and paramedical supervisors, how the process is applied on the ground.

Observations

A method implemented throughout the survey

Observations are conducted during each tracer assessment. They are based on a list of points that can be observed directly on the ground, such as: respect for the patient's dignity and privacy (no nude patients, doors closed, etc.), accessibility of the premises (access ramps, lifts, signs, etc.), control of the risk of infection (professionals' clothing, closed containers, box for sharps, etc.).

In practice

Each method is set out in an assessment grid that covers the assessment items of all the generic and specific criteria, of the target under assessment.

For example, a tracer patient assessment grid for an 81-year-old tracer patient cared for on a day hospitalisation basis includes – in addition to the "tracer patient" assessment items for generic criteria – the "tracer patient" assessment items for the specific criteria relating to elderly patients and the "tracer patient" assessment items for the specific criteria relating to outpatient care.

Calista: a tool to generate assessment grids

For a full assessment, the grids filled in must cover all the assessment items of all the criteria applicable to the healthcare organisation.

These grids are structured according to the target patients to be interviewed or the observations to be conducted.

Methods	Interview			Perusal		Observations
	Patient	Team	Governance	Patient record	Other documents	
Tracer patient	●	●		●		●
Tracer pathway	●	●		●		●
Targeted tracer		●	●		●	●
System audit		●	●		●	

The assessor fills in the grid given to them:

- "Yes" indicates satisfaction with the assessment item;
- "No" indicates dissatisfaction with the assessment item;
- "NA" indicates that the assessment item is not applicable to the situation assessed;
- "RI" indicates that the patient's response is inappropriate.

Outcome-centred assessment

The responses in each grid are aggregated per assessment item for each criterion. For each assessment item, a percentage ratio is calculated: number of positive assessments/number of assessments. "Not Applicable" or "Response Inappropriate" responses do not affect the result obtained.

The multiplication of grids by the various assessors thus ensures the robustness of the results.

The result allocated to a criterion is the average of the results allocated to its assessment items. The result allocated to an objective is the average of the results allocated to its criteria. The result allocated to a chapter is the average of the results allocated to its objectives.

The healthcare organisation's overall score is the average of the results of chapters 1 to 3 of the standard.

The results for advanced criteria are excluded from this score.

As certification is more centred on patient outcomes, quality and safety of care indicators (IQSS) have become a marker of the improvement dynamic of healthcare organisations. The results of the indicators focusing on all or part of the requirements of an assessment criterion are mobilised. On the one hand, this involves assessing the effectiveness of data collection/sharing/analysis/processing and the implementation of improvement plans; on the other hand, it involves assessing the consistency of the results of the assessments with the indicators.

Internal assessment by the healthcare organisation

The internal assessment helps the healthcare organisation to:

- **facilitate the adoption** of the standard **by professionals**;
- **assess its own performance** with respect to the standard's criteria applicable to it.

In order not to sap professionals' energy and divert it from concrete achievements that directly benefit patients, healthcare organisations are no longer required to transmit their internal assessment to the HAS.

External assessment carried out by surveyors

Surveyor teams are:

- multiprofessional and composed of surveyors from different healthcare organisations. They must include a physician;
- led by a coordinator appointed and trained by the HAS in this role, in view of their knowledge of the procedure and their teaching, organisational and management skills;
- sized according to the size of the healthcare organisation, the geographic location of the sites to be assessed, and the number and type of assessments to be carried out;
- sometimes reinforced with tracer patient-centred physicians for the tracer patient method;
- since January 2024, teams have been systematically supported by digital technology expertise.

Surveyors are chosen according to:

- the number of physicians, caregivers or administrators required;
- the healthcare organisation's status, activities, sectors, types of care provided and context;
- their expertise in the healthcare organisation's activity sectors, and their availability with regard to the scheduled survey date;
- any interests they may have reported in their public declaration of interests.

To form the teams, the HAS takes into account the following aspects:

- surveyors conduct their surveys in a geographic area located more than 50 km around their place(s) of work (current or dating back more than 5 years);
- surveyors do not participate in any surveys conducted in healthcare organisations in which they have worked or have had direct interests over the previous 5 years, since this could place them in a conflict of interests situation;
- surveyors only conduct surveys in healthcare organisations that are outside the parent group of the healthcare organisation in which they work.

Preparation of the survey

The healthcare organisation is informed of the date of the survey and composition of the team of surveyors at least three months before the survey. The healthcare organisation's legal representative can ask for the disqualification of one or more surveyors.

The survey programme is drawn up by the HAS in collaboration with the coordinator in accordance with the healthcare organisation's profile (activities, results of other external assessments: indicators, inspections/controls, conclusions of previous certification surveys). It lists all of the assessments to be carried out (methods used and persons interviewed). A schedule sets out their timetable.

The preparation of the survey is finalised through a video conference involving the healthcare organisation's administrative, medical and paramedical governance, the survey coordinator and, if applicable, the HAS representative.

The survey

A survey takes between three and five days and is conducted by two to eight surveyors and one coordinator, depending on the healthcare organisation’s activities, its capacities and the number of attached sites, etc.

In addition to the assessment sequences, a survey is punctuated by various opportunities for discussion between the healthcare organisation and the surveyors: opening meeting, schedule-setting phases, progress reports, end-of-study assessment and plenary report. An additional opportunity for exchange may also be organised during the survey by the coordinator, in consultation with the healthcare organisation, to discuss assessments of essential criteria which have not met the expected performance level and that have led to the drafting of an anomaly report sheet.

For essential criteria, if the assessment does not achieve the expected performance level, an “anomaly report sheet” is produced. This describes the facts observed by the surveyors, specifying how the expectations of the standard have not been met. The surveyors' analysis is shared with the healthcare organisation and is intended to inform the certification committee's decision.

The post-survey period

Two weeks after the survey, the healthcare organisation receives the survey report, composed of:

- the results of the assessments conducted by the surveyors;
- per-chapter summaries;
- anomaly report sheets, if any.

The summaries are a qualitative assessment of quantitative results, highlighting deviations and/or satisfaction of expected requirements or the excellence of the levels achieved.

Upon receipt of the survey report, the healthcare organisation may draft its observations.

The HAS bases its decision on the surveyors' survey report and the healthcare organisation's observations.

The decision

The HAS' decision is notified in the certification report, which is made up of the following:

Introduction	Summarises the key components of the certification procedure regarding quality of care in healthcare organisations, its objectives and the survey methods used.
Certification results	Shows the certification decision validated by the HAS Board.
Presentation of the healthcare organisation	Gives a brief presentation of the main characteristics of the healthcare organisation.
Presentation of the results	- Gives the overall score, in terms of meeting the requirements of the standard for certification decisions. - Provides, for each chapter of the standard, the relevant summaries, the quantitative results for each objective and the related charts.

The HAS bases its decision on:

- the gap between the expected results (target = 100%) and the results achieved for the chapters, objectives and criteria, particularly the essential criteria;
- the existence of practices and/or organisational methods that pose a risk to patients and/or professionals;
- the recurrence of failings mentioned during previous certifications or confirmed by the value of the quality and safety of care indicators (IQSS);
- the criticality of any anomalies found in relation to the essential criteria;
- the observations made by the healthcare organisation.

The HAS can issue three types of decision:

- a certification decision valid for four years, which may be accompanied by a distinction;
- a non-certification decision involving the implementation of a new procedure within a period defined by the HAS depending on the criticality of the deviations observed, and within a maximum of two years;
- a conditional certification decision: a new procedure is then scheduled within a period defined by the HAS depending on the criticality of the deviations observed, and within a maximum of two years; At the end of this second procedure, the HAS decides whether the healthcare organisation has met the conditions required to be certified. It then issues a certification decision, with or without distinction, or, failing this, a non-certification decision.

Publication and dissemination of results

Public dissemination accessible to users

The certification report is published on the HAS website www.has-sante.fr (Qualiscope).

The healthcare organisation must ensure the internal dissemination of the certification report. In particular, it must bring it to the attention of:

Dissemination within the healthcare organisation

- the decision-making body and the Medical Committee;
- the User Committee;
- the public, by displaying the badge associated with its certification level in reception areas. It may also display the badge on its communication media (social media, letterhead, electronic signature).

Moreover, the healthcare organisation should inform hospital patients of the certification results.

Informing of supervisory authorities

The certification results cannot be communicated before the publication of the certification report on the HAS website.

At the end of the procedure, the HAS ensures that the certification reports of each healthcare organisation are accessible and transmits them to the competent regional health agency.

The criteria

Chapters	Objectives	Criteria	Scope of application	Page
1. The patient	1.1 Respecting patient rights	Criterion 1.1-01 The patient's privacy and dignity are respected within a safe environment	Entire organisation	27
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		Criterion 1.1-06 Patients receive compassionate care	Entire organisation	32
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		Criterion 1.2-04 In preparation for their discharge, patients are provided with follow-up instructions concerning their care	Entire organisation	40
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Chapters	Objectives	Criteria	Scope of application	Page
2. The care teams		Criterion 2.2-07 The organisation promotes patient self-administration of medicines during hospitalisation (PAAM)	Entire organisation	84
		Criterion 2.2-08 Teams comply with standard hygiene precautions	Entire organisation	85
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		Criterion 2.3-02 The pre-hospital records of mobile emergency units contain all the required information for the continuation of patients' care	Emergency medical services and mobile emergency units	93
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Chapter 1.
The patient

Objective 1.1
Respecting patient rights

Patients have rights, which are enshrined in law and summarised in the Hospital Patients' Charter. Respecting patients' rights in a healthcare organisation is one of the pillars of their care. The aim is to ensure that special attention is paid to making sure patients' dignity and privacy are guaranteed, along with the confidentiality of their personal data, and, more generally, that they are treated with kindness. These rights aim to protect patients' autonomy while strengthening the relationship of trust with teams.

Criterion 1.1-01 The patient's privacy and dignity are respected within a safe environment

The organisation puts in place measures guaranteeing respect for the patient's privacy and dignity in all circumstances, particularly for patients in rooms with several beds (availability of sanitary facilities, etc.), those waiting in hallways, those under restraint (accessibility of patient call button, etc.), the cleanliness and maintenance of premises, etc. Patients are treated with due respect and spared any inappropriate words or attitudes on the part of professionals (placing of bed in lowered position, etc.). Great care must be taken to avoid the infantilisation of patients during their care. Professionals must be particularly attentive to this if the patient has a disability (physical, mental or sensory) or is a vulnerable elderly person. Finally, the organisation's equipment and services must be effectively accessible to patients and their families (appropriate waiting areas, properly equipped rooms, specialised equipment, and appropriate communication methods). Information (e.g. signs) must also be accessible to the patient.

Entire organisation **Essential**

Assessment items

Patient • From the patient's viewpoint, the conditions surrounding their admission and care have respected their dignity, privacy and integrity. • From the patient's viewpoint, external access ways, patient pathways, consultation rooms, hospital rooms, signs, etc. all allow easy movement.	Tracer patient
Observations • Practices guarantee the patient's dignity, privacy and integrity. • The premises guarantee the patient's dignity, privacy and integrity. • The equipment guarantees the patient's dignity, privacy and integrity. • People, particularly those with physical, mental or sensory disabilities, can easily access and move around the healthcare organisation.	Observation

To support you	
Educational sheets	Emergencies – SAMU/SMUR Elderly patients Critical Care People with disabilities
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.1-02 Minor patients benefit from a suitable environment

Children and adolescents are cared for in an environment specifically designed to meet their needs in a healthcare organisation. Minors should not be hospitalised in an adult ward. However, any exceptions must be subject to suitable measures for the estimated duration of the hospital stay, in a dedicated space, with trained professionals and an environment that ensures the safety and well-being of children and adolescents. The presence of parents provides essential support for children but must take into account the care plan. During their hospital stay, children and adolescents benefit from play and educational activities appropriate to their age group (books, board games, play techniques to provide support in the operating theatre, etc.). For older adolescents, whenever possible, their wishes should be taken into consideration concerning the type of ward in which they are to be hospitalised.

Entire organisation **Essential**

Assessment items

Professionals • In services caring for minor patients, either regularly or occasionally, good practices related to the specific characteristics of this care are applied. • For minor patients, the parents' round-the-clock presence is organised, unless otherwise advised by the doctor. • During a hospital stay, minor patients have access to age-appropriate play and educational activities.	Tracer pathway
Observations • When minors are hospitalised in an adult ward, the environment and premises should be adapted to ensure their privacy, dignity and safety are respected.	Observation

To support you

Educational sheets	Children and adolescents Interventional sectors

Criterion 1.1-03 Patient and medical confidentiality are respected

Protection of patient confidentiality is a fundamental right of all patients in the context of their care. It guarantees the confidentiality of the personal and medical information shared with healthcare professionals. This principle makes it possible to protect the patient's privacy by prohibiting the unauthorised disclosure of data concerning them, unless there is a legal exception. Regular checks are carried out on access to patient records, in order to identify any access that could be fraudulent or unauthorised. Access controls may only be overridden in an emergency situation. Medical confidentiality strengthens the relationship of trust between patients and caregivers, something that is essential for good quality care. Professionals must ensure that patient confidentiality is respected, but without compromising the safety of their care. A hospital patient may refuse all visits and ask that their presence be kept secret.

Entire organisation **Standard**

Assessment items

Patient • From the patient's point of view, patient and medical confidentiality is respected throughout their stay.	Tracer patient
Governance • The healthcare organisation raises awareness of the issue of unauthorised access to patient records among professionals, along with the risks these entail and the sanctions that may be imposed. • The healthcare organisation controls unauthorised access to patient records, which constitute a breach of medical confidentiality. **Professionals** • Professionals are aware of the risks resulting from unauthorised access to patient records and the resulting sanctions that may be imposed.	System audit
Observations • Professionals respect patient and medical confidentiality.	Observation

To support you

Educational sheet	Telehealth Global management through the quality and safety of care
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.1-04 Patients are given appropriate information about their right to provide advance directives in writing

Providing advance directives in writing is a right. Healthcare professionals inform patients that they have the option to draw up advance directives, and explain their usefulness, particularly in situations where they are unable to express their care choices. They can also provide patients with support when writing these directives, answering questions about the different treatment options and helping them to formulate their wishes clearly and precisely. Non-hospital healthcare professionals play a crucial role in the drafting of advance directives, particularly in supporting patients in a local, ongoing follow-up context. Healthcare organisations and non-hospital professionals work together to inform patients and raise their awareness.

Entire organisation **Standard**

Assessment items

Professionals • The team informs the patient of their right to provide advance directives in writing.	Tracer patient
Professionals • The team knows how to approach the issue of collecting advance directives, depending on the profile of the patients cared for. • The team can call on an internal or external resource to support them in their role of collecting advance directives. • If the patient has drawn up advance directives, these can be accessed in the patient record by all professionals involved in the patient's care. A refusal to draw them up is also recorded.	Tracer pathway
Governance The healthcare organisation works with its external correspondents to inform patients, prior to hospitalisation, of the importance of drawing up advance directives.	System audit

To support you

Educational sheets	Intra-hospital pathway Emergencies – SAMU/SMUR Critical Care People with disabilities

Criterion 1.1-05 Patients are provided with care aimed at anticipating or relieving their pain quickly

Any person under the care of a healthcare professional should be able to benefit from regular and appropriate assessment of their pain, whether this is acute or chronic. The patient is the only one who can describe the intensity of their pain. It is therefore essential to adapt the assessment scale to the patient's situation (patient with a disability or who is vulnerable, participation of families, etc.). Anticipating and effectively managing pain not only preserves patients' dignity, but also improves their quality of life and recovery. Healthcare professionals therefore have an obligation to adapt treatments and use the most appropriate techniques to provide rapid and lasting relief from suffering. Assessments and reassessments are noted in the patient's record; where applicable, the results make it possible to adapt the patient's care.

Entire organisation **Essential**

Assessment items

Patient

- Patients are encouraged to express their pain as soon as they feel it or are likely to feel it, and until the pain has subsided and there is an improvement in their well-being and/or their quality-of-life.

Professionals

- Pain anticipation and relief measures, assessed using an appropriate scale, are indicated in the patient record.
- Pain reassessments are documented in the record, enabling adjustment of treatment if required.
- Professionals offer non-medicinal pain management methods.

Tracer patient

To support you

Educational sheets	Children and adolescents Maternity – perinatal People with disabilities
Quality and safety of care indicators (IQSS)	e-Satis Assessment of pain management

Criterion 1.1-06 Patients receive compassionate care

Compassionate care is one of the fundamental principles of patient care, aimed at guaranteeing the respect, dignity and well-being of each individual. It is a culture that involves all players in a healthcare organisation: patients and their families, user representatives, healthcare professionals and supervisory teams, governance of the healthcare organisation, etc. Compassionate care involves not only high-quality medical care (reception, pain management, etc.), but also special attention to communication (announcement of a diagnosis, etc.), personalised support and respect for patient autonomy (hydration, nutrition, toilet assistance, hygiene, etc.). This includes active listening and the absence of any form of ill-treatment, as well as the creation of a reassuring and calming environment. Promoting the compassionate care of patients and their families is inseparable from the well-being of professionals (availability of appropriate equipment, training, care protocols, etc.) and the recognition of actions to enhance quality of work life in the healthcare organisation (prevention of risks in the event of understaffing, staff turnover, regular changes of supervisors, etc.).

Entire organisation **Essential**

Assessment items

Professionals • The patient's autonomy in terms of their basic needs is assessed, even in high-pressure work situations. **Patient** • Throughout the care pathway, the patient's basic needs have been tended to, even in high-pressure work situations. • From the patient's point of view, professional practices are compassionate, even in high-pressure work situations. • All those involved in a patient's care introduce themselves and explain their role to the patient.	Tracer pathway
Professionals • The team identifies any risks that could adversely affect compassionate care and takes action to improve where required. • The team knows how to report any potential internal ill-treatment situations.	System audit

To support you

Educational sheets	Intra-hospital pathway Elderly patients People with disabilities
Patient Safety Flash	Heatwave: people hospitalized and housed in medico-social establishments. Keep patients cool before they suffer the consequences Periods of vulnerability. No vacancy(s) for safety

Criterion 1.1-07 The management of external ill-treatment is organised

The management of ill-treatment suffered by patients outside the organisation is an imperative for healthcare organisations. Whether it concerns physical, psychological, verbal or institutional ill-treatment, healthcare professionals have an obligation to take rapid action to protect patients. Healthcare professionals draw on good practice guidelines and ill-treatment situation detection tools (clinical assessment, screening table, interview, etc.). Any suspected or known ill-treatment must be reported to the relevant bodies, to ensure the safety and dignity of the victims. An investigation must be carried out to assess the facts and take the necessary measures, whether in terms of medical, psychological or legal support. The introduction of prevention and awareness-raising systems is also essential to limit these situations. The institutional measures to prevent ill-treatment will primarily include paying attention to the patients' experience, particularly for vulnerable, isolated patients or those with communication difficulties.

Entire organisation **Standard**

Assessment items

Governance

- Governance performs an annual inventory of cases of external ill-treatment (in particular via the French Medical IT Programme database (PMSI)) and it sends this assessment to the User Committee.
- The healthcare organisation makes sure the system for reporting and following up the management of external ill-treatment situations detected is operational.
- The healthcare organisation protects professionals who blow the whistle on cases of external ill-treatment.

Professionals

- Professionals are aware of situations involving factors/risks of external ill-treatment, in particular for vulnerable or potentially at-risk persons (domestic violence, minors, etc.) in order to promote their detection.
- Professionals apply procedures for detecting, reporting and handling situations of external ill-treatment supported by good practice guidelines and detection tools.

System audit

To support you

Educational sheets	Emergencies – SAMU/SMUR Children and adolescents Critical Care

Criterion 1.1-08 Patients have access to their records within the legal time frames

Within the framework laid down by the regulations, patients or their legal representatives or, if the patient is deceased, their rights-holders, are entitled to see and obtain a copy of the patient's medical records. By law, patients can request access to their records, and healthcare organisations are obliged to provide this within strict time frames (8 days to 2 months if the record dates back more than 5 years). Healthcare organisations are responsible for informing patients of this right.

Entire organisation **Standard**

Assessment items

Patient • The patient knows that they can have access to their records.	Tracer patient
Governance • The healthcare organisation arranges access to the patient's records by patients and their rights-holders unless the patient has advised otherwise. • The healthcare organisation provides support for patients wishing to consult their records. • The regulatory timeframes for handing over patient records are met. • Where appropriate, the healthcare organisation implements improvement measures to follow up on the analysis of delays in transmitting patient records.	System audit

To support you	
Educational sheets	Global management through the quality and safety of care

Criterion 1.1-09 There is an appropriate procedure for dealing with the death of a patient and providing support to their family

A death in hospital is a difficult time, requiring an appropriate approach that takes into account the emotional burden on the patient's family. During this time, it is important to adopt a communication approach that focuses on the members of the family, ensuring they are quickly informed, listening to their concerns and addressing their needs for psychological and practical support. It is also important to respect the wishes and convictions expressed by the patient before death, for example in advance directives, and to respect the dignity of their body (presentation to the family, transfer, etc.).

Entire organisation **Standard**

Assessment items

Professionals • The professionals responsible for informing the family of a patient's death are trained to provide psychological and practical (social and administrative) support for the family and carers. In the sectors concerned, the specific conditions for perinatal bereavement support are well known. • The professionals concerned are familiar with the procedures to be followed in the event of death: the death certificate drawn up by a physician, the length of time the body remains in the care unit, management of personal belongings, etc. • Transport between the place of death and the mortuary respects the dignity of the deceased and the working conditions of professionals. • The conditions under which bodies are preserved and presented to families respect the dignity of the deceased, both in the hospital department and subsequently in the mortuary. Their wishes and convictions are respected. • The patient's primary care physician and the other professionals involved in their care are informed of their death.	Tracer pathway
Governance • In the context of its quality and care pathway improvement policy, the healthcare organisation monitors the annual number of deaths by sector.	System audit

To support you

Educational sheets	Intra-hospital pathway Emergencies – SAMU/SMUR Elderly patients Children and adolescents Maternity – perinatal Critical Care Global management through the quality and safety of care

Chapter 1.
The patient

Objective 1.2
Patient information

Patient information is a right enshrined in the relationship between patients and healthcare professionals. It is based on the principle of transparency and informed consent, guaranteeing that all individuals receive clear, comprehensible information tailored to their situation concerning their health status, the proposed treatments and the associated benefits and risks. This information must be delivered throughout the care pathway, enabling the patient to make informed decisions concerning their care. Respecting this right reinforces trust between patients and their caregivers, while ensuring that patients' autonomy is respected in terms of their choices. Insufficient or poorly communicated information can lead to misunderstandings and compromise the quality of care.

Criterion 1.2-01 Patients are given the information required for their hospital stay

To ensure that patients are cared for in a smooth and well-organised manner, they must be given information about their admission arrangements, the working rules in the healthcare organisation, the care they will receive and the healthcare professionals who will be involved in their care. The information also covers the patient's rights, such as access to their medical record, visiting hours and discharge conditions. Effectively communicating this information to patients helps them better understand their care, reduces anxiety associated with their hospital stay and facilitates their active participation.

Entire organisation **Standard**

Assessment items

Patient • As soon as an appointment is made for a consultation, patients are informed of the place, time, prior precautions, type of consultation, name of the professional, cancellation arrangements, etc. • Patients are given a paper or electronic welcome booklet, and the regulatory signage is displayed. • In addition to the welcome booklet, patients are given all the information they need before their hospitalisation: time of arrival, reminder of pre-surgery or pre-treatment requirements, administrative information, etc. • The patient has appointed a person to be contacted for their discharge or in the event of any difficulties. • The patient is aware of the safety rules and available solutions to ensure the security of their personal belongings.	Tracer patient
Observations • The patient, and/or their family and/or carers, are informed about their obligations (respect for the hospital environment, respect for staff and other users, secular charter, image rights, etc.).	Observation

To support you	
Educational sheets	Patient engagement Emergencies – SAMU/SMUR Elderly patients Maternity – perinatal Critical Care Interventionnal sectors Person with a disability
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.2-02 Patients are given the information they need for their hospital stay

Patients are entitled to clear, comprehensive and appropriate information on the essential elements of their care. That includes diagnoses, the treatments offered, the expected benefits, and the associated risks. This information, which is provided throughout the care pathway, enables patients to understand the different stages of their care and to make informed decisions in collaboration with healthcare professionals. It includes explanations about alternative treatment options and medical follow-up. Healthcare professionals must ensure that the information they give is properly understood. They must use suitable modes of communication and information, in keeping with each situation (disability, chronic illness, children/adolescents, vulnerability, etc.). Special attention must be paid to delivering bad news. The opening of the *"Mon espace santé"* platform for all users enabling access to a medical record on their personal health space that can be consulted at any time by authorised persons, and the essential need to protect health data are information to be shared with patients.

Entire organisation **Standard**

Assessment items

Patient • Patients admitted as an emergency, irrespective of the department to which they are admitted, are informed of the expected duration of their care depending on their health status, as well as all the measures put in place. • Patients are aware of their diagnosis, if one has been made, their health status, their treatments, their care, the expected duration of their treatment, where possible, etc. • For all forms of outpatient care, the patient has a document telling them about warning signs of potential adverse events and the measures to be taken if they occur ("passport"-type document for surgery and other for other activities: medicine, medical care and convalescence, psychiatry etc.). • The patient is aware of the measures needed to ensure that they are properly identified throughout their care. • The healthcare organisation informs patients that their healthcare team will update their medical record on their personal health space in the context of their care, unless they object to this, and that they can consult this record.	Tracer patient
Professionals • The team informs all patients, or their designated person of trust, of any adverse event related to a preventive, diagnostic or care activity during their treatment, of the immediate actions taken and of the analysis of the event.	Targeted tracer

To support you	
Educational sheets	Patient engagement Elderly patients Telehealth People with disabilities Medicine SMR Global management through the quality and safety of care
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.2-03 Patients are informed of the medical devices that are implanted into them during their stay and are provided with appropriate follow-up instructions

Patients are informed of any medical devices that are implanted into them during their stay. This includes an explanation of the nature of the device, how it works, the expected benefits and any risks or complications. Patients must also be informed about the follow-up measures to be taken after implantation, whether in terms of care, medical check-ups or any special precautions. Patients are given an implant card. This indicates:

- information allowing identification of the device, including the device name, serial number, lot number, UDI, device model, as well as the manufacturer's name, address and website;
- any warnings, precautions or measures to be taken by the patient or a healthcare professional with regard to reciprocal interference with reasonably foreseeable external influences, medical examinations or environmental conditions;
- any information about the expected lifespan of the device and any necessary follow-up;
- any other information intended to ensure safe use of the device by the patient, including general quantitative and qualitative information on the materials and substances to which the patients may be exposed;
- all of this information is noted in the patient's various records.

Transparent, patient-specific communication helps reinforce each patient's understanding and their engagement in monitoring their own health, while ensuring the safety and durability of the implanted device.

Surgery and interventional procedures **Standard**

Assessment items

Professionals

- The implantation of the implantable medical device, its identification and the information supplied to the patient are documented in the patient records.
- The implant card, or equivalent, containing all the information related to the implanted medical device is supplied to the patient upon their discharge.

Patient

- Prior to the implantation of the implantable medical device, the patient was given information on: the type of medical device, the expected lifespan, any follow-up required, etc.
- Patients are informed about possible complications and measures to be taken (precautions to be taken by the patient or a healthcare professional and correct use of the device) following implantation of the device.

Tracer pathway

To support you	
Educational sheets	Interventional sectors Medicine
Patient Safety Flash	Implantable Medical Devices (IMDs). Implanting without making a mistake

Criterion 1.2-04 In preparation for their discharge, patients are provided with follow-up instructions concerning their care

In preparation for their discharge, patients must be aware of the follow-up instructions required for the continuity of their care. This information should cover the care to be carried out at home, the treatments to be continued, the medical appointments to be scheduled and the warning signs to watch out for. Clear, personalised explanations are crucial to guarantee the safety and effectiveness of post-discharge care. Patients should also be informed about the resources available to them, such as the healthcare professionals they should contact if they need help, or the support services available at home.

Entire organisation **Standard**

Assessment items

Professionals

- In preparation for discharge, patients are informed of any new treatments prescribed and the need to report any adverse effects associated with the treatment, and any differences between their treatment at the time of their admission and on discharge are explained.
- In preparation for their discharge, patients are given all the post-surgical or post-treatment instructions required to detect any complications or signs warranting urgent consultation of a healthcare professional.
- In preparation for discharge, patients are given all the information they need relating to any technical procedures, additional tests, consultations, planned procedures, etc.
- Patients are told how they can call the department where they stayed directly in the event of a complication, so that they can be referred as appropriate.
- A liaison letter is given to the patient, along with explanations by a physician or another member of the care team, on the day of their discharge or the day before if they are returning home, or added to their medical record on their personal health space, unless they object to this.
- Where appropriate, in preparation for discharge, patients and their families receive advice on psychological, social and medico-social support.

Tracer pathway

To support you

Educational sheets	Patient engagement Intra-hospital pathway Emergencies – SAMU/SMUR Elderly patients Children and adolescents Maternity – perinatal Critical Care People with disabilities Medicine SMR
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.2-05 Patients are informed about the user representatives and/or non-profit associations that can support them for their return home

Patients and their families and/or carers can benefit from the help of user representatives and/or non-profit patient associations (inside or outside the healthcare organisation). These can intervene in several areas to provide information, welcome patients, provide assistance, support patients, train patients, families and professionals, provide therapeutic information and education, provide support for and access to care and entitlements. In addition, it is essential that patients are informed about the technical and human aids appropriate to their needs, such as medical devices, home help services or nursing care. This information, delivered in a clear and accessible way, enables patients to better organise their return home, to maintain their autonomy and to ensure the continuity of their care in a safe environment.

Entire organisation **Standard**

Assessment items

Patient • Patients are informed that support is available from user representatives. • Patients are informed about the structures, individuals and non-profit associations who can assist them. • Patients are given information on how to contact user representatives and associations (phone numbers, office hours, etc.).	Tracer patient
Observations • The contact details of user representatives and patient associations are easily accessible, on their website if one exists, and kept up-to-date; where applicable, information on the associations' office hours is provided.	Observation

To support you	
Educational sheet	Patient engagement
Quality and safety of care indicators (IQSS)	e-Satis

Chapter 1.
The patient

Objective 1.3
Patient engagement in their care plan

Patients' understanding, their agreement with the care, and their participation in the various stages of their care facilitate the implementation of their care plan. In numerous situations, the involvement of family and/or carers constitutes a resource for both the patient and the care team. Their ongoing presence alongside the patient and their knowledge of the patient's habits and needs – in particular if the latter has a disability, limited autonomy or a chronic condition – can be very useful in order to take the patient's specific needs into consideration in the care plan. Accordingly, subject to the patient's consent, their involvement should be encouraged.

Criterion 1.3-01 Patients express their freely-given, informed consent regarding their care plan and its procedures

Involving patients in their treatment is a guarantee of greater effectiveness and reduced risks. Freely-given, informed consent, and patient agreement and compliance with their care plan require the patient to be involved in defining the objectives of their treatment, its implementation and follow-up. This care plan is drawn up following an overall assessment, taking into account the patient's needs and preferences. It is a main thread that runs throughout the patient's care and is readjusted whenever necessary, in consultation with the patient and watching out for any potential deterioration in their mental health.

Entire organisation Essential

Assessment items

Patient

- The different options, in particular therapeutic options, along with their benefits and risks, are presented to patients so that they can express their preferences and needs and have them taken into account in their care plan.
- Patients agree with their care plan and its implementation methods (e.g. hospitalisation at home, day hospital, outpatient care, etc.).

Professionals

- An initial overall assessment (medical, psychological, social, autonomy, rehabilitation) of the patient is carried out by professionals involving the disciplines concerned and the contribution of supportive care.
- Together with the patient, the team has drawn up a care plan based on an overall assessment of the patient's situation, needs and preferences, the benefits and risks, and their usual living conditions.
- Depending on how the initial assessment evolves and any potential deterioration in the patient's mental health and vulnerability, needs and preferences, the care plan is adapted.
- The care plan is logged in the patient's records.

Tracer patient

To support you

Educational sheets	Patient engagement Elderly patients Children and adolescents People with disabilities Mental health and psychiatry SMR
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.3-02 Patients have been able to designate a person of trust

Pursuant to regulatory requirements, the patient's record must include the identification of a person of trust. The person of trust serves as a liaison between the patient and the medical team. In times of stress or uncertainty, having someone familiar with the patient's wishes and preferences helps to ensure clear and effective communication. This can make it easier to pass on crucial information about the state of the patient's health, the treatments envisaged or the medical decisions to be taken. Designating a person of trust ensures that the patient's wishes are respected, even in situations where they are unable to express their own wishes. This is particularly relevant in the event of complex medical decisions or in end-of-life situations. By having a well-informed representative, patients can be sure that their wishes are taken into account and that their autonomy is preserved. Accordingly, healthcare professionals must be able to consult the person of trust, especially when a patient has cognitive problems. This person is identified as early as possible and ahead of crisis situations, particularly in psychiatry.

Entire organisation **Standard**

Assessment items

Patient • Patients know that they can designate a person of trust. • Patients know the role played by a person of trust. **Professionals** • The individual designated as the person of trust has co-signed the written form designating them in this role. • The identity of the person of trust is documented in the patient's records.	**Tracer patient**

To support you	
Educational sheets	Patient engagement Emergencies – SAMU/SMUR Elderly patients Critical Care People with disabilities
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.3-03 Patients receive care that is appropriate to their needs

In addition to providing patients with information and involving them in therapeutic decisions concerning their care, consideration of their expectations, preferences and experience contributes to their engagement. Various actions (attitude of professionals, patient involvement in the implementation of their care, training [including formalised therapeutic education] or simply advice from professionals, such as initial help with breastfeeding for women who so wish) encourage patients' involvement and engagement in their care.

Entire organisation **Standard**

Assessment items

Patient • Patients feel involved in the implementation of their care plan, if they so wish. • Patients know what they can do to manage their care, accelerate their convalescence, and avoid complications. • Patients benefit from information, educational actions and appropriate training (including therapeutic education) that take into account their experience and promote their involvement in their care.	Tracer patient
Governance • As part of its upstream and downstream risk management approach, the healthcare organisation offers a training programme incorporating a simulation-based teaching method aimed at patients.	System audit

To support you	
Educational sheets	Patient engagement Children and adolescents SMR
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.3-04 Patients with a disability are offered a care plan designed to maintain their autonomy

Any patient with a disability can lose their autonomy in the basic activities of daily life. This loss of autonomy can be due to several interrelated factors: some are patient-related (their disease and health before hospitalisation); others are related to the care methods and the hospital environment. The patient's abilities are systematically assessed. Appropriate measures must be implemented to preserve the autonomy of hospitalised patients at every stage of their care. In order to avoid any risk of decompensation and/or deterioration in the quality of life of patients with a disability, their needs and preferences, as well as those of their family and/or carers, are taken into consideration by the teams in their care plan. This care plan is defined in a multiprofessional way and includes professionals providing supportive care.

Entire organisation **Standard**

Assessment items

Professionals • The consultation and outpatient care sectors identify the capacities of patients with disabilities and pass on the information needed to adapt their care to the hospitalisation (internal or external) sectors. • The abilities, capacities and any care deficiencies of patients with disabilities, assessed from admission to discharge, are taken into account to establish and adapt their care plan. • The care plan includes a support plan for patients with disabilities. **Patient** • Measures designed to maintain the autonomy of patients with disabilities are put in place.	Tracer pathway

To support you

Educational sheets	Intra-hospital pathway Patient engagement Person with a disability SMR

Criterion 1.3-05 Socially vulnerable patients are provided with support for referral to the appropriate social services and associations

The health and care pathway of socially vulnerable patients is closely linked to their living conditions. The care teams work in association with the professionals concerned to organise the patient's health/care pathway.

Entire organisation **Standard**

Assessment items

Professionals

- For patients who are socially vulnerable, it is important to identify any care deficiencies so that they can be dealt with.
- Teams work in association with the professionals concerned (social workers, etc.) to organise the care pathway of socially vulnerable patients.
- Social support has been offered to the patient, according to their needs.

Patient

- To organise their discharge, vulnerable patients are steered towards the appropriate social aid, if they so wish.

Tracer pathway

To support you	
Educational sheets	Intra-hospital pathway Patient engagement

Criterion 1.3-06 The family, social and school connections of minor patients are maintained throughout their stay

Maintaining the family, social and school connections of minor patients throughout their hospital stay, particularly in the event of a long stay, is a priority that must not be underestimated. Maintaining contact with their family environment and friends helps them to cope better with their treatments and overcome potential feelings of isolation. Guaranteeing educational continuity also enables young people to continue learning and developing skills that are essential for their future. By offering them an environment where these connections can flourish, in addition to providing care, the healthcare organisation gives them an opportunity to grow up in a secure environment, to feel valued and to prepare for a promising future. This holistic approach fosters the harmonious development of each child and adolescent.

Children and adolescents **Standard**

Assessment items

Patient • Parents can be involved in their child's care, particularly for young children. • For long and/or repeated hospital stays, solutions are proposed to parents in or near the healthcare organisation in order to facilitate their presence by their child's side.	Tracer patient
Professionals • In difficult clinical situations, the minor patient's siblings can be supported by trained staff. • For long and/or repeated hospital stays, educational and schooling support tailored to their needs is offered to the child or adolescent and their parents.	Tracer pathway

To support you	
Educational sheets	Patient engagement Children and adolescents Critical Care

Criterion 1.3-07 Elderly patients are offered a care plan designed to maintain their autonomy

Any elderly person may lose their autonomy in the basic activities of daily life. This loss of autonomy can be due to several interrelated factors: some are patient-related (their disease and health before hospitalisation); others are related to the care methods and the hospital environment. Appropriate measures taking into account their needs, preferences, abilities and usual living conditions, must be implemented to preserve the autonomy of hospitalised persons, including help and support with certain functions (washing, eating, etc.). The risk of iatrogenic dependency must be managed via:

- systematic assessment on admission and ongoing monitoring throughout the hospital stay;
- measures to prevent and rapidly address the six causes of iatrogenic dependency associated with hospitalisation.

Elderly patient **Standard**

Assessment items

Patient

- The needs, preferences, abilities and usual living conditions, as well as the risk of dependency of patients over 75 years of age are taken into account to establish and monitor the care plan.
- Patients over the age of 75, and their families and/or carers are aware of the risk of hospitalisation-related iatrogenic dependency.
- From the point of view of patients over the age of 75, their autonomy is maintained, except for the effects that are inherent to their care.

Professionals

- The abilities, capacities, and risk factors for dependency of patients over 75 years of age are assessed from admission to discharge.
- Measures to prevent and rapidly address risk factors for iatrogenic dependency in elderly patients over 75 years of age are implemented.

Tracer patient

To support you	
Educational sheets	Patient engagement Elderly patients

Criterion 1.3-08 Patients receiving long-term care benefit from activities that enable them to maintain their autonomy and social links

A long-term care unit is a genuine living space where the person receives care. Consequently, professionals focus on promoting not only the physical health but also the psychological and social well-being of individuals, taking into account their life course, needs and preferences. Patients receiving long-term care benefit from activities that enable them to maintain their autonomy and social links. These activities are designed to stimulate the mind, encourage interaction and enable patients to remain active in their daily lives. This not only helps to improve their quality of life, but also gives them a sense of identity and dignity, which are crucial to their well-being within the community.

Long-term care **Standard**

Assessment items

Patient • In the long-term care unit, patients are offered activities every week, in order to maintain their autonomy. • In the long-term care unit, bedbound patients are offered activities every week. **Professionals** • The long-term care unit team puts in place measures aimed at maintaining social and family links. • In long-term care units, solutions are proposed to families in order to facilitate their presence at the patient's bedside.	Tracer patient

To support you	
Educational sheets	Patient engagement Elderly patients

Criterion 1.3-09 Patients with mental health problems benefit from a care plan that promotes their social inclusion

For patients whose health status so requires, the care plan includes psychosocial rehabilitation to promote their social inclusion and boost their autonomy and quality of life (access to appropriate housing, employment, life in the community, public services, cultural/sporting activities, knowledge of mutual help groups, etc.).

Mental health and psychiatry **Standard**

Assessment items

Patient • Patients with mental health problems have expressed their expectations and specific needs in terms of social inclusion (access to appropriate housing, employment, life in the community, public services, cultural/sporting activities, knowledge of mutual help groups, etc.). **Professionals** • To promote the social inclusion of patients with mental health problems, the care plan includes a personalised support component that sets objectives for social inclusion, promotion of autonomy and improving quality of life.	Tracer patient
Professionals • The care plan, drawn up jointly with the patient, is guided by a diagnosis based on the current international classification. • Teams identify the partners they need to implement psychosocial rehabilitation plans. • Psychosocial rehabilitation care is provided in order to achieve the objectives set.	Tracer pathway
Governance • Hospital stays of more than three months in psychiatric wards are monitored using indicators (length of stay, etc.) in order to draw up an action plan aimed at reducing iatrogenesis (particularly for full-time hospitalisation) and developing rehabilitation (particularly for day hospitalisation facilities).	System audit

To support you	
Educational sheet	Patient engagement Mental Health and psychiatry Global management through the quality and safety of care
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.3-10 Patients benefit from prevention messages so they can take action to improve their health

In the field of health, prevention is partly based on raising individual awareness. To achieve this, healthcare professionals develop appropriate, personalised actions using a motivation-centred approach, in order to boost patients' ability to take action to preserve and/or improve their own health (regarding smoking, alcohol, other drugs, physical activity, nutrition, hygiene, sexual health, screening, etc.). Patients are offered an assessment of their vaccination status.

Entire organisation **Standard**

Assessment items

Patient • Patients are aware of the main risk factors associated with their disease or condition and the appropriate recommendations to preserve their health and reduce risks (regarding smoking, alcohol, other drugs, physical activity, nutrition, hygiene, sexual health, screening, assessment of their vaccination status, etc.). **Professionals** • Professionals log the risk factors and actions recommended and/or implemented. • Patients benefit from appropriate actions to improve their health and reduce risks (referral to a consultation for smoking/alcohol, other drugs, prescription of physical activity, nutrition, hygiene, sexual health, screening, vaccination status, etc.).	Tracer patient
Observations • Recent, appropriate public health (vaccination, ill-treatment, national suicide prevention helpline, organ and tissue donation, etc.) and primary prevention (smoking, alcohol, other drugs, physical activity, nutrition, hygiene, sexual health, screening, etc.) messages are available in the departments.	Observation

To support you	
Educational sheets	Patient engagement Maternity – perinatal Children and adolescents Mental Health and psychiatry SMR

Criterion 1.3-11 With the agreement of the patient, their family and/or carers are involved in their care plan

Involving the patient's support network, whether family members, friends or homecare professionals, results in a better understanding of the patient's needs, continuity of care and improved quality of life. Including these players in the care plan fosters a dynamic of emotional and physical support, which is essential for healing, rehabilitation and adaptation to daily living. The care plan drawn up with patients and their families enables clear, achievable objectives to be defined, while taking into account each person's experiences and expectations. This also requires open, honest communication between all the players involved. By creating a space where everyone can express their concerns and expectations, a solid partnership is forged that contributes to the success of care pathways.

Entire organisation **Standard**

Assessment items

Patient • If the patient agrees, their family and/or carers are involved in the implementation of their care plan (HAH in particular). **Professionals** • With the agreement of the patient, in difficult clinical situations, the presence of their family and/or carers outside visiting hours is facilitated.	Tracer patient
Professionals • In difficult clinical situations, solutions are offered to the patient's family and/or carers (bed, sanitary facilities, room to eat or relax, etc.). • In difficult situations, appropriate rooms make it possible to talk to the patient's family and/or carers in conditions that respect privacy and confidentiality.	Tracer pathway

To support you	
Educational sheets	Intra-hospital pathway Patient engagement Emergencies – SAMU/SMUR Elderly patients Critical care People with disabilities SMR
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.3-12 Patients and their families and/or carers adhere to the specific HAH arrangements

In the context of hospitalisation at home, close cooperation between healthcare professionals, patients and their families ensures that care objectives are mutually understood. Depending on their disease/condition and their needs, each patient benefits from specific care arrangements. Therefore, it is important that patients and their families and/or carers adhere to the specific HAH arrangements. This not only promotes the effectiveness of the care delivered, but also contributes to patients' general well-being, allowing them to feel safe and supported in a familiar environment. To achieve this, it is necessary to:

- provide them with specific information and support (purposes and operation of HAH, role of the coordinating physician);
- regularly assess their role in the care pathway (before admission, during follow-up and for HAH discharge);
- schedule organisational measures to help them if the need arises, in coordination with local players.

Hospitalisation at home **Standard**

Assessment items

Patient • Social and/or psychological and/or logistic assistance is offered, if needed, to family members and/or carers, at least during hospitalisation. • The hospitalisation at home plan is jointly explained to patients and their families and/or carers, and supported by information documents, in order to ensure their adherence to it. • Patients and/or their families and/or carers know who to contact at any time, including in a vital (life-threatening) emergency situation. **Professionals** • Professionals inform and support the patient in their HAH care. • If the need arises, a physician or a state-registered nurse are on call to attend to the patient round the clock.	Tracer patient
Professionals • The numbers to call are indicated in a document available in the patient's home.	Tracer pathway

To support you	
Educational sheet	Patient engagement

Chapter 1.

The patient

Objective 1.4

Involvement of patients and their representatives in the life of the healthcare organisation

In addition to patients' individual engagement in their care, the engagement of patients or their representatives can also serve the community. This individual engagement serving the community may take different forms: user representatives, patient associations, peer groups, partner patients, etc. This engagement reinforces patients' involvement in their care and helps improve the healthcare system.

Criterion 1.4-01 Patients are invited to share their experience and express their satisfaction

Quality of care can be improved by taking into consideration the perspective, feelings and experience of patients, enabling them to play a role in the improvement of hospital practices and relationships between healthcare professionals and patients. To this effect, a system is put in place for the collection and analysis of patient experience data. It is for this purpose that patients are invited to share their experience and express their satisfaction. The methods used for the collection and analysis of patient experience data can vary according to the type of care and its duration. These methods can range from questionnaires - in particular, the national e-Satis questionnaire - to regular meetings between patients and professionals. Patients can report any care-related adverse events (CRAEs). They must be informed of this possibility and of the reporting procedure. They may also be consulted by professionals to provide their viewpoint on a CRAE. In addition to providing valuable information, this approach also strengthens the bond of trust between the patient and the medical team, helping to ensure that care is increasingly appropriate.

Entire organisation **Standard**

Assessment items

Patient • Patients are aware that they can express their satisfaction and views on their experience during and after their stay (e-Satis, internal questionnaires). • Patients know that they can make a complaint or express appreciation during and after their stay. • Patients know that a mediator is available to help them in the event of communication difficulties between themselves (or their carers, companions or relatives) and the teams. • Patients are aware that they can report a care-related adverse event (CRAE). **Professionals** • The organisation has questionnaires concerning patient-reported experience measures (PREMs) in care units or technical platforms: e-Satis, satisfaction surveys, etc.	Tracer patient
Observations • The badge associated with the certification level and publicly available quality and safety of care indicator (IQSS) results, including e-Satis results, are clearly displayed in the healthcare organisation's reception areas and on its website, where applicable.	Observation

To support you	
Educational sheets	Patient engagement Elderly patients People with disabilities
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.4-02 Patient satisfaction and experience are taken into consideration

In order to guide definition of its quality and safety of care improvement policy, and its implementation via a set of actions, the healthcare organisation takes into account the results of patient-reported satisfaction and experience measures. The detailed results are analysed with professionals, and regular monitoring of the results ensures that the improvement targets set are met.

Entire organisation Essential

Assessment items

Governance

- The healthcare organisation encourages patients to take part in the various internal and national surveys, by seeking to collect email addresses for e-Satis.
- The healthcare organisation monitors and improves the participation of its patients in patient-reported satisfaction and experience surveys: monitoring of internal questionnaire submission rates, monitoring of patient feedback rates, monitoring of collection and transmission of patient e-mail addresses for e-Satis, etc.
- The quality improvement programme incorporates the improvement actions arising from analysis of patient satisfaction and experience results, as well as the contribution of user representatives.

Professionals

- The results of assessments of patient satisfaction and experience, broken down by unit, are shared with the care teams every six months (e-Satis results and comments, other internal systems).
- The team analyses its own e-Satis results and comments, or other systems to record patient satisfaction and experience, and implements improvement measures.
- When recommendations are proposed by the User Committee, professionals implement the proposed improvement measures.

System audit

To support you

Educational sheets	Patient engagement Telehealth Global management through the quality and safety of care
Quality and safety of care indicators (IQSS)	e-Satis

Criterion 1.4-03 Governance supports the use of questionnaires aimed at measuring patient-reported care outcomes

Measuring quality of care is a prerequisite for defining actions to be implemented and demonstrating progress for the purposes of improving the service delivered to patients. This approach, which has long been led by professionals, is now being enriched by including the voice of patients in the evaluation of their care. Initiatives using patient-reported quality of care measures demonstrate improvements in terms of quality of care, especially in routine clinical practice, with a direct impact for patients. Hence, the measurement of patient-reported outcomes, or PROMs, helps:

- patients to gain a clearer understanding of their disease/condition and their symptoms, to identify their most important symptoms and to communicate them more effectively. They facilitate communication with professionals and promote patient engagement;
- professionals discuss any care difficulties with patients. Professionals are able to identify more symptoms or at an earlier stage, implement more effective follow-up and propose more appropriate care, leading to impacts on health outcomes (e.g. improving the quality of life of patients).

The entire healthcare organisation **Advanced**

Assessment items

Governance

- Governance supports (information, assistance for a department: choice of appropriate questionnaire, training, collection circuit, analysis of results, etc.) the implementation of PROMs in departments.
- Governance supports the involvement of partner patients for the choice of PROMs used in departments.
- An annual assessment relating to the use of PROMs questionnaires is shared by the organisation's bodies.

Professionals

- In departments using PROMs questionnaires, teams use the results to:
  - rapidly adapt the care of patients;
  - and, subsequently, teams use the results to improve practices and organisational methods.

System audit

To support you

Educational sheet	Patient engagement

Criterion 1.4-04 Partner patients and patient associations are involved in the construction of care pathways

Considering patients' needs and expectations, while seeking to improve the quality of care delivered, is increasingly done by involving patients and their representatives in decision-making processes that affect their health. In this way, patient partners and patient associations contribute not only their real-life experiences, but also their expertise on the practical and emotional issues associated with the disease/condition.

Entire organisation **Standard**

Assessment items

Governance • Initiatives leveraging partnership with patients are supported by governance. • Partner patients are involved in approaches mobilising their expertise (therapeutic education, patient support, training of professionals, prevention days, etc.). • Partner patients participate in the definition of improvement actions resulting from collective practice improvement approaches (morbidity and mortality review (MMR), experience feedback committee (CREX), clinical pathways, etc.).	System audit
Professionals • Patients' experience of their illness/condition and state of health is taken into account in order to adapt care pathways and treatments.	Tracer pathway

To support you	
Educational sheets	Intra-hospital pathway Patient engagement

Criterion 1.4-05 User representatives are involved in the life of the healthcare organisation

User representatives are essential players who ensure that the rights of patients cared for in the healthcare organisation are respected and that the quality and safety of their care is improved. The active participation of user representatives in projects and procedures to improve the quality and safety of care now involves much more than the collective representation of patients in the healthcare organisation's decision-making and advisory bodies. Governance encourages collective, constructive discussions in which the viewpoints of user representatives are listened to and taken into account in the various aspects of patients' day-to-day life.

Entire organisation **Standard**

Assessment items

User Representatives • User representatives contribute to the definition of the healthcare organisation's patient reception and care policy. • The user plan is conducted in coordination with the medical and care plan. • User representatives give their opinions on projects to improve the daily life of patients (reception, premises, signs, renovation of premises, etc.). • Awareness-raising and information actions aimed at patients conducted by user representatives and/or associations are encouraged in consultation with care teams. • User representatives participate in the assessment actions taken following analysis of concerns, complaints, serious adverse events (SAEs), care-related adverse events (CRAEs), responses to satisfaction questionnaires, e-Satis survey results and collective practice improvement processes.	**System audit**

To support you	
Educational sheet	Patient engagement

Criterion 1.4-06 User representatives have access to the information they need to fulfil their roles

Involving user representatives in the life of the healthcare organisation means, first and foremost, sharing the results of satisfaction surveys or adverse events, with them, so that they can contribute their perspective.

Entire organisation **Standard**

Assessment items

User Representatives • The results of the satisfaction surveys and patient experience questionnaires are presented to the User Committee and analysed with user representatives. • At each meeting, the User Committee is informed of any care-related adverse events, especially and serious adverse events that have been reported. • The action plan resulting from analysis of CRAEs, including near-misses, is presented to the bodies responsible for relations with users. • The User Committee is informed of the number of requests made by patients to access their records, transmission times, and follow-up of improvement actions implemented.	**System audit**

To support you	
Educational sheet	Patient engagement

Chapter 2.

The care teams

Objective 2.1
Coordination of patient care teams

Team coordination is essential to ensure the quality and safety of care. This firstly means ensuring the coordination of the professionals providing care to the patient. Secondly, it means ensuring the transmission of information so that each professional involved in the care of the patient receives all the information they require to fulfil their role, while preserving the confidentiality of personal data. Lastly, this coordination is just as important within the patient's pathway in the hospital as in the interfaces between this care pathway and the patient's health and life pathway more generally.

Criterion 2.1-01 Teams from consultation and outpatient care sectors coordinate with teams from hospitalisation sectors

Simplifying care pathways by making it easier for patients to access outpatient services or consultations, or by providing the help patients need to book appointments, reinforces the patient-centred approach. This approach is also supported by improved coordination between the consultation and outpatient teams, based on exchanges of information to ensure more fluid and personalised care, while guaranteeing that patients receive follow-up tailored to their specific needs.

Entire organisation **Standard**

Assessment items

Professionals

- During the consultation, if an additional investigation (imaging, laboratory tests, etc.) for diagnostic or therapeutic purposes is prescribed, the team assists the patient to make the next appointment(s).
- The consultation reports are available in the healthcare organisation's medical record and added to the shared medical record in the patient's personal medical space.
- The consultation and outpatient care sectors implement improvement actions following discussions with the other professionals involved in the patient's hospital pathway.

Patient

- In outpatient sectors (consultation, imaging, etc.), patients can make appointments online or using a dedicated phone number.
- During the consultation, if an additional investigation (imaging, laboratory tests, etc.) for diagnostic or therapeutic purposes is prescribed, the patient is helped to make the next appointment(s).

Tracer pathway

To support you	
Educational sheets	In-hospital pathway Maternity – perinatal care SMR Global management through the quality and safety of care

Criterion 2.1-02 Care teams have access to the patient's information via an appropriate information system

Technology is playing an increasingly important role in the coordination of professionals. Electronic patient records provide an integrated view of the treatments dispensed and the interventions carried out, giving every member of the team access to up-to-date, relevant information. Consequently, healthcare professionals must be able to securely access the patient records (internal and their personal health space) for which they are responsible, so that they can make informed, personalised decisions. The interoperability of information systems ensures that this information is accessible to professionals, who need support in learning how to use new applications. The information system must make it possible to track all aspects of care in a timely manner. A high-performance information system facilitates communication and the sharing of information between different players, ensuring a coherent and integrated approach to care.

Entire organisation **Standard**

Assessment items

Professionals • All useful information for the coordination of the patient's care (medical history, clinical examinations, prescriptions, check-up results, allergies, multiresistant bacteria, etc.) is accessible in the patient record. • All professionals involved (physicians, care teams, providers of supportive care, etc.) can track all the information they need, at the right time, for the coordination of the patient's care (traceability and access to the record). • The information system ensures professionals can have simultaneous access to all the data they need for patient care. • Teams are trained in the use of professional software and can be supported by a competent person to learn how to use the tools.	Tracer pathway
Professionals • Medical and paramedical teams can consult the patient's shared medical record.	System audit

To support you	
Educational sheets	In-hospital pathway Telehealth SMR

Criterion 2.1-03 Teams liaise to implement the care plan

The development and implementation of a care plan tailored to the patient's needs and preferences depends on smooth, regular communication between all those involved in the care process. To develop the care plan, professionals can refer to internal or external expert consultants, using telehealth methods, in particular. Multi-professional coordination and cooperation with the patient are key factors to ensure the high-quality implementation of the care plan, particularly for outpatient and hospitalisation at home care.

Entire organisation **Standard**

Assessment items

Professionals • The care plan is drawn up with the participation of all the players involved in the care pathway (supportive care teams, all the teams when the patient is accommodated in another unit due to a lack of available beds, etc.). • The personalised care plan includes preventive activities, taking into account each patient's individual risk factors. • Teams have direct access to expert consultants (pain, hygiene, antibiotic therapy, palliative care, addiction specialist, psychiatrist, etc.) inside or outside the facility. • In traditional hospitalisation, HAH prescription is envisaged within the care plan, right from the patient's admission, and analysed with HAH specialists. • In the event of a chronic condition, during the transition from adolescent to adult, teams (paediatric or paedopsychiatric and adult) liaise to ensure continuity of care for the patient.	Tracer pathway

To support you	
Educational sheets	In-hospital pathway Elderly patients People with disabilities SMR

Criterion 2.1-04 Teams perform medication reconciliation for targeted populations

Medication reconciliation is a formal process whereby a new prescription is considered in the light of all the medicinal products taken or to be taken by patients with a profile presenting risk factors. This process involves the patient and is based on information-sharing and coordination between professionals. It prevents or corrects medication errors by promoting the transmission of accurate and comprehensive patient medication information between healthcare professionals at points of transition, i.e. hospital admission, discharge and transfers.

Entire organisation **Standard**

Assessment items

Professionals • Medication reconciliation is implemented for the highest-risk sectors and profiles (geriatrics, oncology, polymedicated elderly patients, patients receiving chemotherapy, etc.). • Medication reconciliation is scheduled for the highest-risk sectors and profiles (geriatrics, oncology, polymedicated elderly patients, patients receiving chemotherapy, etc.) in which it has not already been performed. • Medication reconciliation is performed in accordance with good practices, with in particular: three information sources, a meeting with the patient/or their family, medico-pharmaceutical exchange. • The medication assessment is accessible in the patient record. • An assessment is carried out concerning the relevance of the reconciliation activity (reconciliation assessment) and the corrections made.	**Targeted tracer**

To support you	
Educational sheets	Elderly patients Medicine

Criterion 2.1-05 Teams liaise to implement the palliative care process

In departments caring for end-of-life patients, a specific approach is used to reinforce the support provided to patients: pain relief, psychological care, supportive care, partial or total limitation of previously initiated treatments or investigations, deep, continuous sedation. This approach is defined in keeping with the wishes expressed by the patient, particularly in advance directives, and requires the setup of a care plan defined with the entire care team, including supportive care professionals. In departments that are not specialised in end-of-life care, the patient, their person of trust or their legal representative can ask for the intervention of a mobile palliative care team.

Entire organisation **Standard**

Assessment items

Professionals

- The palliative care process is subject to multiprofessional, multidisciplinary consultation.
- If necessary, access to a specialised palliative care unit is provided, where professionals can receive advice, support and specific training.
- For palliative situations, patients' relatives receive support (psychologist, etc.) to alleviate their own distress if necessary.
- For the limitation and withdrawal of active treatment, teams check for the presence of any advance directives drawn up by the patient by whatever means, in particular by consulting the patient's personal health space. In the absence of advance directives, expression of the wishes of the patient is sought or the person of trust is asked to testify to the wishes expressed by the patient.
- In order to prevent any unreasonable therapeutic obstinacy, the therapeutic actions and the method of care are systematically analysed by the team before the patient is expected to die.

Tracer pathway

To support you	
Educational sheets	In-hospital pathway Critical care

Criterion 2.1-06 Teams liaise to prevent nutritional problems in patients

Nutritional problems can have a significant impact on patients' physical and mental health, and require a multidisciplinary approach: physicians, dieticians, psychologists, nurses, catering department. Close cooperation between these professionals enables personalised care plans to be drawn up, tailored to the specific needs of each patient. By encouraging fluid communication and information-sharing, the coordination of health teams helps to improve the assessment of nutritional needs, the implementation of prevention strategies and the regular monitoring of progress made. It is therefore essential to explore practices and tools that facilitate this synergy, in order to improve the quality of care and optimise outcomes for patients suffering from nutritional problems.

Entire organisation **Standard**

Assessment items

Professionals • Teams identify patient profiles requiring specific nutritional management, enabling them to personalise nutritional care by leveraging specialised professionals (dietician, for example). • In situations where this is required, particularly for obesity management and screening for undernutrition and sarcopenia, the team implements the latest recommendations throughout the stay. • Professionals are trained to identify and implement action(s) to help ensure balanced nutrition for patients.	Tracer pathway
Governance • The healthcare organisation assesses the nutritional characteristics of its meals, including if they are supplied by a service provider, to ensure that they meet patients' needs.	System audit

To support you	
Educational sheets	In-hospital care pathway Elderly patients People with disabilities Mental Health and psychiatry Global management through the quality and safety of care

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Criterion 2.1-07 Interventional sector teams liaise for patient care

Interventional sectors are spaces where the roles, procedures and tasks for scheduled procedures and emergencies are defined and recorded in an operating room charter or interventional sector internal regulations. One of the key documents is the surgical schedule, which must be jointly drawn up and take into account emergencies and the organisation of the postoperative recovery room. The quality and safety of care in the operating theatre and interventional sectors are ensured by teamwork, communication, information traceability, shared decision-making and coordination between the various players. Monitoring of indicators, in particular reprogramming times and assessment of the quality of information transmitted between teams, ensures that patients are cared for safely.

Surgery and interventional procedures **Standard**

Assessment items

Professionals

- The operating charter/internal rules for the operating theatre and interventional sectors specify the working methods (organisational management, care circuits, responsibilities, material and human resources, etc.).
- The operating schedule is drawn up by the surgeon, anaesthetist and theatre manager and validated by the scheduling committee.
- The operating schedule takes into account the organisation of the postoperative recovery room.
- Teams share all useful information before and after the intervention to ensure the safety of patient care.
- The quality of the information transmitted is reviewed on a regular basis, leading to improvement actions whenever required.

Targeted tracer

To support you	
Educational sheet	Interventional sectors Global management through the quality and safety of care

Criterion 2.1-08 Maternity unit teams help future parents to develop a parenthood project

Pregnancy and the arrival of a child are major milestones in the lives of parents-to-be, marked by intense emotions and numerous questions. Maternity unit teams provide support to these families in the development of their parenthood project. This support begins at the very start of the conception process and any referral to specialist medically assisted reproduction teams. It then takes the form of close collaboration between healthcare professionals and future parents, facilitating the development of a birth plan that meets their wishes and expectations concerning the type of birth, care of the baby and stay in the maternity ward, as long as no constraints arise due to a clinical situation posing risks for the mother or child. Maternity unit teams are also careful to take into account any vulnerability factors that could influence the parenting pathway, whether psychological, social or medical. By identifying these specific characteristics, they can refer parents towards the appropriate resources, such as additional consultations, support groups or paediatric services. This comprehensive, personalised support helps future parents to prepare as well as possible for welcoming their child, while boosting their confidence and autonomy in this new role. In this way, the maternity unit is transformed into a genuine space for co-construction, where parents are actively involved in their own parenting journey and can look to the future with peace of mind.

Maternity unit **Standard**

Assessment items

Patient • From the start of the pregnancy, a birth plan (delivery methods, type of anaesthesia, breastfeeding, etc.) is drawn up with future parents who so wish. • Birth and parenthood preparation sessions are systematically offered to parents.	Tracer patient
Professionals • If necessary, the team refers future parents to specialised teams (medically assisted reproduction, etc.) and specialist associations, as soon as a parenthood project is expressed. • Situations of vulnerability (individual fragility as a result of medical, psychological or social circumstances with an aggravating cumulative effect) are identified using tools, as soon as the parenthood project begins and throughout the pregnancy. • Situations of vulnerability are discussed at medico-psycho-social or perinatal staff meetings attended by all the partners concerned. • Mandatory interviews (prenatal and postnatal) are carried out.	Tracer pathway

To support you

Educational sheet	Maternity – perinatal care

Criterion 2.1-09 Teams liaise for the home care of patients

The hospitalisation at home (HAH) team coordinates the various professionals involved and organises their intervention to ensure continuity of care. The patient's primary care practitioner is a key player in their care, and as such is the recipient of the care protocol drawn up for HAH care. Where necessary, the team organises the readmission of patients, calling on emergency medical services if necessary. To ensure the safety of the healthcare product circuit in the patient's home, the healthcare organisation implements a personalised home risk management procedure that takes into account the risks associated with healthcare products, situations, practices and patients. The safety of healthcare products is ensured through an initial assessment and ongoing follow-up, and is based on:

- the capability of the patient and/or their family and/or carers to administer the treatments;
- the patient's psychosocial environment;
- the complexity of the treatment;
- the storage conditions in the patient's home (appropriate in view of the family environment, particularly in the presence of children);
- monitoring of consumption of healthcare products. The safe management of hazardous waste is ensured.

Hospitalisation at home **Standard**

Assessment items

Professionals • In hospitalisation at home, a care protocol, drawn up at admission and specifying all those involved in the care process, is communicated to the patient's primary care practitioner. • The HAH practitioner coordinates one or more multidisciplinary team meetings bringing together hospital and non-hospital professionals, for monitoring of the care plan. • If so required, readmission of patients to hospital is organised in the appropriate care unit and by contacting the emergency services on 15 if necessary. • Professionals apply and implement safety rules for the health products and medical devices circuit in the patient's home (delivery, storage, waste, any returns, etc.).	**Tracer pathway**

To support you	
Educational fact sheets	Under review
Patient Safety Flash	Home hospitalisation. A well-oiled organisation to prevent home hospitalisation from grinding to a halt

Criterion 2.1-10 In the fields of mental health and psychiatry, access to care is organised and monitored

Access to care can be delayed by a variety of factors. However, for severe mental health problems, the onset of the symptoms is a critical period, during which early multimodal care can positively alter the course of the condition and improve the functional and personal prognosis. Consequently, outpatient psychiatric care units must define care access procedures that include the early consideration of families' concerns, the rapid assessment of warning signs and signs of severity, as well as access to a range of appropriate and diversified care. During their hospital stay, some patients may experience episodes of violence, which need to be handled by the care team, who will seek to use different methods to achieve a “de-escalation”. For these situations, drawing up a shared prevention plan, in cooperation with the patient, can improve and secure the management of these episodes. To ensure coherent and coordinated patient care, the healthcare organisation sets up collaborative arrangements between outpatient psychiatric services and general practitioners. The aim is to ensure harmonised follow-up of mental health problems and any physical comorbidities. In the case of hospitalisation, the liaison letter on admission and on discharge constitutes the pivot of this coordination, along with the shared medical record, where available.

Mental health and psychiatry **Standard**

Assessment items

Professionals

- In outpatient psychiatric units, there are structured, known arrangements in place to allow early access to care.
- With the patient's approval, outpatient psychiatric care units liaise with the general practitioner as necessary to ensure the coordination of the care pathway, taking into account any associated physical comorbidities indicated in the patient’s records.
- The shared prevention plan for patients requiring it (suicide risk, risk of self-harm or harm to others, situation of decompensation of a serious mental health problem, etc.) is drawn up jointly with the patient and, if they so wish, their support network, and is monitored on the basis of an analysis of the clinical outcomes.
- The rate of hospitalisation in situations of imminent danger is monitored and analysed in conjunction with the teams that refer patients to the hospital (emergency department, mobile emergency unit, etc.).

Tracer pathway

To support you

Educational sheets	Mental health and psychiatry

Criterion 2.1-11 Psychiatric teams liaise to prevent suicide attempts throughout the care pathway

Suicide prevention is a public health priority. In the general population, the average annual suicide rate in France is close to 20 to 25 per 100,000 inhabitants for men and 5 to 7 per 100,000 inhabitants for women, with variations according to age. The estimated number of suicide attempts is around 200,000 a year, making France one of the European countries most affected by this problem. Around 80% of hospital suicides occur in psychiatric units. Professionals must therefore be trained in the prevention, detection of warning signs and management of patients at risk of suicide. Professionals must be provided with the appropriate tools required for their care. One of these tools, the VigilanS system, is a genuine monitoring tool that reduces the risk of recurrence of suicidal behaviour by almost 40% for patients included in VigilanS compared with a group of patients not included in the scheme.

Mental health and psychiatry **Standard**

Assessment items

Professionals • Professionals are trained in the prevention, detection of warning signs and management of patients at risk of suicide. • In outpatient psychiatric units, alert criteria (suicide risk, risk of self-harm or harm to others, situation of severe mental illness decompensation, etc.) are assessed using tools known by the team. • For inpatients, the suicide risk is assessed using tools shared by the healthcare team, particularly at key moments (admission, first leave, before discharge for example) and logged in the patient's record. • After a suicide attempt, the team suggests that patients be included in the VigilanS scheme on discharge. • Any suicide or attempted suicide that occurs during care, including during leave, is reported as a serious adverse event and analysed by a multiprofessional team.	Tracer pathway

To support you	
Educational sheets	Mental health and psychiatry
Patient Safety Flash	Suicide. Prevention is better than death

Criterion 2.1-12 Teams conduct a physical examination for any patient hospitalised in a psychiatric unit

Psychiatric care includes a physical examination to enable differential diagnosis of conditions and identification of any physical comorbidities that could interfere with the patient's psychiatric care. This physical examination, carried out within 24 hours for non-consensual admissions or earlier for other admissions by a physician other than the physician having conducted the mental health assessment, results in regular follow-up, in coordination with the primary care practitioner and/or specialised services if necessary. This follow-up is recorded in the liaison letter.

Mental health and psychiatry **Essential**

Assessment items

Professionals

- A physical examination is carried out within 24 hours of a non-consensual full hospital stay in a psychiatric unit.
- For patients admitted voluntarily, without passing through an emergency department, the physical examination is carried out within a time frame adapted to their profile (maximum of three working days).
- If the patient was admitted via the emergency department, the visit report is included in the patient's record and follow-up instructions are implemented, monitored and tracked.
- Regular physical examinations take place throughout treatment and are recorded in the liaison letter.

Tracer pathway

To support you	
Educational sheets	Mental health and psychiatry
Quality and safety of care indicators (IQSS)	Coordination and physical care in full-time hospitalisation

Criterion 2.1-13 Teams liaise for the in-hospital transportation of patients

The arrangements and methods used for in-hospital transportation (trained professionals and suitable equipment) are appropriate, and waiting times are consistent with continuous high-quality care. Continuity of activity is ensured for other patients when transport is carried out by someone other than a patient transporter.

Entire organisation **Standard**

Assessment items

Professionals • Transportation times are adapted to the activity schedule. • When patients are transported by a member of the team other than the patient transporter, continuity of activity is ensured for all other patients on the ward. **Patient** • Patients are informed of internal transportation destinations and times in real time.	Tracer pathway
Observations • Patient safety, confidentiality and comfort are ensured during their transportation (functional equipment, adequate protection, etc.).	Observation

To support you	
Educational sheets	In-hospital pathway Critical care

Criterion 2.1-14 A discharge liaison letter is given to the patient and ensures the continuity of their care pathway

The liaison letter is a key component in the continuity of care. It must be given to patients on the day of their discharge and addressed to their primary care practitioner. It summarises the conclusions of the hospitalisation and indicates recommendations for care after discharge to ensure effective "hospital/community care" coordination. In addition, post-discharge care must be organised. Therefore, the healthcare organisation must ensure that the patient or their family will be able to get the necessary medicinal products and, if required, the equipment and material they need, irrespective of the time or day of the discharge (Sundays and public holidays). The shared medical record in the patient's personal health space is updated. For minors, the child health record acts as a common thread running through the care provided and the "hospital/community care" link.

Entire organisation **Standard**

Assessment items

Professionals • Follow-on care and prescriptions, along with the required equipment, are planned ahead of discharge. • The information required for the continuity of care following a transfer within or outside the hospital includes: the patient's full identity, their medical history, their risk factors, the referring department's conclusions on the hospitalisation, the results of the latest additional tests, prescriptions, and the therapeutic assessment. This information is also communicated to the patient. • Before a child's discharge, the team updates the child health record with useful information for their follow-up, while ensuring the preservation of medical confidentiality.	Tracer pathway
Governance • The organisation monitors time frames for the delivery of the liaison letter and consultation report on the patient's discharge, and makes the required improvements.	System audit

To support you	
Educational sheets	In-hospital pathway Emergency – SAMU/SMUR Elderly patients Children and adolescents Maternity – perinatal care Critical care People with disabilities SMR Global management through the quality and safety of care
Quality and safety of care indicators (IQSS)	Coordination on discharge and pain management

Chapter 2.
The care teams

Objective 2.2
Control of practice-associated risks

Professional practices entail risks for patients: identity vigilance, the medication circuit, the risk of healthcare-associated infections, blood transfusions, the use of ionising radiation, etc. Patient safety is a team concern that mobilises both individual skills and collective implementation capabilities.

Criterion 2.2-01 Teams comply with good patient identification practices at all stages of their care

Identity vigilance limits the risk of potentially serious errors due to incorrect identification (wrong operating site, treatment error, laboratory results errors, etc.). Reliable and unique identification of the patient at each admission and at all stages of their care makes it possible to link the person's identity to a procedure. The use of the National Health Identity number (INS) to reference health data has been compulsory since 1 January 2021. It is made up of the individual's Identification Number (*Numéro d'Identification au Répertoire des Personnes Physiques* or *Numéro Identifiant Attente* for people born outside France) and the five INS features: surname at birth, first name(s) at birth, date of birth, gender, place of birth. On admission, the INS must be qualified by calling the INSi telephone service. During the stay, teams inform the patient that, at each stage of their care, the match between their identity and their prescriptions and procedures will be verified. Teams make every effort to involve the patient in this safety procedure.

Entire organisation **Standard**

Assessment items

Professionals • All paper documents in the patient record are identified (identity block or patient label containing the required identity features). • If patients are unable to identify themselves, secondary identification of the patient is ensured by a suitable identification device (bracelet or any other alternative means of identification, while maintaining patient confidentiality and dignity).	Tracer pathway
Governance • The healthcare organisation has defined a governance procedure for identity vigilance: strategic decision-making body, identity vigilance operational unit or operational personnel, identity vigilance officer with a mission statement or job description. • The identity vigilance unit/committee and/or the identity vigilance officer analyses and corrects identity errors (duplicates, conflicts, etc.) and manages complex cases of national health identity (INS) qualification (inconsistencies between the INS and the identity present on the identification system, "no identity found" or "several identities found" responses from the INSi telephone service). **Professionals** • The patient identification rules defined by the healthcare organisation (identity vigilance charter) are applied: INS qualification by authorised staff on initial admission in the presence of the patient, failsafe mode (telephone service rejection, information system unavailability, anonymity, etc.). • Teams report nonconformities to the identity vigilance unit/committee (duplicates, conflicts, national health identity (INS) qualification not possible, etc.) based on a document specifying anomalies to be reported and the reporting methods.	System audit

To support you

Educational sheets	In-hospital pathway Emergency – SAMU/SMUR Children and adolescents Maternity – perinatal care Critical care Global management through the quality and safety of care

Criterion 2.2-02 Teams comply with good medication prescribing practices

Compliance with good medication prescribing practices by teams is essential to ensure the safety and efficacy of treatments. This implies clear, appropriate prescriptions that comply with recommendations, taking into account patients' health status, their medical history, their allergies and potential interactions with other treatments. Prescriptions must be comprehensible and legible in order to avoid any confusion when administering treatments. Rigorous follow-up is also essential in order to adjust treatment based on the evolution of the patient's condition.

Entire organisation Essential

Assessment items

Professionals • Prescriptions on admission take into account the patient's usual treatments. • The prescription clearly includes the prescriber's identification and signature, the date and time, the name of the drugs (INN), the dosage, the solvent and its volume (for injection) and the route of administration. • Any conditional prescription is justified by reference to a threshold value. • Prescriptions are produced in real time by qualified professionals, with no retranscription by non-medical professionals.	Targeted tracer

To support you	
Educational sheets	Medicine
Patient Safety Flash	Patients on neuroleptics. Vigilance is good practice Biological monitoring of anticoagulants (heparins and vitamin K antagonists). A blood test to prevent blood loss Long-acting neuroleptics (LANs). LANs can sometimes go wrong Medication events that should never happen (never events). Lidocaine and colchicine in the spotlight

Criterion 2.2-03 Teams comply with good medication dispensing practices

Before dispensing, the pharmacist analyses the prescriptions to check their relevance, the doses prescribed, possible interactions and any contraindications. The analysis of the prescriptions covers the entire prescription and therefore includes all medications taken by the patient during their hospitalisation. It is coupled with an analysis conducted upon the dispensing of the medicines. Care teams then ensure that each medicine is dispensed in accordance with the prescriber's instructions. This collaborative work between physicians, pharmacists and nurses helps to avoid medication errors and ensure that every patient receives appropriate, safe care.

Entire organisation **Standard**

Assessment items

Professionals • The pharmacist performs a pharmaceutical analysis of the prescription based on the patient's laboratory data and access to their record. • Pharmaceutical interventions are taken into account by prescribing departments. • The dispensing of medicines is adapted to the needs of the departments (daily, weekly, monthly) with respect to prescriptions. • A pharmacist is consulted at multidisciplinary team meetings. • Governance provides the healthcare organisation's professionals with appropriate software to facilitate and optimise pharmaceutical analyses. • Software choices are made in accordance with the digital medical device control plan implemented within the organisation.	**Targeted tracer**

To support you	
Educational sheets	Medicine Elderly patients

Criterion 2.2-04 Teams comply with good healthcare product procurement practices

Compliance with good healthcare product procurement practices (medicinal products, sterile medical devices and implantable medical devices) guarantees the availability, safety and quality of treatments delivered to patients. Teams must follow rigorous protocols to ensure secure procurement (secure containers, cold storage, authorised personnel, etc.), from ordering through to receipt, including the storage and distribution of healthcare products (appropriate premises and equipment, compliance with storage temperatures, secure and identified storage, appropriate storage for high-risk medicines, etc.). Particular attention is paid to stock management, expiry dates and any stock-outs or shortages to prevent any interruption of care.

Entire organisation **Standard**

Assessment items

Professionals • Procurement procedures are defined meeting the needs of professionals, in particular to cope with any urgent requirement for a healthcare product. • The pharmacist identifies risks associated with stock shortages, informs prescribers and implements countermeasures in collaboration with users. • Healthcare products are stored in appropriate conditions in the organisation's in-house pharmacy and in care departments. • Healthcare products are transported in appropriate and secure conditions.	Targeted tracer
Observations • Checks on the storage of healthcare products are carried out, and expired products are withdrawn.	Observation

To support you	
Educational sheets	Medicine
Patient Safety Flash	Storage of curare. Errors that are not so rare Stock shortages of healthcare products. Don't break contact! Medication events that should never happen (never events). Lidocaine and colchicine in the spotlight

Criterion 2.2-05 Teams comply with good medication administration practices

Medication administration is the last stage in the medicinal product circuit. Any error occurring at this stage or that is not corrected at this stage can lead to a medication error that may potentially cause harm to the patient. Care teams follow medical prescriptions, checking the patient's identity, the nature of the medication, the dosage, the route of administration and the right time for each dose (“5 rights” method). Medication is prepared in accordance with good practice guidelines (freshly prepared, crushing in accordance with recommendations, identification right up until administration, use of labels in accordance with recommendations for all products for injection). Administration is recorded in the patient record in order to guarantee complete traceability. The quality and safety of the administration of medicines needs to be ensured while taking into account the patient's autonomy.

Entire organisation Essential

Assessment items

Professionals • Qualified professionals follow good preparation practices and avoid interrupting tasks. • Qualified professionals comply with good administration practices. • Risky situations (products for injection, reconstituted medicines in paediatrics, electric syringe pump, PCA, chemotherapy, preparation of infusion bags with reconstitution, multiple preparations, etc.) requiring special precautions have been identified and good practices implemented. • The match between the product, the patient and the prescription is systematically checked before administration by qualified professionals. • Administration of the medication, or the reason for non-administration, is recorded in the patient's record by authorised professionals at the time the dose is administered.	Targeted tracer

To support you

Educational sheets	Medicine
Patient Safety Flash	Calculating medication doses. The rule of three must remain the rule. Medical devices. Use them properly...to avoid the worst. Medications in paediatrics. It's not child's play. Use of morphine derivatives. Misuse of opiates leads to overdose. Medication events that should never happen (never events). Lidocaine and colchicine in the spotlight.

Criterion 2.2-06 Teams prevent any risks of medication error

The prevention of medication errors is based on rigorous practices and the vigilance of care teams. Ongoing training for healthcare professionals plays a key role, enabling them to master protocols, anticipate the risks of interactions and comply with safety rules. High-risk medicinal products generate a higher risk of harm to patients. In addition, errors due to such medicines are more frequent. Therefore, they must be managed in a specific way throughout all stages of the medicinal product circuit. Their list is dynamic and takes into account feedback and never events. Preparation in a controlled atmosphere, particularly for sterile medicinal products and chemotherapy drugs, is essential to avoid contamination and ensure dose precision. Finally, the systematic analysis of drug-associated adverse events makes it possible to identify shortcomings and take corrective action.

Entire organisation Essential

Assessment items

Professionals • Professionals are trained in the prevention of medication risks. • Professionals know the control methods for the highest-risk medications. • A jointly drawn up list of the highest-risk medicines is adapted to the activity and known to professionals. • The controlled atmosphere preparation circuit (chemotherapy, immunotherapy, biologic therapy, parenteral nutrition, radiopharmaceuticals, etc.) is under control (prescription, pharmaceutical analysis, preparation, release, transport, storage and administration). • Medication errors are analysed by the team and are the subject of a tracked action plan.	Targeted tracer

To support you

Educational sheets	Medicine
Patient Safety Flash	High-risk medications: Underestimating the risk is risky Accidents related to high-risk medications. When it comes to potassium (KCl), maximum vigilance is required Medication events that should never happen (never events). Lidocaine and colchicine in the spotlight

Criterion 2.2-07 The organisation promotes patient self-administration of medicines during hospitalisation (PAAM)

This approach enables patients to manage their routine treatments themselves, under medical supervision. Changes in the regulations governing the administration of medicines address a need for patients' involvement in their own care, and in particular, the self-administration of their own medicines. A framework to ensure the safety of this practice is proposed by the HAS, which is publishing a guideline and a toolkit guide aimed at healthcare professionals. The objectives are multiple:

- to assert patients' autonomy and their engagement in safe care;
- to reinforce multiprofessional teamwork;
- to reduce the risks of error when patients are discharged from the healthcare organisation;
- to improve patient understanding.

The PAAM programme is part of an overall policy within the healthcare organisation relative to risk management and patients' active involvement in their own medication management.

The entire healthcare organisation **Advanced**

Assessment items

Professionals • Departments wishing to apply this approach, on a voluntary basis, define the criteria for rolling out the hospitalised patient self-administration of medication (PAAM) programme and its assessment indicators. • Departments and patients wishing to apply this approach, on a voluntary basis, implement the hospitalised patient self-administration of medication (PAAM) programme, tailoring it to the patients concerned. • An assessment of the hospitalised patient self-administration of medication (PAAM) programme is performed jointly and improvement actions are put in place.	Targeted tracer
Governance • Through its overall policy risk management policy, governance supports patients' active involvement in their own medication management (identification of departments volunteering to take part in the programme, training, prioritised deployment, available equipment, etc.).	System audit

To support you	
Educational sheets	Medicine Patient engagement Global management through the quality and safety of care

Criterion 2.2-08 Teams comply with standard hygiene precautions

Standard precautions are the indispensable prerequisite for the prevention of care-related infections. They must be applied to all patients at all times. In particular, they concern hand hygiene, the wearing of personal protective equipment (gloves, masks, gowns), the management of excreta and waste, and the cleaning of equipment and surfaces. Healthcare teams must use alcohol-based hand sanitizers at key moments: before and after each contact with a patient, before any invasive procedure, after contact with potentially contaminated surfaces, and after removing gloves. The absence of any jewellery on the hands and wrists improves the quality of hand disinfection. These simple but fundamental steps, regularly monitored and reinforced by ongoing training, help to reduce the spread of infectious agents and improve the quality of care.

Entire organisation Essential

Assessment items

Professionals • The team complies with good hand hygiene practices: before and after any contact with a patient, before aseptic procedures, after a risk of exposure to a body fluid and after any contact with a patient's environment. • The team favours hand disinfection using an alcohol-based rub. They are familiar with the rare indications for washing hands with soap and water. • The team applies good practices in the management of excreta: compliance with standard precautions during handling (in particular wearing PPE), suitable equipment in good condition (bedpan and bedpan washer), maintenance of equipment carried out, and existence of a failsafe procedure in the event of a breakdown. • The team is familiar with the precautions to be taken and what to do in the event of a blood exposure accident. • The team improves its practices in terms of standard hygiene precautions by regularly analysing its indicators in conjunction with the operational hygiene team.	Targeted tracer
Observations • The team complies with hand hygiene prerequisites: no jewellery on the hands or wrists, short sleeves, no nail polish, short nails.	Observation

To support you

Educational fact sheet	Healthcare-associated infections
Quality and safety of care indicators (IQSS)	Use of alcohol-based hand sanitisers (ICSHA)

Criterion 2.2-09 Teams comply with additional hygiene precautions

Additional precautions are required to control the spread of certain airborne microorganisms and those transmitted through droplets or hand contact: multiresistant bacteria and emerging highly resistant bacteria. These additional measures, which are designed to limit the transmission of such microorganisms (movement restrictions, keeping the patient in a single room, keeping the door closed, wearing personal protective equipment, etc.) must be medically warranted, explained to the patient, and accompanied by measures to facilitate their implementation and acceptability. At the same time, professionals already apply standard precautions and comply with good practice when it comes to wearing personal protective equipment (masks, gloves, gowns in the patient's room, etc.). By taking these measures, teams reduce the risks of cross contamination.

Entire organisation **Standard**

Assessment items

Patient • The risk of infection, along with the prescription and use of additional precautions, are explained to the patient and their family members.	Tracer patient
Professionals • The team knows the situations that require the use of additional precautions in addition to standard precautions. • Additional precautions are applied and are the subject of a medical prescription or a validated protocol, and the information given to the patient is recorded in their record.	Targeted tracer
Observations • The team uses personal protective equipment in accordance with the guidelines (no wearing of their medical masks around their neck or without covering their nose and mouth, and/or untied, gloves (sterile or otherwise) disposed of immediately after the procedure, changed between patients, no wearing of gowns outside patients' rooms, etc.).	Observation

To support you

Educational fact sheet	Healthcare-associated infections
Quality and safety of care indicators (IQSS)	Additional contact-related precautions

Criterion 2.2-10 Teams manage the risk of infection associated with the use of invasive devices

Control of all stages of the invasive medical device circuit helps prevent the risk of infection. Devices such as catheters, probes or drains, although necessary for treatment, represent a high risk of care-associated infections if they are not handled with rigorous precautions. Teams must follow strict protocols for their insertion, maintenance and removal, including sterile conditions, disinfection of implantation sites and regular monitoring for signs of infection. In addition, ongoing training for staff in infection prevention practices relating to these devices, as well as raising patient awareness, are essential to limiting these risks. Finally, professional practice assessments identify any improvement actions to be defined in cooperation with the operational hygiene team.

Entire organisation **Standard**

Assessment items

Professionals • The team applies protocols for inserting and maintaining vascular (peripheral and central venous, and arterial), urinary drainage and assisted ventilation ports. • The date of insertion or of the procedure involving the device is logged in the record. • For invasive devices that require it (venous ports and catheters in particular), the relevance of their maintenance is reassessed periodically in accordance with good practice guidelines. • Infection rates associated with invasive devices are monitored in liaison with the operational hygiene team. Teams are informed of the results.	**Targeted tracer**

To support you	
Educational sheet	Healthcare-associated infections
Patient safety flash	Catheters and healthcare-associated infections. If it stays in too long, you risk infection Central venous catheter and air embolism. All it takes is one bubble and everything changes

Criterion 2.2-11 Teams manage blood transfusion-associated risks

Each type of transfusion (red cells, platelets and plasma) is subject to specific protocols. All stages, from prescription to administration, are supervised, whether the transfusion is carried out on an emergency or planned basis. This includes rigorous verification of blood compatibility, patient identification and compliance with blood product storage and transport conditions. For each patient, the indication for transfusion is systematically assessed through a benefit/risk analysis. In addition, the traceability of blood products is essential to be able to react quickly in the event of an adverse event.

Entire organisation **Standard**

Assessment items

Professionals

- A benefit/risk analysis is conducted for any transfusion procedure, particularly at night.
- The last check at the patient's bedside is performed in accordance with good transfusion practices;
- The prevention of transfusion risks complies with HAS guidelines.
- Professionals are trained in good transfusion practices.
- The team improves its transfusion practices by regularly analysing its indicators and reported adverse events.

Targeted tracer

To support you	
Educational sheets	Under review

Criterion 2.2-12 Teams are proficient in the management of vital emergencies

The management of vital (life-threatening) emergencies requires an immediate response and optimum coordination to preserve the patient's life. Healthcare professionals must receive ongoing training in emergency protocols. Clear organisation, including rapid identification of the situation, fluid communication between teams and immediate availability of equipment and medicines, is essential. Procedures are regularly assessed and improved through emergency simulation drills.

Entire organisation Essential

Assessment items

Professionals • There is a unique, dedicated number, known by professionals, to directly contact a physician who is qualified to deal with vital emergencies. • All healthcare professionals are trained in first aid (detection of a vital emergency, measures to be taken, etc.). • Emergency trolleys or bags are adapted to the patients accommodated in the unit and are accessible. • Emergency trolleys or bags are checked in the care units, their verification is logged and a log of use is kept. • Healthcare professionals carry out drills.	Tracer pathway
Governance • An assessment of the system for the management of vital emergencies validates its efficiency.	System audit

To support you

Educational sheets	Intra-hospital pathway Life-threatening emergencies SMR Global management through the quality and safety of care

Criterion 2.2-13 Teams manage the risks associated with the use of ionising radiation

Risks associated with the use of ionising radiation particularly concern imaging units, operating theatres, and interventional, radiotherapy and nuclear medicine. units. Conditions must comply with the requirements of the French Authority for Nuclear Safety (ASN). Teams must be proficient in good practices, ensuring they follow radiation protection principles, such as optimisation of doses administered, medical justification of the investigations and exposure limitation. Ongoing training of professionals in protection techniques, regular maintenance of equipment and compliance with safety protocols are essential. In addition, regular monitoring of radiation doses and practice audits ensure compliance with radiation protection standards and minimise the risks associated with ionising radiation.

Entire organisation **Standard**

Assessment items

Professionals • Radiological examinations are carried out by authorised professionals (radiologists, physicians, radiopharmacists) using equipment connected to the dosimetric data collection and archiving system. • The relevance of ionising radiation prescriptions is regularly justified and assessed. • For any medical procedure involving ionising radiation, the patient record contains the following: justification of the prescription and the procedure performed, the equipment used and the amount of dose received by the patient or estimated during the procedure. • The examination report, stating the radiation doses received, is uploaded to 'My Health Space'. • The professionals in the team are able to explain the measures to be taken (in particular compliance with the ASN declaration obligation and the requirement to inform the person in charge of radiation protection) in the event of any incident linked to ionising radiation (overexposure, complication, burns, etc.) concerning a patient or a professional.	Tracer pathway
Observations • Professionals use the personal protective equipment and dosimeters.	Observation

To support you	
Educational sheet	Interventional sectors Ionising radiation and radiotherapy

Chapter 2.

The care teams

Objective 2.3

Safety in units with major risks (emergency departments, surgery and interventional procedures, maternity care, critical care, emergency medical services and mobile emergency units, mental health and psychiatry, radiotherapy)

Units with major risks, exposed to complex situations and intensive care procedures, require specific care protocols and team coordination. Professionals in these units need regular training in practices and the use of specific equipment. The traceability of actions ensures safe care. Assessment and continuous improvement of practices are key factors in maintaining a high level of quality and safety in these critical environments.

Criterion 2.3-01 Each person calling the emergency medical service for a health problem is guided and managed thanks to medical call handling appropriate to their situation

Each person calling the emergency medical services for a health problem benefits from an immediate medical assessment carried out by a medical call handler. This call handling process analyses the seriousness of the caller's situation, taking into account the symptoms described, the medical history and the context. Based on this assessment, the patient is referred to the most appropriate response: medical advice, treatment by a community practitioner, dispatch of an ambulance, or intervention by a mobile emergency unit team. Medical call handling ensures that emergencies are dealt with quickly and appropriately, while optimising available resources. It also makes it possible to prioritise critical cases in order to maximise their chances of survival and limit serious complications.

Emergency medical services and mobile emergency units **Standard**

Assessment items

Professionals

- Emergency medical service professionals apply the protocol for organising medical call handling, the roles of the medical call handling assistant and the handling physician.
- The medical emergency service team is trained to respond and listen to callers and to refer them as appropriate.
- All communications are traced in a medical call record.
- Particular patients (HAH, geographically isolated pregnant women, patients on respiratory assistance, etc.) are identified, and are subject to special management measures.
- Following the intervention of emergency medical services, the patient's referral is discussed, taking into account direct admission channels and, wherever possible, the patient's preferences.
- Emergency medical service teams analyse their practices and the appropriateness of their decisions, in particular by listening to recordings of calls again in order to improve these

Targeted tracer

To support you	
Educational sheet	Emergencies – SAMU/SMUR
Patient Safety Flash	SAMU. What if coordination meant communication SAMU. What if everyone played their part

Criterion 2.3-02 The pre-hospital records of mobile emergency units contain all the required information for the continuation of patients' care

The pre-hospital medical record of mobile emergency units is a tool for ensuring continuity of care when treating a patient in an emergency situation. It must contain all the relevant information gathered on the ground, such as the patient's identity, medical history, the circumstances of the intervention, the symptoms observed, the medical procedures carried out (intubation, infusion, etc.) and the treatments administered. Once the patient has been transferred, this record provides hospital teams with an immediate, clear and complete picture of the medical situation, facilitating the continued care of the patient in the safest and most efficient conditions. In addition to its role in the continuity of care, this record also enables regular analysis of practices and assessment of the relevance of decisions taken on the ground.

Emergency medical services and mobile emergency units **Standard**

Assessment items

Professionals

- The composition of the mobile emergency unit team is logged in the intervention schedule.
- The pre-hospital medical records are complete: diagnostic hypothesis, treatment implemented, monitoring carried out, name of physician, etc.
- Regular analysis of records by mobile emergency unit teams results in actions to improve their practices (activity management, training, adaptation of resources etc.).
- The mobile emergency unit team implements improvement actions in line with the regular analysis of its care indicators (average mobile emergency unit send-out time, mobile emergency unit immobilisation time, time taken to transmit the report to the emergency medical services, transfer times, etc.).

Targeted tracer

To support you	
Educational sheets	Emergencies – SAMU/SMUR Global management through the quality and safety of care

Criterion 2.3-03 The emergency department team ensures that patients are referred to the appropriate channels and within the appropriate time for their care

The emergency department team plays a key role in referring patients to the care channels best suited to their health status. As soon as the patient arrives, a rapid assessment is carried out to determine the seriousness of the situation and define the priority for treatment, based on medical emergency criteria. This process ensures that every patient receives the care they need within the appropriate time frame, whether this involves consultations, additional tests or hospitalisation. Special attention is paid to patients with disabilities, as well as vulnerable or dependent patients. The presence of accompanying family members/carers is facilitated, depending on the patient's clinical situation. Patients are examined and monitored in closed, protected rooms. Finally, the organisation of emergency departments relies on effective coordination between the various healthcare professionals, to optimise patient pathway while avoiding unjustified delays.

Emergency Department Standard

Assessment items

Professionals

- As soon as the patient arrives, triage is carried out by a qualified professional (specialised reception and triage nurse, triage and referral physician) trained in this role and using a validated triage scale.
- Waiting times are communicated to the patient in real time.
- An in-house or external specialist physician can be easily contacted for an opinion. If requested, this opinion is logged in the patient's record.
- The emergency department team has access to the records of a patient who has already stayed or consulted in the healthcare organisation, as well as to the shared medical record on their personal health space.

Patient

- When patients are admitted to the Emergency Department, they are informed about the different stages of their treatment and, if the situation allows, a family member/friend remains at their side while they wait.

Tracer pathway

To support you	
Educational sheets	People with disabilities Emergencies – SAMU/SMUR Mental health and psychiatry
Patient Safety Flash	Diagnostic errors in emergency departments. Missed diagnosis, worsened emergency

Criterion 2.3-04 Professionals are proficient in the management of patient anaesthesia

Before any anaesthetic is administered, an anaesthesia-related risk assessment is carried out, taking into account the patient's health status, medical history and the complexity of the surgical procedure. The choice of anaesthesia method is then justified and adapted to each clinical situation. After surgery, monitoring in the postoperative recovery room is carried out by trained professionals, with systematic checking of equipment and continuous monitoring of vital signs. Discharge from the postoperative recovery room is only authorised once the patient is medically stable. Extubation, a tricky moment, is carried out by qualified professionals only (who have undergone specific and documented training, and subject to the availability of an anaesthetist and resuscitation specialist who can intervene at any time), thereby ensuring patient safety at every stage of the anaesthesia pathway.

Surgery and interventional procedures **Standard**

Assessment items

Professionals • The reports for the pre-anaesthetic consultation and pre-anaesthetic visit (carried out within the required time frame, excluding emergencies) contain an assessment of the anaesthesia-related risk and justification of the choice of method.	Tracer pathway
Professionals • Interventional room and recovery room professionals record the compliance of anaesthesia equipment when the room is opened. • In the postoperative recovery room, good extubation practices are applied by qualified professionals. • Patients' fitness to leave the recovery room is medically validated or assessed on the basis of a medically validated score.	Targeted tracer

To support you	
Educational sheet	Interventional sectors

Criterion 2.3-05 Teams are proficient in good practices for antibiotic prophylaxis associated with invasive procedures

Good antibiotic prophylaxis practices during invasive procedures prevent postoperative infections and limit the risk of bacterial resistance. Teams must follow protocols to ensure appropriate antibiotic use. This includes a prior assessment of the risks of infection associated with the surgical procedure, selection of the most appropriate antibiotic, and compliance with treatment doses, times and duration. To be effective, antibiotic prophylaxis must be administered within a specific time frame before the invasive procedure. Teams are also trained in reassessment of the need for postoperative treatment.

Surgery and interventional procedures **Standard**

Assessment items

Professionals

- The prescription of useful antibiotic prophylaxis, which is systematically carried out at the pre-anaesthetic or pre-operative consultation, is documented in the patient's record.
- In specific cases (high BMI, antibiotic-resistant microorganism carrier, etc.), antibiotic prophylaxis is adapted.
- Antibiotic prophylaxis complies with the protocol according to the type of surgery and the patient's situation (drug, dosage, time of administration and duration of antibiotic prophylaxis) in accordance with the most recent good practice guidelines.
- Interventional sector teams implement improvement actions based on an analysis of antibiotic prophylaxis practices.

Targeted tracer

To support you	
Educational sheet	Interventional sectors Healthcare-associated infections Global management through the quality and safety of care

Criterion 2.3-06 Interventional sector teams manage the risks, particularly risks of infection, associated with equipment and professional practices

In interventional sectors, teams ensure that hygiene practices are strict, that equipment is sterilised and that premises are maintained in accordance with current standards. Equipment must be disinfected regularly, and its correct operation checked before each procedure. Healthcare professionals follow strict protocols to limit the risks of contamination, whether in terms of aseptic procedures, management of invasive devices or appropriate clothing. Particular attention is paid to personnel movements in the premises in order to minimise the risk of cross-infection.

Surgery and interventional procedures **Essential**

Assessment items

Professionals • The team performs all stages of patient preparation in accordance with the protocol in force (shower, hair removal if required), defined with the operational hygiene team. • Before the procedure, the team performs skin antisepsis following the protocol in force. • Interventional room professionals record the compliance of operating equipment when the room is opened.	Targeted tracer
Observations • The team wears appropriate clothing and equipment (tunic, trousers, mask) strictly dedicated to the interventional sector.	Observation

To support you

Educational sheet	Interventional sectors Healthcare-associated infections
Quality and safety of care indicators (IQSS)	Operating site infections following total hip replacement Operating site infections following total knee replacement
Patient Safety Flash	Perioperative management of anticoagulants. Patients, carers and Healthcare professionals: coagulate! Forgotten surgical equipment and healthcare-associated infections. Good accounts make for good care

Criterion 2.3-07 Teams manage the risk of infection associated with the thermosensitive reusable invasive medical device circuit

Thermosensitive reusable invasive medical devices follow a specific disinfection and sterilisation process, appropriate to their thermal sensitivity. Such devices include:

- endoscopes;
- endocavitary ultrasound probes;
- ophthalmic microsurgery equipment.

Teams must follow strict decontamination protocols, including manual or automated cleaning, followed by low-temperature disinfection or chemical sterilisation, to preserve the integrity of the devices while eliminating pathogens. Traceability of treatment steps, checks to ensure sterilisation equipment is working properly and regular training of professionals are essential to guarantee the safety of the circuit. Monitoring and assessment of practices reduces the risks of infection associated with these sensitive devices.

Surgery and interventional procedures **Standard**

Assessment items

Professionals

- Professionals responsible for disinfecting thermosensitive reusable invasive medical devices are trained and qualified.
- The list of the active stock of thermosensitive reusable medical devices is kept up-to-date.
- The conditions and procedures for disinfecting and storing thermosensitive reusable invasive medical devices comply with good practices.
- The results of microbiological controls on thermosensitive reusable invasive medical devices, analysed with the operational team for hospital hygiene, attest to the fact that the risks of infection are controlled. In the event of non-compliant results, procedures are followed and improvement actions are implemented.
- The reference of the thermosensitive reusable invasive medical device is documented in the test report.
- For each thermosensitive reusable invasive medical device, a log records all the information relating to it: procedures performed, cleaning and disinfection operations, maintenance and microbiological controls.

Targeted tracer

To support you

Educational sheet	Interventional sectors Healthcare-associated infections Global management through the quality and safety of care

Criterion 2.3-08 Teams secure the outpatient surgery pathway

Coordination between professionals helps to optimise care, while ensuring patient safety. Hence, during outpatient surgery, teams ensure that every stage of the process, from pre-operative preparation to discharge, is managed:

- assessment of patient eligibility for outpatient surgery;
- verification of medical and social conditions;
- early discharge planning.

The medical examination authorising discharge is carried out immediately before the patient is discharged. An alternative to the discharge medical examination may be a conditional sign-off based on a score, i.e. the possibility of discharging the patient without them seeing a physician again. In this case, it is based on a proven scoring method that paramedics have been trained to use. For the patient's return home, postoperative safety is based on the transmission of clear instructions, explained to the patient and collated in a document that is given to them or easily accessible.

Surgery and interventional procedures **Standard**

Assessment items

Patient • Patients undergoing surgery are informed about the pre-, peri- and postoperative procedures involved in their outpatient care. **Professionals** • The team documents the patient's eligibility for outpatient care.	Tracer patient
Professionals • The discharge authorisation document is signed by a physician, or is signed off conditionally on the basis of a score (on prescription), assessed by trained professionals. • The outpatient surgery team performs patient follow-up by telephone or text message once they have returned home.	Tracer pathway

To support you	
Educational sheet	Interventional sectors
Quality and safety of care indicators (IQSS)	e-Satis Outpatient surgery process indicators

Criterion 2.3-09 Teams in interventional sectors improve their practices by analysing "Patient safety" checklist implementation methods

The "Patient safety" checklist, introduced to improve the safety of surgical procedures, enables critical elements to be systematically checked at each stage of the care process: identification of the patient, verification of the surgical site, control of devices and equipment, and validation of the procedure. To facilitate the adoption of the checklist by professionals – the best way of improving patient safety – the HAS encourages professionals to adapt the checklist to facilitate its adoption. By regularly analysing how the checklist is implemented, teams can identify any deviations or points to watch out for, adjust their practices and improve communication between the various professionals. This evaluation and adjustment process helps to prevent errors, optimise coordination and guarantee patient safety throughout their intervention pathway.

Surgery and interventional procedures **Essential**

Assessment items

Professionals • A checklist, potentially adapted on the basis of HAS recommendations, is systematically and exhaustively implemented by operating theatre and interventional sector teams at every stage. • The checklist is implemented in the presence of the professionals concerned. • Checklist implementation assessments are monitored by operating theatre and interventional sector teams (in particular, Go/No Go monitoring). • Operating theatre and interventional sector teams implement improvement actions based on analysis of the results of checklist implementation monitoring indicators.	Targeted tracer

To support you

Educational sheet	Interventional sectors Global management through the quality and safety of care

Criterion 2.3-10 Teams implement major obstetric risk prevention measures

Preventing major obstetric risks is a key issue in the care of pregnant women. Care teams are trained to detect potential complications, such as postpartum haemorrhage, pre-eclampsia and obstructed labour, at an early stage. Strict protocols are applied to anticipate these risks, including reinforced prenatal monitoring for at-risk patients and effective management of obstetric emergencies. The implementation of emergency drills and fluid communication between the various parties involved ensure optimum responsiveness. Thanks to these measures, teams can intervene quickly and effectively to prevent or limit the consequences of major obstetric complications, thereby ensuring the safety of patients and their newborn infants.

Maternity unit **Essential**

Assessment items

Professionals

- On admission, the healthcare organisation has access to all the information in the patient's record collected outside and inside the hospital setting, even during emergency transfers.
- The team is proficient in the interpretation of foetal heart rates following training.
- The team is proficient in obstetric manoeuvres following training.
- Vital emergency equipment, in the event of primary postpartum haemorrhage, has been verified and is compliant.
- The vital emergency procedure for postpartum haemorrhage is available in the delivery rooms and known to professionals.

Tracer pathway

To support you

Educational sheets	Maternity – perinatal care

Criterion 2.3-11 Teams ensure safe neonatal care

Ensuring safe neonatal care improves the health and well-being of infants from the very first moments of life. Care teams follow protocols to ensure immediate identification of the infant, to prevent infection and to assess vital functions (in particular via the Apgar score). Continuous monitoring means that any abnormality or complication requiring specialist treatment can be detected quickly. Essential care, such as maintaining body temperature and managing feeding, is systematically delivered. Finally, clear communication with the parents ensures a smooth transition, while encouraging close monitoring of the newborn's first moments of life.

Maternity unit **Essential**

Assessment items

Professionals

- All healthcare professionals caring for newborn infants in the delivery and maternity unit receive drill training when they take up their duties and throughout their professional career.
- Professionals are familiar with neonatal care procedures in the delivery suite and maternity unit (neonatal resuscitation, neonatal infection, etc.).
- Professionals record delayed clamping of the umbilical cord and skin-to-skin contact in the patient record. When they are not carried out, the reason is given.
- Professionals record the temperature of the newborn in the patient record on leaving the delivery suite and on admission to the care unit.
- Breastfeeding support is part of a formalised quality approach (specific training, trained professionals, with dedicated time, etc.).
- Professionals analyse their outcomes and define improvement measures where necessary (for example: rate of delayed cord clamping, antenatal corticosteroid therapy, monitoring of neonatal temperatures, length of hospital stay, breastfeeding monitoring, etc.).

Tracer pathway

To support you

Educational sheet	Maternity – perinatal care Global management through the quality and safety of care

Criterion 2.3-12 Critical care teams manage the risks associated with their practices

In critical care sectors, multidisciplinary teams (physicians, nurses, intensive care specialists, anaesthetists) work closely together to prevent and manage complications associated with complex care, such as mechanical ventilation, high-risk infusions or haemodynamic monitoring. Patient transport, which is often critical, is governed by protocols to avoid any incidents while patients are being moved. Continuous visual and audio surveillance, using monitoring devices, makes it possible to respond quickly in the event of life-threatening problems. Professionals are also trained to recognise and treat post-intensive care syndrome (PICS), a common complication in critical care patients.

Critical care **Standard**

Assessment items

Professionals • All critical care patients are subject to visual and audio monitoring, supported by a monitoring system management procedure (definition of alarm thresholds, alarm reporting, etc.), carried out by trained professionals. • Critical care teams transport patients following a multiprofessional benefit/risk analysis and in conditions that guarantee continuity of monitoring and safety. • Critical care teams prevent PICS (mobilisation protocol, detection and treatment of delirium, etc.) in accordance with good practice guidelines. • Medical decisions are explained to the team during multiprofessional staff meetings to promote understanding and enable questions to be shared.	Tracer pathway

To support you	
Educational sheet	Critical care
Patient Safety Flash	Tracheostomised patient in critical care. Tracheostomy: when life depends on a tube Intra-hospital transport of critical care patients. Transport is also critical Monitoring of patients in critical care. Constant vigilance to ensure that no patient fails

Criterion 2.3-13 Organ, tissue and haematopoietic stem cell retrieval and transplantation activities are assessed, giving rise to improvement action plans for which the effects are measured

Organ transplantation teams assess their outcomes using the Cumulative Sum Control Chart (CUSUM) deployed by the French Biomedicine Agency. This method consists in analysing the team's post-transplantation outcomes (3-month failure rate) in comparison with its own past performance or national outcomes over a recent period. Since 2010, the French Biomedicine Agency has been running a quality programme and approach for healthcare organisations authorised to harvest organs and tissues, Cristal Action®, making it possible to put in place any required action by analysing the care provided to potential donors based on the study of hospital deaths. The JACIE (Joint Accreditation Committee-International Society for Cellular Therapy & EBMT) develops international procedures and a peer accreditation system to ensure that patients get the best quality of care and to improve the performance of laboratories and centres specialised in the collection, management and transplantation of haematopoietic stem cells (HSCs).

Critical care **Standard**

Assessment items

Professionals • Critical care teams have access to a suitable environment for talking to relatives (awareness-raising, dedicated space, information support on organ donation, etc.) in liaison with the hospital organ and/or tissue retrieval coordination unit (CHPOT). • All patients declared brain dead are analysed to determine if they are eligible for organ donation. • Critical care teams know how to contact the hospital organ and/or tissue retrieval coordination unit (CHPOT). • Organ and tissue retrieval teams follow the indications proposed by the French Biomedicine Agency and implement the recommendations resulting from audits performed by the Biomedicine Agency. • The teams involved in the retrieval, treatment, storage and transplantation of haematopoietic stem cells assess their outcomes using the French Biomedicine Agency indicators, implement action plans and are engaged in the JACIE accreditation programme. • Hospital organ and tissue retrieval coordination units assess their practices using the indicators proposed by the French Biomedicine Agency, including Cristal Action® indicators.	Tracer pathway

To support you

Educational sheets	Critical care

Criterion 2.3-14 Teams comply with good practices in terms of restraint and isolation measures implemented as part of non-consensual hospital admissions

Isolation and restraint implemented in non-consensual hospital admissions are practices governed by strict rules to ensure that the rights and dignity of the patients concerned are respected. These measures, which should only be used as a last resort, are intended to prevent imminent danger to the patient or others. Care teams must follow good practice in this area, ensuring that each decision is medically justified, proportionate to the situation and regularly reassessed.

Mental health and psychiatry Essential

Assessment items

Professionals • In compliance with the regulations in force and good practice guidelines, decisions taken by a psychiatrist to isolate and/or restrain a patient are logged in the patient's record. The decision specifies the monitoring methods (indications and frequency). • A psychiatric and physical examination is performed when the patient is placed in isolation and/or restrained. • Isolation, with or without a prescription for restraint, is carried out in a dedicated area that respects the patient's privacy, dignity and safety. • In compliance with the decision, the nurse monitors the patient's physical and psychological state and logs this in the patient's record. • On leaving isolation or after restraints are removed, patients are offered the opportunity to discuss the episode with the team in order to prevent a recurrence of the violent episode that led to the measure being indicated. This clinical analysis is logged in the patient's record. • The team analyses the clinical practice indicators related to isolation and restraint.	Targeted tracer

To support you

Educational sheets	Mental health and psychiatry

Criterion 2.3-15 Teams implement electroconvulsive therapy risk prevention measures

Electroconvulsive therapy (ECT), which is recognised as an effective treatment for certain severe psychiatric conditions, requires preparation and follow-up to minimise complications. Multidisciplinary teams, including psychiatrists, anaesthetists and nurses, implement protocols to assess contraindications and monitor vital functions before, during and after each session. A pre-anaesthetic assessment is systematically carried out to ensure that the patient is tolerant to anaesthesia. In addition, careful post-ECT monitoring can detect any cognitive or physiological side effects. Ongoing training for professionals on the risks associated with ECT and regular analysis of incidents help to improve the safety and quality of care.

Electroconvulsive therapy Standard

Assessment items

Professionals

- The appropriateness of recourse to electroconvulsive therapy is documented in the patient's record and/or shared medical record.
- To determine the frequency and number of electroconvulsive therapy sessions to be carried out, the team analyses the benefits and risks. This analysis is recorded and adjusted based on the evolution of the patient's clinical condition.
- The reports for the pre-anaesthetic consultation and pre-anaesthetic visit (carried out within the required time frame) contain all the information required to assess the anaesthesia-related risk prior to the electroconvulsive therapy session.
- Electroconvulsive therapy is carried out on a specific site in the presence of trained professionals (at least: a psychiatrist, an anaesthetist and a nurse).
- Post-interventional monitoring in electroconvulsive therapy patients is carried out in an appropriate, safe environment.
- Teams implement improvement actions based on analysis of indicator results and/or analysis of the relevance of the electroconvulsive therapy procedure.

Targeted tracer

To support you

Educational sheet	Mental health and psychiatry Global management through the quality and safety of care

Criterion 2.3-16 Teams manage the risks associated with radiotherapy procedures

Radiotherapy, which is used to treat cancer, exposes patients to ionising radiation, requiring protocols to prevent adverse effects and optimise the effectiveness of the treatment. Multidisciplinary teams (oncologists, medical physicists, radiation therapists) follow procedures for planning, calibrating equipment and checking the doses administered. Every stage, from the initial simulation to the treatment session, is monitored to avoid any positioning or dosage errors. Continuous monitoring of equipment, combined with regular training of professionals and analysis of incidents, ensures that risks are reduced. Finally, close monitoring of patients means that any treatment-related complications can be detected quickly.

Radiotherapy **Standard**

Assessment items

Professionals

- The patient's identity and treatment protocol, as well as the irradiation side, if applicable, are double-checked before each radiotherapy procedure.
- In radiotherapy, the stereotactic positioning of the patient is defined prior to treatment and is effective throughout the treatment.
- For radiotherapy procedures, the dose received by the patient in the target volume is logged in the record: dose per session, total cumulative dose, number of sessions.
- In radiotherapy, a log in which all internal and external maintenance and quality control operations are recorded is available for each therapeutic medical device (software, machines and dedicated equipment).
- Radiotherapy professionals are trained to identify events that should be considered to be adverse.
- Radiotherapy teams analyse incidents or risks of incidents involving a therapeutic medical device that could lead to serious complications for the health of a patient or user.

Tracer pathway

To support you

Educational sheet	Ionising radiation and radiotherapy

Chapter 2.

The care teams

Objective 2.4

The culture of appropriateness and assessment

The main objective of health interventions is to improve patient health. Quality procedures are based on this objective, so that the can be integrated into professional practices and make sense for care teams. Appropriateness or relevance (the right healthcare intervention at the right time, in the right place for the right patient) is an essential aspect of quality of care and a major factor to ensure patient safety. Care is appropriate when the expected health benefit (e.g. increased life expectancy, pain relief, reduced anxiety, improved functional capacity) outweighs the expected negative consequences (e.g. mortality, morbidity, anxiety, pain, length of time off work) by enough for it to be considered worthwhile to undertake the procedure, regardless of its cost. For healthcare professionals, caring about patient outcomes means focusing on their core purpose. Hence, teams are expected to engage in actions focused on improving the outcome for patients and to achieve this, it is essential that they measure the impact of their practices. The objective here is to assess teams' implementation of this analysis, rather than the observed outcome level.

Criterion 2.4-01 Teams' actions are based on its protocols, which incorporate good practice guidelines

A guarantee of quality and safety for patients, the use of up-to-date good practice guidelines ensures that the care delivered minimises errors and risks to patients. The use of protocols based on good practice fosters a positive working environment, where transparency and accountability are central to interactions. This contributes to the engagement of professionals, who feel valued and empowered to participate in the continuous improvement of care.

Entire organisation **Standard**

Assessment items

Governance

- Medical and healthcare authorities regularly identify changes in the most important clinical or organisational practice guidelines in relation to the activity.

Professionals

- The most important clinical or organisational practice guidelines in relation to the activity are accessible to teams.
- Where necessary, teams adapt their procedures (diagnostic and therapeutic procedures, care, etc.) to good practice guidelines.
- The team has a continuous process for assessing the clinical outcomes of its patients in areas where it has identified potential for improvement in line with good practice guidelines (professional practice assessment).
- Analysis of assessments of the appropriateness of care pathways, in particular using the alert indicators employed by the team (e.g. admissions, 48-hour transfer rate, length of stay, readmission rate, etc.), enables improvement actions to be implemented.

System audit

To support you

Educational sheets	Telehealth Medical accreditation Global management through the quality and safety of care
Patient Safety Flash	Teleconsultation: be extra vigilant when working remotely

Criterion 2.4-02 The appropriateness of antibiotic prescriptions is justified and reassessed

The teams' compliance with good antibiotic therapy practice guidelines is indispensable to combat antibiotic resistance, which can cause serious complications, prolongation of hospitalisation or even death. In particular, combating antibiotic resistance involves justifying prescriptions for antibiotic treatment and reassessing antibiotic therapy between the 24th and 72nd hour. More generally, combating antibiotic resistance is based on monitoring indicators such as the percentage of antibiotics prescribed in line with clinical guidelines, the proportion of infections caused by antibiotic-resistant bacteria in the population and the implementation of improvement measures.

Entire organisation Essential

Assessment items

Professionals

- Practitioners are trained in the correct use of antibiotics, particularly those engaged in studies.
- Any antibiotic prescription is justified in the patient record.
- Practitioners refer to local guidelines for antibiotic therapy and can consult an internal and/or external antibiotic therapy expert.
- Assessments of the appropriateness of an antibiotic prescription are systematically performed between the 24th and 72nd hour.
- The healthcare organisation is improving its indicators for combating antibiotic resistance.
- The operational team for hospital hygiene, the in-house pharmacy and teams monitor their antibiotic use and participate in the national antibiotic use and resistance monitoring network (CONSORES).

Targeted tracer

To support you	
Educational sheet	Medicine
Quality and safety of care indicators (IQSS)	Rate of patients with an antibiotic prescription for 7 days or less for a lower respiratory tract infection

Criterion 2.4-03 The appropriateness of the use of freedom-restricting measures (limitation of contacts/ visits, removal of personal items) is discussed and reassessed

With the exception of measures taken to ensure the patient's safety on a one-off basis, the use of freedom-restricting measures is subject to a medical decision based on clinical data resulting from a medical examination and must be justified in the patient's record. This justification must include the prior measures taken without success in order to establish that the measures really are taken as a last resort. It includes the benefit/risk assessment and must be proportionate and reassessed throughout the hospital stay. Clear and explicit information must be provided to the patient and/or their person of trust and noted in the patient's record, in particular for elderly patients.

Entire organisation **Standard**

Assessment items

Patient • Prior to the restriction of freedom, the patient and/or the person of trust have received clear and explicit information.	Tracer patient
Professionals • With the exception of measures taken to ensure the patient's safety on a one-off basis, the use of freedom-restricting measures is subject to a medical decision specifying the implementation methods (restraint points, freedom-restricting methods, day or night, duration, monitoring and assessment methods). • With the exception of one-off safety measures, the use of freedom-restricting measures is subject to a multidisciplinary benefit/risk analysis, which is documented in the patient's record. • With the exception of one-off safety measures, the appropriateness of maintaining the freedom-restricting measure is systematically reassessed. • The healthcare organisations implements a risk reduction approach by promoting alternatives to freedom-restricting measures, particularly in the case of patients at risk of falls or pathological wandering.	Targeted tracer

To support you

Educational sheet	Elderly patients Mental health and psychiatry

Criterion 2.4-04 Teams are engaged in a reflection process to ensure eco-responsible care

Eco-responsibility in healthcare is not just about managing waste or reducing the carbon footprint. It encompasses a vision in which every action matters. Teams work together to rethink daily practices and integrate sustainable solutions into their activities. This collective reflection process results in strategies such as promoting the use of recyclable materials, but also the assessment of practices in terms of their environmental impact, thereby encouraging the development of greener treatments that take into account clinical efficacy and the preservation of ecosystems. Working on eco-responsible care represents an opportunity for teams to provide care and preserve the environment for future generations. This approach, driven by the expertise and engagement of professionals, marks an essential move towards a sustainable and resilient healthcare system, in harmony with the planet.

Entire organisation **Standard**

Assessment items

Governance

- The healthcare organisation informs its teams of the efforts made in terms of water and energy consumption and greenhouse gas emissions.

Professionals

- A multiprofessional reflection process on eco-responsible care is being carried out to identify improvement actions within departments.
- The revision of care protocols takes into account the dimension of eco-responsible care (reduction of unnecessary interventions, review of necessary equipment, etc.).
- The team assesses the impact of the eco-responsible care initiatives it implements.

System audit

To support you

Educational sheets	Healthcare-associated infections Global management through the quality and safety of care

Criterion 2.4-05 The appropriateness of a patient's admission to and stay in a medical care and convalescence unit is discussed and reassessed by the team

In medical care and convalescence (under full hospitalisation, day hospitalisation or HAH), admission requests are examined by a multiprofessional team to ensure that the care objectives are consistent with the healthcare organisation's missions and that the patient's characteristics (main disease/condition, age, comorbidities if any, living conditions, etc.) are consistent with the specialisation and types of stay offered by the healthcare organisation. After the first phase of the stay, the reassessment confirms the appropriateness of this care. Discharge arrangements are prepared and adjusted as needed, following discussions with the patient, in particular concerning the technical and human assistance required for the patient's return home.

Medical and convalescence care **Standard**

Assessment items

Professionals

- Requests for admission to medical care and convalescence facilities are processed every working day.
- Requests for admission to medical care and convalescence facilities are subject to a multi-professional appropriateness analysis based on the information declared in VIA TRAJECTOIRE referral service or other methods (professional resources, technical platform, etc.).
- To prepare these requests, needs and obstacles to discharge (home, equipment, etc.) are identified as soon as the patient is admitted, in coordination with community medicine practitioners and social services.
- Medical care and convalescence teams work with downstream facilities to analyse the appropriateness of discharge referrals.
- Teams analyse appropriateness indicators (sterile medical device, appropriateness of hospitalisation days, etc.).

Tracer pathway

To support you

Educational sheets	SMR
Quality and safety of care indicators (IQSS)	Coordination of care and clinical practices

Criterion 2.4-06 Teams improve their practices on the basis of analysis of their clinical practice indicator results

The results of indicators, including quality and safety of care indicators, are data that enable the level of quality and care safety to be objectively assessed for a given objective. Joint analysis and monitoring of the results enable teams to identify avenues for progress and collectively come up with improvement actions to be put in place. The principle of regular team reviews promotes the involvement of all players in the continuous improvement of quality of care.

Entire organisation **Standard**

Assessment items

Professionals • Teams monitor indicators (internal clinical practice indicators and/or quality and safety of care indicators) and analyse them. • Teams improve the results of indicators that concern them (internal clinical practice indicators and/or quality and safety of care indicators).	Tracer pathway
Governance • A set of improvement actions is implemented and includes the actions derived from the analysis of indicators (internal clinical practice indicators and/or quality and safety of care indicators). • The results of indicators (internal clinical practice indicators and/or quality and safety of care indicators), their analysis and their evolutions are presented to the healthcare organisation's bodies (Medical Committee, Nursing, Rehabilitation and Medico-Technical Care Committee, User Committee, etc.).	System audit

To support you	
Educational sheet	Intra-hospital pathway Emergency – SAMU/SMUR Elderly patients Healthcare-associated infections People with disabilities SMR Global management through the quality and safety of care
Quality and safety of care indicators (IQSS)	Quality and safety of care indicators in healthcare organisations

Criterion 2.4-07 Teams in interventional sectors improve their practices by analysing their indicators

Continuous improvement of practices in interventional sectors is based on systematic analysis of performance and quality indicators. Whether they relate to patient safety, clinical practices or risk management, these indicators are used to measure the effectiveness of actions taken and to identify areas for improvement in order to optimise the safety and quality of care. This process is strengthened by a culture of sharing feedback, promoting improved patient care and reducing risks.

Surgery and interventional procedures **Standard**

Assessment items

Professionals

- Surgical, anaesthesia and interventional sector teams implement improvement actions based on analysis of operating theatre and interventional sector indicators (room occupancy rate, actual room occupancy rate, overflow, etc.).
- Surgical, anaesthesia and interventional sector teams put in place improvement actions based on the analysis of scheduling discrepancies (difference between what is scheduled and what is performed, rescheduling time).
- Surgical, anaesthesia and interventional sector teams put in place improvement actions based on the analysis of infection prevention measures: appropriate work wear, hand hygiene, skin preparation, discipline (number of people in the room, opening of doors, comings and goings, etc.).
- Interventional sector teams implement improvement actions based on the analysis of operating site infections.

Targeted tracer

To support you

Educational sheet	Interventional sectors Global management through the quality and safety of care

Criterion 2.4-08 Critical care sector teams improve their practices focusing, in particular, on their patient care methods

Critical care requires a multidisciplinary approach in which each member of the team contributes to the overall and personalised care of patients. This interdisciplinary collaboration helps improve quality of care and adapt treatments to the specific needs of each patient. To improve their practices, these teams rely on constant evaluation of care methods, whether by updating therapeutic guidelines, analysing treatment outcomes or taking part in clinical trials. In addition, feedback and discussion of complex clinical situations help to identify grey areas and implement improvement strategies.

Critical care **Standard**

Assessment items

Professionals • Critical care teams monitor indicators specific to the department, analyse them collectively and improve patient care. • Critical care teams analyse the appropriateness of critical care unit stays. • Critical care teams implement improvement actions based on the analysis of readmissions within 48/72 hours.	Tracer pathway
Governance • Governance has anticipated the need to provide backup to critical care sectors in the event of a crisis (training of professionals, availability of equipment, etc.).	System audit

To support you	
Educational sheet	Critical care Global management through the quality and safety of care

Criterion 2.4-09 Teams improve their practices by analysing the quality of medical imaging investigation and laboratory test results

Coordination between healthcare teams and biomedical/pathology teams is necessary to improve the quality of test and investigation results. This ensures that the investigation provides an answer to a clinical question, that samples ae taken in accordance with good practices, that examination conditions comply with the imaging standards of learned societies, and that the results are delivered within an appropriate time frame in view of the patient's needs.

Entire organisation **Standard**

Assessment items

Professionals

- Internal or external laboratories are COFRAC-accredited.
- For difficult cases having required their opinion (oncology, chronic infectious diseases, possibly emergencies, etc.), imaging specialists take part in multidisciplinary team meetings.
- Teams implement improvement actions to follow up on the collective analysis of adverse events (delays, prescriptions, unusable samples, etc.) related to laboratory activities.
- Teams implement improvement actions to follow up on the collective analysis of adverse events (delays, prescriptions, image quality, etc.) related to imaging activities.

Tracer pathway

To support you

Educational sheet	Intra-hospital pathway Global management through the quality and safety of care

Chapter 3

The healthcare organisation

Objective 3.1

Global management through the quality and safety of care

The organisation develops a forward-looking approach to its care provision, based on its local area's healthcare needs. The healthcare organisation's strategic plan correlates its care provision – whether health-related or medico-social – with that of the local area, with the aim of providing graded, complementary care that is easily accessible to patients.

Criterion 3.1-01 Governance deploys a quality and safety of care improvement policy

The policy of continuous improvement in the quality and safety of care sets healthcare organisation-specific improvement objectives, i.e. determined on the basis of an analysis of all available data: the patient and user perspective, the results of indicators, upstream and downstream risks, etc. Co-steered by management and the Medical Committee, its development, implementation and evaluation must be participative and involve management, professionals, the nursing, re-education and medico-technical care committee (if one exists) and user representatives. Its objectives are set out in a single, structured, relevant and personalised action programme.

Entire organisation **Standard**

Assessment items

Governance

- The Medical Committee draws up and monitors the quality and safety of care policy with management, professionals and user representatives.
- The priorities of the quality and safety of care policy are based on an analysis of all the indicators (in particular the quality and safety of care indicators, including patient experience indicators), risks specific to the healthcare organisation and available knowledge.
- The quality and safety of care improvement programme (PAQSS) takes into account the recommendations and risk analyses of other external assessment and/or control authorities: regional health agency (ARS), French Nuclear Safety Agency (ASN), French Controller-General of Places of Deprivation of Liberty (CGLPL), French Biomedicine Agency (ABM), etc.
- The priorities of the quality and safety of care policy are set out in a structured, relevant, up-to-date and unique programme for improving the quality and safety of care, which is reassessed annually.

Management

- Medical and paramedical managers are familiar with the main actions in the quality and safety of care improvement programme that concern them, so that they can translate them into concrete actions in their sector.

Professionals

- Professionals are familiar with the actions in the quality and safety of care improvement programme that concern them.

System audit

To support you

Educational sheets	Patient engagement Telehealth Exceptional health situations Global management through the quality and safety of care

Criterion 3.1-02 The healthcare organisation supports a culture of quality and safety among its professionals

The healthcare safety culture combines all the ways of doing and thinking shared by all the organisation's players and contributing to patient safety. This involves the reporting of care-related adverse events (CRAEs), feedback, high-quality teamwork, and a culture of "fairness" (human error is analysed rather than condemned). It is built on the interaction between players and the involvement of users. Governance must promote values, behaviours and attitudes that foster this benevolent culture aimed at improving the quality and safety of care. Accreditation of physicians and medical teams is a mechanism that should be promoted, as are safety meetings, which demonstrate governance's commitment to patient and professional safety and facilitate communication between governance and professionals in the sectors where the meetings take place.

Entire organisation **Standard**

Assessment items

Governance • The healthcare organisation regularly assesses the quality and safety of care culture of all its professionals using a defined method (e.g. safety culture survey, etc.). • Governance has participated in at least one safety meeting inspired by the methods promoted by the HAS. • Governance promotes the accreditation mechanism to eligible physicians (information, incentive, logistic and financial support, etc.). **Management** • Medical and paramedical managers are aware of the results of assessment of the quality and safety of care culture and implement improvement actions adapted to their sector. **Professionals** • Professionals participate in activities focused on the quality and safety of care organised within the healthcare organisation. • The mechanism for bottom-up and top-down vigilance alerts and all reports are properly managed: responsibilities are identified; reception procedures are defined; transmission procedures are defined. The system is monitored round the clock.	System audit

To support you

Educational sheet	Global management through the quality and safety of care Medical accreditation

Criterion 3.1-03 Physicians and medical teams are accredited

The accreditation of physicians and medical teams in “high-risk” specialities and activities is one of the programmes designed to improve professional practice and patient safety that has been in operation for over 15 years. The HAS promotes the team accreditation programme (for one or several disciplines) as a model that is particularly suited to the work performed in healthcare organisations, irrespective of their status. The accreditation process, which is voluntary, is based on speciality programmes, developed by peers and supported by professional bodies approved by the HAS for accreditation and in accordance with a method and an assessment overseen by the HAS. This programme helps develop a safety culture within teams. Each accreditation programme now comprises five aspects: improvement of teamwork, professional practices, patient safety, the relationship with patients and the health of professionals. Accreditation thereby guarantees the maintenance of skills in accordance with the requirements of periodic healthcare professional certification. The HAS' national feedback recording system enables it to define safety solutions that can subsequently be shared. At present, such programmes are only available for surgical and interventional specialities. However, all disciplines can set up programmes based on this model.

The entire healthcare organisation **Advanced**

Assessment items

Professionals • Eligible teams are aware of the physician and team accreditation mechanism.	Tracer pathway
Governance • Governance has identified eligible physicians who are not involved in the accreditation process and has drawn up a timetable with them for their involvement. • Sectors with a so-called “high-risk” activity (gynaecology/ obstetrics, anaesthesia/resuscitation, surgery, interventional specialities, as well as obstetric ultrasound, resuscitation and intensive care activities) have at least one accredited physician or team. • The actions carried out as part of the accreditation mechanism are linked to the organisation’s quality and safety of care improvement approach.	System audit

To support you

Educational sheets	Global management through the quality and safety of care Medical accreditation

Criterion 3.1-04 The healthcare organisation promotes a culture of reporting adverse events, including near misses

To instil a benevolent culture in which human error is analysed rather than condemned, governance promotes a culture of reporting adverse events and near misses. In reality, care-related adverse events (CRAEs including near misses, complaints, clinical, therapeutic or pharmaceutical errors, etc.) and vigilance management provide an opportunity to analyse practices and encourage a collective drive to improve patient safety.

Entire organisation **Essential**

Assessment items

Professionals • Serious care-related adverse events are systematically analysed, involving the teams concerned and user representatives, employing the methods promoted by the HAS. • A summary of contributing factors (or root causes) in care-related adverse events, including near misses, and of the results of the action plans put in place following this analysis, is disseminated to professionals and user representatives. • Serious care-related adverse events are systematically reported on the adverse health events reporting portal. Part 2 is implemented no later than three months after Part 1. • Care-related adverse events that are analysed and reported as part of the accreditation process are also passed on within the healthcare organisation, and the improvement actions resulting from collective analyses contribute to the quality and safety of care improvement programme.	Targeted tracer
Professionals • Professionals are trained in the reporting of healthcare-related harm.	System audit

To support you

Educational sheets	Global management through the quality and safety of care Patient engagement Telehealth Medical accreditation

Criterion 3.1-05 Exceptional health situations are properly managed

The organisation has identified threats potentially giving rise to a situation of hospital tension: massive influx of patients, weakening of emergency services, exceptional health crises. To cope with these situations, a graduated management plan has been put in place, with two levels of mobilisation.

- Level 1: internal mobilisation plan for events with a limited impact on care provision (for example, a seasonal epidemic or fuel shortage).
- Level 2, or emergency preparedness plan: events with a major impact on care provision. This plan sets out the general measures to be implemented in the event of a crisis, such as the activation of a crisis unit, the mobilisation of human resources and communication. Specific measures are set out in sections tailored to each situation, including a component dedicated to digital risks. The plan must be adjusted according to the threats and resources available, with care targets set by the regional health agency (ORSAN components).

In the event of a crisis, a crisis unit, operational within 45 minutes following the alert, steers the hospital's response, organising early discharges, transfers, the opening of additional beds, dispatch of additional staff to emergency and intensive care departments, and the availability of medical and personal protective equipment. A training component completes this mechanism in order to prepare professionals. This training incorporates practical drills.

Entire organisation **Essential**

Assessment items

Governance • The categories of risks, including digital risks, that can generate hospital tensions or exceptional health crises have been identified. • The healthcare organisation's plan(s) for the management of hospital tensions and exceptional health situations have been produced on a collective basis (governance, supervisory bodies, professionals). • The crisis unit is operational within 45 minutes following the alert. It has the required tools and procedures to fulfil its role as decision-maker and coordinator (provision of medical care to patients, crisis organisation, security/safety, communication, monitoring of victims and reception of their families, support functions). • Exercises or drills to manage hospital tensions and exceptional health situations, as well as real activations of the plan, are followed by improvement actions based on feedback. • To deal with an exceptional health situation, the material and human resources, microbiological diagnostic capacities and biomedical testing capacities required for the provision of care are known to governance and can be rapidly mobilised. They are monitored to verify operationality. **Professionals** • The professionals involved in activating crisis plans are aware of the governance structure for managing hospital tensions and exceptional health situations (identified in the organisation chart), as well as the alert and implementation procedures.	System audit

To support you

Educational sheets	Global management through the quality and safety of care Exceptional health situations Critical care

Criterion 3.1-06 The organisation promotes and supports ethical questioning by all players

Some clinical situations, particularly complex ones, can lead to conflicting values that can take the form of ethical dilemmas, sometimes making decisions difficult, in terms of the choices professionals need to make when seeking the best solutions for patients and their families. These situations require timely collective and interdisciplinary discussion, based on structured and shared methods at both organisation and ground level. These methods, adapted to the type of activities of the organisation, involving the patient and their family, protect patient's rights and professional practices. They can be supported by external resources.

Entire organisation **Standard**

Assessment items

Governance

- An inventory of ethical questions is shared with all professionals.
- As part of its ethical considerations, the organisation takes into account the impact of new technologies (robotisation, artificial intelligence, telehealth tools, etc.) that it uses on patients and professionals.
- An ethical discussion forum, including user and/or partner patient representatives, meets at defined intervals.

Professionals

- Professionals are regularly made aware of ethical issues.
- In addition to those identified in the inventory of ethical issues, professionals discuss the ethical issues they face (patient rights, health status, therapeutic strategy, proposed care), if necessary with external resources.

System audit

To support you	
Educational sheets	Patient engagement Telehealth Global management through the quality and safety of care

Criterion 3.1-07 Digital safety risks are properly managed

To manage digital risks, the healthcare organisation must be able to rely on a secure IT system. The organisation performs digital security audits and cyber attack drills to pilot an action plan. The organisation also trains professionals in how to detect the signs of an attack and what to do if one occurs. To detect a crisis, digital security monitoring is in place, and to manage it:

- the emergency preparedness plan includes a component relative to digital risks;
- there is a business continuity plan (BCP) and a business resumption plan (BRP) adapted to the activities most at risk;
- significant or serious IT security incidents are reported immediately to the competent centre. The emergency measures proposed by the centre to limit the impact and improve security are implemented.

Entire organisation **Standard**

Assessment items

Governance

- In its most at-risk sectors, the organisation has deployed a formalised business continuity and resumption plan.
- The organisation has implemented the corrective action plan resulting from Active Directory and Internet exposure audits.
- The organisation has a multiannual training plan for IT health and security, and organises awareness-raising campaigns for all professionals.
- The organisation has trained IT security officers to act as relays for the IT teams in care sectors.
- Significant or serious information system security incidents are reported immediately to the French Digital Healthcare Agency. The recommendations and emergency measures proposed by the French Cybersecurity Agency (ANSSI), to minimise the impact of those measures, intended to improve security, are implemented. In the absence of significant or serious incidents that warrant a report, the organisation has a procedure for qualifying what constitutes a significant or serious incident and for reporting them.

Professionals

- Teams know what to do in the event of an incident/cyber attack (contact details of the digital security officer, identification of fraudulent emails, failsafe modes, etc.).

System audit

To support you

Educational sheet	Under review

Criterion 3.1-08 The identification of users and patients in the information system is secure

To prevent access to personal health data within the meaning of the GDPR by unauthorised persons, it is essential that the organisation defines rules for access to its information system for all users (professionals, temporary staff, students, interns, patients, etc.). In addition, to secure internal access, professionals use a unique personal login and password and there is no generic login and password known by everyone (temporary staff, students, etc.). Remote access to the information system must use two-factor authentication (teleworking, the establishment's “guest” Wi-Fi, etc.) to ensure that users have access rights in their own name.

Entire organisation **Standard**

Assessment items

Governance • The rules governing access to the health information system (access, user rights, etc.) are defined. • The organisation has put in place an arrival/departure management system for granting information system access (particularly for temporary staff, students, interns, etc.). • The organisation provides a workstation (professional workstation) for mobile staff (on call or working remotely) or a remote login system. • For remote access, identities and access to health data are managed by a reinforced two-factor authentication system. **Professionals** • Internal staff use a personal login and a unique personal password to access the information system and all the professional applications, enabling them to log in by name.	System audit

To support you

Educational sheets	Telehealth

Criterion 3.1-09 Patient data are secure

The opening of the *"Mon espace santé"* personal online health space system and exchanges between internal and external professionals highlight the essential need to protect patients' health data by eliminating unsecured health data use in favour of the use of the personal health space shared medical record and secure health messaging.

Entire organisation **Standard**

Assessment items

Governance • The organisation has mapped unsecured exchanges of health data and drawn up a plan for transferring them to a secure health messaging system. • The quality and completeness of the information entered in the patient's personal health space is assessed by the organisation. The results are presented to the Medical Committee and User Committee, and an action plan is drawn up to improve the rate at which the shared medical file is updated. • In the event of a data leak, there is a procedure for informing patients whose data are involved. Where applicable, this procedure has been implemented. **Professionals** • Authorised professionals are trained in the use of a secure healthcare messaging system, as well as how to add data to and consult the patient's personal health space. • Professionals are made aware of the need to eradicate the storage of health documents containing personal medical data on their workstations. • The professionals concerned are aware of the documents from the patient's record, as defined by the regulations, which must be added to their personal health space.	System audit

To support you	
Educational sheets	Under review

Chapter 3.
The organisation

Objective 3.2
Proficient use of professional resources and skills

The organisation must ensure the good distribution of skills and tasks in order to guarantee the quality and safety of the care delivered to patients, including during periods of tension associated with an influx of patients or the absence of professionals. An adequate number of qualified healthcare professionals are needed to meet the ever-increasing demands of an ageing population, as well as evolutions in diseases, techniques and care methods. Whenever resources are insufficient, the organisation must adapt its activities, while measuring the risks associated with the situation and the time it will take to return to normal.

It has been demonstrated that quality of work life (QWL) and quality and safety of care are linked. A QWL policy in the healthcare organisation is designed to look after employees and find the right balance between improving employees' working conditions and the overall performance of the organisation. Multidisciplinarity, decompartmentalisation and the principle of subsidiarity are all part of this approach.

Teams are essential to improve the organisation's ability to fulfil its roles and meet its challenges. Their commitment creates a favourable climate for the ongoing and reactive adaptation of organisational structures and practices, and the search for innovative solutions for the benefit of patients, professionals and the organisation as a whole.

Criterion 3.2-01 Continuity of care is ensured for all care units

The continuous availability of medical and paramedical professionals is crucial to ensuring that patients receive prompt and appropriate care throughout their pathway. It also contributes to better management of emergency situations, continuous monitoring of patients, and appropriate support for patients and their families. In practice, it is based on presence rules, as well as a system of on-call duty, defined to ensure round-the-clock care.

Entire organisation **Standard**

Assessment items

Professionals • The medical organisation enables care to be provided in line with guidelines and regulations. • The paramedical organisation enables care to be provided in line with guidelines and regulations. • Care teams know how to contact a physician at any time. • Solutions are mobilised in the event of unforeseeable absenteeism.	**System audit**

To support you	
Educational sheets	Professional resources Emergencies – SAMU/SMUR Maternity – perinatal care Critical care
Patient Safety Flash	Periods of vulnerability. No vacancies for security

Criterion 3.2-02 The organisation ensures that the available human resources are consistent with quality and safety of care

In France, a distinction is made between standardised and non-standardised care sectors. In the absence of standards, requirements are determined by a tool for calculating staff numbers: the organisational model. The target organisational methods, described in the organisational model, are communicated to bodies and staff. To ensure that the available human resources are consistent with quality and safety of care, the healthcare organisation assesses discrepancies between the target and actual organisational methods, particularly during risky periods. It sets out in a contract with management a roadmap for achieving the target organisation set out in the model (training, mobility, provisional holiday planning, management of HR consumption by department). In the event of divergence from this roadmap, adaptation measures are put in place: overtime, temporary work or even a reduction in activity. In addition, professionals, particularly managers, need to know how to report malfunctions linked to a mismatch between resources and quality and safety of care.

Entire organisation **Standard**

Assessment items

Governance

- Governance monitors the differences between target staff numbers, defined by a standard or by organisational models adapted to the operation of the department, and the staff numbers actually available.
- To ensure that there is a balance between the permanent staff present and temporary staff who are not familiar with the healthcare organisation, governance monitors the rate of temporary employment for each sector.
- When there are occasional discrepancies between target and actual staff numbers, immediate measures are taken (overtime, temporary work, failsafe mode, temporary reduction in activity).
- When there are recurrent discrepancies between target and actual staff numbers, measures are taken (mobility of non-medical personnel, reduction or suspension of activity).
- For regulated healthcare activities, if the minimum number of medical and paramedical professionals is not respected, the regional health agency and the relevant bodies (Medical Committee, Nursing, Rehabilitation and Medico-Technical Care Committee, User Committee, etc.) are informed immediately.
- New arrivals, in particular temporary staff, interns, students, etc., are provided with the information (welcome booklet, induction day at which user representatives participate, intranet, website, etc.) and supervision required to carry out their activities and integrate into the team.

System audit

To support you

Educational sheets	Professional resources
Patient Safety Flash	Periods of vulnerability. No vacancies for security

Criterion 3.2-03 The healthcare organisation makes sure that teams have the required skills to ensure the quality and safety of care

The performance of teams is based primarily on the skills of professionals. Governance must ensure that technical and non-technical skills are acquired and maintained. To this end, it focuses on verifying:

- the qualifications and skills of professionals to define their area of practice;
- the right of physicians to practise medicine, particularly for physicians who have qualified outside the European Union.

To maintain the skills of professionals and help them acquire new ones, management assesses them regularly. If they are no longer in line with their roles and tasks, the organisation takes the necessary action: training, skills maintenance and development programmes with pre- and post-training assessments, etc.

Entire organisation **Standard**

Assessment items

Governance

- The healthcare organisation verifies the qualifications of healthcare professionals to ensure an adequate match between their roles and their skills. Otherwise, the organisation puts in place the required actions.

Management

- Medical and paramedical managers have a record of the ongoing professional training undertaken by their team.
- Medical and paramedical managers carry out annual reviews to take the necessary steps to ensure that their roles and skills match up (training, continuous professional development in compliance with HAS methods, etc.).

Professionals

- Professionals can benefit from training consistent with the quality and safety of care improvement programme actions implemented in their department.
- Collective skills maintenance and development programmes, with pre- and post-training assessments, are followed by the teams (simulation of risk events in critical sectors, good practice workshops, assessment of professional practices (EPP) etc.).
- Professionals are aware of the players who can help them with their career plans, skills development programmes, skills assessments, etc.

System audit

To support you

Educational sheets	Professional resources Emergencies – SAMU/SMUR Telehealth Exceptional health situations

Criterion 3.2-04 The healthcare organisation provides its professionals with risk management training using health simulation tools

Health simulation and risk management share a number of values: multiprofessional approach, educational role, involvement of players, positive error culture, impact on patient safety, etc. In healthcare establishments, governance (general management, Medical Committee, care management, risk management coordination, etc.) must get involved in order to drive a risk management approach and make simulation an institutional priority, allocate the necessary resources and promote team and interprofessional approaches.

The entire healthcare organisation Advanced

Assessment items

Governance • A multiprofessional project group identifies the need for a simulation-based training programme. • As part of its upstream and downstream risk management approach, the healthcare organisation offers a training programme incorporating a simulation-based teaching method for professionals. • Simulation-based training programmes, whether developed in-house or offered by external training bodies used by the healthcare organisation, comply with the HAS methodological guide on health simulation and risk management. • If available, the healthcare organisation shares its simulation-based training programmes with other organisations (local area, group, etc.).	System audit

To support you

Educational sheets	Professional resources

Criterion 3.2-05 Team managers are trained and supported in their role

To develop a quality and safety of care culture, leadership is needed at all levels of the organisation. Medical and paramedical managers play a key role in translating policy into concrete action on the ground. Managers must unite their team, provide a common vision and set objectives to achieve results. Therefore, medical and paramedical managers receive management training to ensure they acquire the necessary skills and attitudes. In addition, managers share their experience and benefit from coaching or support, particularly in managing conflicts and interpersonal difficulties.

Entire organisation **Standard**

Assessment items

Management • The healthcare organisation's management charter provides for the involvement of all medical and paramedical managers, the harmonisation of management practices and the clarity of roles. • Medical and paramedical managers have followed the manager pathway (e.g. modules taken, tools used, etc.) or are trained in management (e.g. taking care of their team, identifying complex professional situations, secularism, etc.). • In the exercise of their supervisory roles, medical and paramedical managers benefit from support, co-development workshops, coaching and/or mentoring for acting managers. • Medical and paramedical managers are trained in the prevention and management of discrimination, bullying, sexual and gender-based violence and disputes or conflicts between employees.	**System audit**

To support you	
Educational sheets	Professional resources

Criterion 3.2-06 Governance implements a health policy for its professionals

A healthy professional is one who is present and able to provide good quality care. To this end, the healthcare organisation:

- ensures the provision of psychological support programmes accessible to all professionals;
- checks compulsory vaccinations, raises awareness among professionals of the benefits of recommended vaccinations, provides free and easy access to vaccinations, analyses vaccination coverage rates and implements improvements;
- provides protective equipment that the team uses correctly: medical masks, gloves, gowns, sharps containers, alcohol-based hand sanitisers, etc.;
- has premises and equipment that respect the health of professionals: for example, for the disinfection of endoscopes, the use of ionising radiation (PPE, dosimeters, measures to be taken in the event of overexposure, complications, burns, etc.) and the preparation of cytotoxics.

Entire organisation **Standard**

Assessment items

Management

- Actions to prevent occupational risks (physical and psychosocial) identified in the unified occupational risk assessment document are implemented, in particular with the occupational health unit.

Governance

- Governance analyses the absenteeism rate in relation to occupational illnesses and accidents by department and, where necessary, implements improvement measures.

Professionals

- Professionals are supported throughout the recommended (whooping cough, measles, chickenpox, seasonal influenza, Covid-19, etc.) and compulsory (hepatitis B, etc.) vaccination campaigns: information and answers to vaccine hesitations, vaccination officers, etc.
- Professionals have free and easy access to recommended and compulsory vaccinations (occupational health unit, mobile vaccination team, vaccination relays in departments, adaptation for night shifts).
- Teams have access to premises and use equipment that guarantee the prevention of occupational risks and, ultimately, their health (e.g. cytotoxic reconstitution unit, disinfection premises, dosimeters, sharps containers, etc.).
- Professionals can access counselling and psychological support services.

System audit

To support you

Educational sheets	Professional resources Healthcare-associated infections Global management through the quality and safety of care
Quality and safety of care indicators (IQSS)	Influenza prevention in healthcare organisations, influenza vaccination coverage indicator for hospital staff
Patient Safety Flash	Tunnel effect in healthcare. Calling a friend can save lives

Criterion 3.2-07 Governance implements a safety policy for its professionals

The safety of professionals underpins any professional practice, and, in particular, any quality of work life policy. Violence committed against healthcare professionals means that making healthcare organisations secure is a challenge that organisations must manage by:

- working with professionals to identify risky situations (disorder, aggression, intrusion, etc.) in the unified occupational risk assessment document;
- having a security plan, appropriate to the challenges and resources, which defines the policy and organisation of healthcare organisation security in normal and crisis situations;
- providing appropriate security systems (facilities, equipment, instructions, awareness-raising and training, access to protected areas);
- evaluating the effectiveness of these systems and evolving them to improve them.

Entire organisation **Standard**

Assessment items

Governance • Actions to prevent risks to the safety of professionals (malicious acts, disorder, aggression, intrusion, high-risk patients, etc.), prioritised in a security plan, are implemented. • Governance prepares professionals to deal with safety risks (training, tools, simulation drills, etc.). **Professionals** • Professionals know the safety rules, the players involved and the security solutions in the event of a critical situation.	System audit
Observations • The work environment contributes to the safety of professionals (equipment, premises, access).	Observation

To support you

Educational sheets	Professional resources Emergencies – SAMU/SMUR Critical care

Criterion 3.2-08 The healthcare organisation implements a quality of work life policy

It has been demonstrated that quality of work life (QWL), quality and safety of care and efficiency are linked. Hence, a QWL policy is designed to look after employees and ensure the right balance between improving quality of life in the workplace and ensuring overall performance. The healthcare organisation is expected to have a quality of work life policy that:

- is developed with professionals and staff representatives;
- is based on a diagnosis based on actual conditions on the ground and takes into account data specific to the healthcare organisation: activities, professions, environment, work organisation, generational distribution, etc.;
- sets objectives: multidisciplinarity, decompartmentalisation, principle of subsidiarity;
- is assessed using indicators shared with staff representative bodies and professionals.

Entire organisation **Standard**

Assessment items

Governance • The healthcare organisation has developed a quality of work life policy based on indicators, a survey of professionals on the ground, forward-looking management of professions and skills and the priority risks set out in the unified occupational risk assessment document. • Staff representative bodies are involved in drawing up, implementing and monitoring the quality of work life policy. • The quality of work life policy is adjusted based on monitoring of indicators, the survey conducted among professionals on the ground, forward-looking management of professions and skills and the priority risks set out in the unified occupational risk assessment document. **Professionals** • Professionals have participated in the study aimed at developing the quality of work life policy. • Internal communication enables professionals to be easily informed about the latest developments and projects at the healthcare organisation. • Professionals know the roles and responsibilities of each player, as well as the decision-making and delegation circuits	System audit

To support you

Educational sheets	Professional resources

Criterion 3.2-09 The healthcare organisation has an environment conducive to quality of work life

For the operational implementation of the QWL policy, the healthcare organisation schedules:

- organisational methods that enable a better work-life balance;
- a working environment conducive to quality of life at work;
- opportunities for professionals to talk about their experience of their work and how it is organised, and to put forward proposals for organisational solutions and innovations.

Entire organisation **Standard**

Assessment items

Governance • A number of mechanisms are available to help ensure a better work-life balance (e.g. teleworking, catering, access to public transport, childcare services, housing assistance, etc.). **Professionals** • There are local opportunities and platforms where professionals can discuss the work itself and devise solutions to improve the way work is organised (schedules, working hours, etc.). • The team, in conjunction with governance, helps to implement solutions to improve situations detrimental to the performance of work (workload, staff turnover, lack of coordination and/or communication, etc.) and, ultimately, the quality and safety of care. • Professionals are consulted on programmes to refurbish premises. • Professionals see that their experience is valued to disseminate care practices within their team.	System audit
Observations • The working environment contributes to quality of work life (cleanliness, decor, fittings designed by and for professionals, etc.).	Observation

To support you	
Educational sheets	Professional resources

Criterion 3.2-10 Governance implements an interpersonal difficulties and conflict management policy

As interpersonal difficulties and conflicts are inevitable in work situations, prevention and control mechanisms are required. These mechanisms aim to preserve interpersonal and interprofessional relations, and thus team cohesion. Management, particularly line managers, plays a key role in this and must be supported in this role. Conflicts that remain unresolved or are not prevented can have a severe impact on the functioning of teams, adversely affect quality of work life, affect the work itself and have detrimental repercussions on the quality and safety of care.

Entire organisation **Standard**

Assessment items

Governance

- In conjunction with the occupational health and prevention service, governance supports measures to anticipate and prevent interprofessional difficulties and conflicts.
- Governance puts in place a graduated system for responding to and assisting professionals (including those in training) in resolving conflicts.
- Professionals benefit from support following the management of an interpersonal conflict situation.

Professionals

- Difficulties arising in interprofessional, interdisciplinary or interpersonal relations and work conflicts can be discussed by personnel and their managers according to known procedures specific to the organisation, in addition to professional assessment procedures.
- Professionals are familiar with conflict resolution mechanisms inside (conciliation) and outside the healthcare organisation (mediation).

System audit

To support you

Educational sheets	Professional resources

Criterion 3.2-11 The healthcare organisation promotes teamwork

The team is the cornerstone of the quality and safety of care. Engagement in a shared project reinforces the meaningfulness of work and fosters motivation and recognition among team members. By encouraging improvement, collaboration and knowledge-sharing, governance and management are essential to promoting teamwork. To foster teamwork:

- the healthcare organisation supports dedicated initiatives: simulation exercises, team building, health CRM, identifying critical communication moments, etc.;
- teams develop approaches promoted by the HAS: Teamwork improvement programme (Pacte, team accreditation, etc.);
- working hours are organised to synchronise medical and paramedical time.

Entire organisation **Standard**

Assessment items

Governance

- In compliance with regulations and good practice guidelines, governance supports advanced practice and the delegation of tasks between professionals.

Professionals

- Teams develop specific teamwork improvement initiatives (health CRM, Pacte, team accreditation, simulation exercises, teambuilding, identifying critical communication moments, etc.).
- Organisational methods, particularly the organisation of working hours, ensure time can be dedicated to team projects (analysis of practices following an adverse event, knowledge-upgrading activities) or quality/risk management projects.
- Medical and non-medical times are synchronised.

System audit

To support you	
Educational sheets	Professional resources Medical accreditation

Chapter 3.
The organisation

Objective 3.3
Local positioning

The quality of care for patients depends on the entire care pathway, from the time they are admitted to the time they are discharged, but also before and after their hospital stay. It is therefore important for the healthcare organisation to coordinate its care provision with that of the local area, whether in the health or medico-social field, or with community medicine players and other healthcare organisations.
In addition to care, this coordination is also necessary to meet the needs of prevention, teaching and research. Although these missions are not directly carried out by the healthcare organisation, it is involved in the training of its professionals and the development of research; coordination on these themes is therefore expected between all healthcare organisations, depending on whether they are direct or indirect players.

Criterion 3.3-01 The healthcare organisation participates in the coordination of local care pathways

To ensure continuity of care in the local area and avoid any interruption in patient care, the healthcare organisation – within the framework of the regional healthcare plan – takes part in the construction and coordination of its patients' care pathways, in collaboration with other local players (healthcare organisations, including HAH facilities, social and medico-social services, community medicine professionals) and local coordination systems. It helps improve the overall quality of local care channels.

Entire organisation **Standard**

Assessment items

Governance • The healthcare organisation has identified the channels associated with its patient pathways. • The healthcare organisation monitors indicators for each of its sectors (active patient list, number of consultations, number of advanced consultations, etc.). • The healthcare organisation helps to organise intra-sector meetings with local players (emergency medical services (SAMU), local health professional communities (CPTS), local mental health plan (PTSM), other health, social and medico-social facilities, community medicine professionals, etc.). • The healthcare organisation participates in experience feedback committees or morbidity and mortality reviews between partners in its sectors.	**System audit**

To support you	
Educational sheets	Territorial positioning SMR

Criterion 3.3-02 The healthcare organisation refers patients to an appropriate pathway

In view of the population cared for and its geographic location, the healthcare organisation has a map of the area's care provision and disseminates its care provision offering to local partners. The healthcare organisation is organised to avoid diagnostic delays and loss of opportunity due to lack of referral or inappropriate care.

Entire organisation **Standard**

Assessment items

Governance • For healthcare organisations that have them, expert or reference centres (particularly for rare diseases) are easily identifiable on their websites and in their activity reports. • Healthcare organisations which do not have expert or reference centres identify possible partnerships and actions to enable eligible patients to have access to them. • To combat diagnostic delay, the healthcare organisation assesses its care activity and/or refers patients to appropriate channels (rare disease centres, specialist centres, etc.). • To prevent inappropriate hospitalisations, the healthcare organisation implements a health-related feedback (RETEX) approach focusing on difficulties relative to referral of patients to appropriate care. **Professionals** • Professionals in healthcare organisations who do not have expert or reference centres are aware of possible partnerships and actions to enable eligible patients to have access to them.	**System audit**

To support you	
Educational sheets	Territorial positioning Intra-hospital pathway Children and adolescents Maternity – perinatal care People with disabilities SMR

Criterion 3.3-03 The healthcare organisation is actively involved in the local mental health plan

The local mental health plan (PTSM) is the cornerstone of mental health policy in the local area. It structures and coordinates healthcare provision and social and medico-social support. The priorities of the PTSM are to set up:

- the conditions for the early detection of mental health problems, the establishment of a diagnosis, and access to care and social or medico-social support;
- an uninterrupted high-quality health/life pathway, in particular for people with severe long-term mental health problems, or people with or at risk of developing a mental disability, for the purpose of their recovery and social inclusion;
- the conditions to enable people with mental health problems to access physical care in keeping with their needs;
- the conditions to prevent and deal with crises and emergency situations;
- the conditions to ensure that the rights of people with mental health problems are respected and promoted, their decision-making and action power is reinforced, and the stigmatisation of such illnesses is prevented;
- the conditions to act on social, environmental and local factors.

As a player in the local mental health plan, the healthcare organisation helps improve mental health pathways.

Mental health and psychiatry **Standard**

Assessment items

Governance • Early detection of mental health problems and access to a diagnosis, in line with good professional practice (diagnosis of ADHD, for example), are measured using indicators steered by governance. • The facility identifies pathway disruptions and puts forward appropriate solutions based on the integration of practices and the development of diversified care, giving preference to outpatient care and aiming to maintain and develop individual capabilities. • The priorities set out in the local mental health plan (PTSM) are reflected in projects of departments, with the aim of promoting the health and life pathways of people with mental health problems in the local area, as well as early access to care. Concrete commitments are defined and monitored in the following areas, for example: - early access to psychiatric care; - home support services; - participation in adapted work and/or leisure activities; - physical care on an outpatient basis; - support for carers; - etc. • A shared evaluation session is organised each year based on the results of the indicators (time to start of care, number of referrals to alternatives to hospitalisation, number of referrals to suitable accommodation, etc.).	**System audit**

To support you	
Educational sheets	Territorial positioning Mental health and psychiatry

Criterion 3.3-04 The healthcare organisation organises unscheduled care

The effectiveness of specialised pre-hospital emergency care and on-call emergency care services (cardiac emergencies, neurovascular emergencies, severe traumatology, intensive care, specialised imaging associated with these services, etc.) depends in part on the organisation of rapid and fluid care for patients sent from the emergency department or external structures. For the healthcare organisations concerned, the procedures to gain direct access to specialised units are operational, known by referring partners and by the organisation. They are revised as required with all the players involved in the specialised care channel.

Entire organisation **Standard**

Assessment items

Governance

- Co-construction and regional cooperation between healthcare organisations, with or without emergency facilities, community medicine professionals and medico-social services and facilities (particularly care homes for the elderly) are formalised and implemented for unscheduled care channels.
- The procedures for prioritising unscheduled admissions are defined by speciality.
- The healthcare organisation's consultation slots allow it to deal with unscheduled patients.
- The real-time situation of beds available for unscheduled treatment is known to the professionals concerned.
- The healthcare organisation has identified probable periods of tension (epidemics, cultural and sporting events, tourism, etc.) and has deployed adaptation measures.
- Depending on the four possible channels for unscheduled care (consultations, telemedicine, emergencies and direct admissions), the hospital improves its indicator results (e.g. patient satisfaction, time taken to receive medical care, transfer times, etc.).

System audit

To support you

Educational sheets	Territorial positioning Emergencies – SAMU/SMUR Critical care

Criterion 3.3-05 The healthcare organisation prevents avoidable transfers of elderly people

To limit avoidable admissions of elderly people over 75 years of age into general emergency wards, the healthcare organisation – in coordination with its community practice partners, general practitioners, care homes for the elderly, HAH and other partners – has laid down quick-access pathways and/or set up telemedicine networks.

Entire organisation Essential

Assessment items

Governance

- Specialist departments (cardiology, pulmonology, psychiatry, internal medicine, gastroenterology, neurology, etc.) work with geriatric departments and the emergency department to care for unscheduled elderly patients: an organisation of players is in place.
- Healthcare organisations liable to seek an opinion in order to avoid the unscheduled transfer of an elderly patient have identified the referral facility to be contacted.
- Healthcare organisations liable to implement unscheduled care of elderly patients have tools that enable telemedicine links (consultation and/or advice).
- Each speciality department in the referral facility offers telemedicine solutions to the local contacts requesting an opinion in order to avoid the need to transfer their elderly patients.
- Indicators are measured:
  - total number of emergency department visits by patients aged 75 and over followed by hospitalisation;
  - total number of French Medical IT Programme database (PMSI) medical, surgical and obstetric stays of patients aged 75 and over;
  - total number of emergency department visits by patients aged 75 and over not followed by hospitalisation;
  - total number of emergency department visits by the adult population.
- The healthcare organisation draws up an improvement programme based on the results of its indicators for the unscheduled care of elderly patients.

System audit

To support you

Educational sheets	Territorial positioning Elderly Patients Telehealth Global management through the quality and safety of care

Criterion 3.3-06 The healthcare organisation is easy to contact for both users and corresponding professionals

The organisation makes sure that its means of communication are easily accessible in order to facilitate user access to care and ensure fluid contacts with local players. In a secure manner, it participates in the communication of patient data to other care and medico-social care players, in compliance with confidentiality rules.

Entire organisation **Standard**

Assessment items

Governance • The healthcare organisation's website makes it easy for users to book appointments (by telephone with set times and/or online). • Useful numbers and contacts are mentioned on appointment letters and in the welcome booklet. • The organisation provides telephone numbers dedicated to “referrers” within the framework of care channels. • The organisation ensures that its partners and “referrers” can contact it and access its useful numbers or contacts, by periodically assessing their satisfaction in this area. • A secure messaging system allows rapid data transfers (sensitive data, test results, etc.) among the local professionals involved in the care of the patients.	**System audit**

To support you

Educational sheets	Territorial positioning

Criterion 3.3-07 The healthcare organisation, whether a university hospital or not, promotes clinical research on its premises or in collaboration with other local players

The development of clinical research in healthcare organisations is a lever to improve the quality of care. Experimentation and the assessment of new diagnostic, therapeutic, organisational and care practice models help to improve the quality and safety of care. By supporting medical and paramedical professionals wanting to conduct research and assessments (within the organisation or in partnership with other players), governance fosters a drive for progress.

Entire organisation Standard

Assessment items

Governance • As a minimum, governance identifies professionals and partner patients wishing to get involved in assessment projects and research. • If appropriate, governance has defined a clinical research framework and/or support policy, which is known to the professionals wishing to get involved. • When there are teams and/or partner patients wishing to get involved, support is provided for submissions to national/regional calls for projects, participation in clinical and/or technological trials, primary care studies, nursing care studies and care organisation studies, and these efforts are recognised. • If there is a list of the persons involved in the scientific publication query, management and analysis system (SIGAPS), the clinical trial and research management and information system (SIGREC), or the management and information system for patents, subsidies, etc., such a list is identified and put to use for contributing teams. • The organisation supports partnerships that promote the inclusion of eligible patients in clinical trials on its own premises or in local centres.	System audit

To support you	
Educational sheets	Territorial positioning

Criterion 3.3-08 The healthcare organisation participates in local teaching activities

The development of teaching in healthcare organisations is a lever to improve the quality of care. The organisation's staff training policy is in line with its missions and its local project. Healthcare organisations with the capacity to provide theoretical and/or practical training share their offer with their local area.

Entire organisation Standard

Assessment items

Governance • The healthcare organisation has developed a training policy in line with local needs. • The organisation distributes the training it organises to other local healthcare organisations. • The organisation disseminates the patient education programmes it organises to other local healthcare organisations. • The internship policy and offering are formalised and evaluated. • Healthcare trainees' placement plans are formalised and an internship log is provided for monitoring and assessment purposes. • Student satisfaction is collected and an action plan to improve the reception and supervision of healthcare students is included in the quality and safety of care improvement programme (PAQSS).	System audit

To support you	
Educational sheet	Territorial positioning Global management through the quality and safety of care

Chapter 3.
The organisation

Objective 3.4
Adaptation to eco-responsible care and digital innovations

To address environmental and technological challenges in the short and medium term, the healthcare organisation has a policy enabling it to prepare for and adapt to these changes. These adaptations must enable it to maintain and improve its care provision.

Criterion 3.4-01 The healthcare organisation maintains its premises and its equipment

The quality of premises and equipment is a prerequisite for the quality of care and the conditions required to deliver care. The training of professionals in the use of equipment, particularly in view of rapid technological developments, guarantees the well-managed delivery of care.

Entire organisation **Standard**

Assessment items

Observation • Premises are well-maintained and clean.	Observation
Governance • The healthcare organisation follows up the conclusions of safety inspection reports in an action plan. • The organisation has a maintenance plan for its premises and equipment, in accordance with the maintenance rules. • The organisation bases its equipment management plan on the needs of its activities and the needs expressed by its professionals. **Professionals** • The organisation trains its professionals in the correct use of its equipment.	System audit

To support you	
Educational sheets	Healthcare-associated infections SMR Global management through the quality and safety of care

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Criterion 3.4-02 The healthcare organisation is engaged in an eco-responsible care process

A sustainable development approach offers many benefits for a healthcare organisation:

- development of a culture of sustainable and inclusive development shared by all players;
- framework for professional engagement;
- user involvement;
- development of a partnership dynamic and an outward-looking approach;
- unifying projects and a mult-disciplinary approach through project-based teaching.

Entire organisation **Standard**

Assessment items

Governance • The healthcare organisation project incorporates a sustainable development strategy shared with local partners. • The organisation puts in place procedures promoting eco-responsible procurement practices. **Professionals** • All departments, or at least units, develop initiatives to promote sustainable development. • The Sustainable Development Officer supports professionals in the implementation of “sustainable development” projects at unit and department level. • Teams are made aware of eco-responsible care and the environmental impact of their practices (waste management, use of resources (equipment, products, water, electricity, etc.)).	System audit

To support you

Educational sheets	Healthcare-associated infections Global management through the quality and safety of care

Criterion 3.4-03 The healthcare organisation takes action for the ecological transition

According to the French Agency for Ecological Transition (ADEME), the healthcare sector accounts for 2% of national energy consumption and 8% of French greenhouse gas emissions. Every healthcare organisation must contribute to reducing the impact of the hospital sector on the environment, taking action to guarantee the sustainability of the healthcare system and ensure its long-term future. Actions must cover all areas: medicinal products, eco-responsible care, buildings and energy consumption, waste treatment, sustainable mobility, etc.

Entire organisation Standard

Assessment items

Governance • The organisation adjusts its strategy to the environmental risks to which it is exposed. • The organisation promotes sustainable mobility for its professionals and patients. • The organisation reduces its waste at source. • An appropriate channel is in place for each type of waste and adheres to the traceability procedure. • The organisation implements a renovation plan for its premises.	System audit
Observation • Waste sorting is operational (easily accessible sorting bins for different types of waste and posters explaining sorting rules).	Observation

To support you	
Educational sheets	Global management through the quality and safety of care

Criterion 3.4-04 The healthcare organisation uses telehealth methods to improve the patient care pathway

Telehealth is a form of remote patient care that meets the same requirements as face-to-face practice. Telehealth covers telemedicine (including teleconsultation, tele-expertise, remote medical monitoring, remote assistance and medical call handling) carried out by medical professionals, and telecare carried out by pharmacists or medical auxiliaries.

Setting up telehealth organisations within the healthcare organisation can facilitate access to care, in particular by enabling patients to be treated as close as possible to where they live and avoiding the need for them to travel to the hospital; it can also improve the range of care on offer, for example by facilitating access to a specialist opinion in the context of tele-expertise; it can also help reduce the time taken to access care.

The organisation may offer remote care to patients, whether or not they are being treated by a professional in the healthcare organisation, in order to facilitate access to care. In parallel, the organisation can also call on outside professionals to provide telehealth care for its patients. Whether it requires or provides telehealth services, the organisation organises its activity and adapts the patient pathway to improve the quality of care.

Entire organisation **Standard**

Assessment items

Governance

- The healthcare organisation has identified the care situations that are eligible for telehealth and has put in place the organisational structures needed for effective deployment.
- The healthcare organisation provides professionals with tools that comply with the applicable requirements for telehealth activities.
- For remote medical monitoring, the organisation must declare its activity and organisational arrangements to the regional health agency beforehand. Self-employed non-hospital physicians register individually with the regional health agency.
- The healthcare organisation evaluates its telehealth activities in order to manage them and improve its practices.

Professionals

- Teams practising telehealth organise this activity: eligibility criteria, identification of professionals who can be consulted for tele-expertise, organisation of the patient's pathway (before, during and after the telehealth procedure), traceability in the patient's record in accordance with applicable requirements.
- The professionals involved in the telehealth activity are trained in and familiar with the tools, procedures and clinical protocols appropriate to the healthcare organisation.

System audit

To support you

Educational sheet	Intra-hospital pathway Telehealth People with disabilities SMR

Criterion 3.4-05 The healthcare organisation manages the use of digital medical devices for professional use, in particular those using artificial intelligence

Digital medical devices (DMDs) for professional use are digital tools with a medical purpose, used by healthcare professionals as screening aids, diagnostic aids, medical decision aids and therapeutic decision aids (e.g. assistance in interpreting X-rays to identify bone fractures or lung nodules, delimitation of a tumour with a view to radiotherapy, assistance in interpreting ECGs to diagnose arrhythmia, pharmaceutical analysis, etc.). These DMDs may correspond to artificial intelligence systems.

Numerous DMDs for professional use are employed in routine care today. However, their utility or relevance in relation to the existing arsenal are not always established or known. Consequently, healthcare professionals may use digital medical devices in the context of a medical procedure without being fully informed about their performance or limitations or, conversely, be reluctant to use them for these same reasons.

The establishment must manage the use of DMDs for professional use, in particular by mapping their use, implementing a structured organisation for their acquisition and implementing a quality process that may involve, where appropriate, a process of human checking of results. Users' knowledge of the performance, conditions of use and limitations of DMDs for professional use, together with good patient information, are key factors.

Entire organisation **Standard**

Assessment items

Governance

- The organisation has begun mapping all digital medical devices for professional use and, where appropriate, analyses the risks and impact of each one (data transmission, reuse by manufacturers, etc.).
- To address the needs of care teams, the healthcare organisation has structured arrangements for the acquisition of digital medical devices, involving the relevant departments, in particular the IT and legal teams.
- The organisation arranges training for professionals using a digital medical device so that they are familiar with its performance, conditions of use and limitations.
- In the context of care, for digital medical devices for professional use, the organisation has a quality control process involving, where appropriate, human checking of the results given by the digital medical devices in real-life use.
- In accordance with the organisational arrangements of the healthcare organisation and the regulations in force, users report potential malfunctions of digital medical devices for professional use (care-related adverse events, medical device vigilance events for digital medical devices, etc.).

Professionals

- When professionals use a digital medical decision support device involving the processing of algorithmic data, particularly for diagnostic or therapeutic purposes, they ensure that the subject concerned has been informed and, where appropriate, provided with warnings about the resulting interpretation.

System audit

To support you	
Educational sheet	DMDs and technological tools

Criterion 3.4-06 The healthcare organisation uses innovative technological tools without a medical purpose to improve its organisation, in particular those using artificial intelligence

Innovations in the organisation of care, healthcare products (medicinal products and medical devices) and digital technology are an opportunity to improve patient care and contribute to the efficiency of healthcare pathways. Encouraging their development is a question of fairness between patients and regions, and a matter of efficiency. However, their correct use depends on their judicious use by trained professionals who take care to manage them properly. The implementation of these devices must be systematically assessed to ensure that they do not generate new risks, such as an increased workload, loss of meaning or uncontrolled drift in their uses and on patient care.

The entire healthcare organisation Advanced

Assessment items

Governance • The organisation manages the acquisition of these tools, involving the IT and legal teams. • The organisation adopts a quality control process for this type of tool, insofar as it involves technologies whose operation is based on an artificial intelligence system. • The professionals who use them are trained in the use of these technologies, the conditions of use and their limitations. • The healthcare organisation assesses the impact of the use of innovative technological tools on the organisation of care: substitution allowing closer contact with patients and a positive impact on their care.	System audit

To support you	
Educational sheet	DMDs and technological tools

Glossary

Term	Definition
Access to care service (SAS)	The SAS is a new service that guides the public through the healthcare system, accessible by dialling 15. If the attending physician is unavailable, the caller can remotely access a healthcare professional. The healthcare professional can provide medical advice, offer a teleconsultation or refer the patient to an unscheduled consultation at a doctor's surgery, health centre or nursing home, or to an emergency department if necessary. They can also call out an SMUR (mobile emergency and resuscitation service) or arrange medical transport. Thus, 15 is changing: previously reserved for medical emergencies, it is now also the number for accessing healthcare services.
Accreditation of physicians and medical teams	Accreditation recognises the commitment of professionals practising a “high-risk” speciality in a healthcare organisation to continuous improvement of their practices and risk management. It is a quality label for professional practices. (HAS)
Additional precautions	Hygiene measures to be taken in addition to standard precautions in order to prevent the transmission of certain pathogenic microorganisms. They are necessary for infections transmitted by air or droplets. They may be indicated for patients carrying microorganisms transmitted by direct or indirect contact, with a high potential for spread or epidemiologically significant. In certain circumstances and for certain microorganisms, different types of precautions may be combined. These precautions are primarily technical measures, particularly during care. The implementation of geographical measures (geographical isolation, restriction of residents' movements) may be necessary in certain situations. (ANFH).
Advance directives	An advance directive is a written statement that sets out in advance the wishes of its author "Regarding the conditions for continuing, limiting, stopping or refusing medical treatment or procedures" (Art. L1111-11 of the Public Health Code).
Advanced consultation	External consultation performed by practitioners working in another healthcare organisation. Such consultations may allow broader access to in-hospital specialist consultations in peripheral or remote areas and allow the scaling of institutional care according to the complexity of the patient's situation and of the care provided.
Advanced practice	Advanced practice allows paramedical professionals (e.g. nurses) to perform more advanced tasks and use more advanced skills that were previously reserved for doctors. Advanced practice has two objectives: to improve access to care and the quality of patient care pathways by reducing the workload of doctors for specific conditions. In addition, it promotes diversification in the practice of paramedical professionals and leads to the development of skills to a high level of proficiency.
Adverse event associated with care (AEAC)	An adverse event associated with healthcare provided during investigations, treatments, cosmetic medical procedures or preventive measures is an unexpected event in view of the person's state of health and pathology, with potentially harmful consequences (regulatory definition – Article R1413-66-1 of the PHC).
Adverse event reporting	Action by which any incident or adverse event is reported by a healthcare professional to the competent vigilance body for the collection, assessment and validation of the case.
Antibiotic	Antibiotics are drugs that are natural, semi-synthetic, or synthetic. They are only effective against bacteria. They work by killing bacteria or preventing them from multiplying. They can be classified into two categories: • broad-spectrum antibiotics, which eliminate a wide variety of bacteria, • narrow-spectrum antibiotics, which destroy a specific group or type of bacteria. (Ministry of Labour, Health, Solidarity and Families).
Antibiotic prophylaxis (or prophylactic antibiotic therapy)	Aims to reduce the risk of bacterial infection in a given patient. It may be useful following exposure to a pathogen (invasive meningococcal infections, pertussis, etc.), before or during surgery, after an infection to avoid a relapse, or in some patients with a high risk of bacterial infection (especially in haematology). It will be all the more relevant and effective if the targeted pathogen is unique (allowing the use of a narrow-spectrum antibiotic), if the exposure is of a limited duration, if the disease is potentially serious, and if the antibiotic is easy to use and is well tolerated.
Appropriateness of care (review of)	Method for assessing the adequacy of care and length of hospital stay with patients' needs. It applies to a treatment or a care programme and may relate to the indication, initiation or continuation of care. It aims to establish a balance between the specific needs of a patient and the resources available in the management of a health care system.

Term	Definition
Assessment of professional practices	Analysis of professional practices in relation to guidelines and according to a validated methodology comprising the implementation and follow-up of actions to improve practices.
Assisted reproductive technology	Assisted reproductive technology, formerly known as medically assisted reproduction, refers to clinical and biological practices that enable in vitro fertilisation, the preservation of gametes, germ tissue and embryos, embryo transfer and artificial insemination (Public Health Code). It involves various techniques: • artificial insemination. • in vitro fertilisation. • embryo transfer.
Birth plan	The birth plan is a combination of the aspirations of the woman and the couple and the local healthcare services available. It includes the organisation of care with medical follow-up and preparation for birth and parenthood, the terms of delivery, the possibilities for follow-up during the postnatal period, including the conditions for an early return home, and recourse in case of difficulties. It is a communication tool. Ideally, this document should be drawn up well in advance of the due date, in ongoing dialogue with the professionals who are supporting the pregnancy and delivery. This preparation process should enable the woman (or couple) to identify what she wishes to share with the team that will be caring for her, in terms of her strengths, vulnerabilities and needs. This birth plan also gives the team that will be caring for the woman an overview of what is important to the couple. This information will enable professionals to focus on the essentials and quickly establish a personalised relationship (HAS – CNGOF, 2023).
Blood-derived medicinal products	**Blood-derived medicinal products** are medicines derived from blood or from manufactured blood components. They mainly include albumin, coagulation factors and immunoglobulins of human origin. Blood-derived medicinal products differ from blood products in terms of the regulations applicable to them. Prior to their marketing, these products must obtain a marketing authorisation. They must also comply with specific advertising rules.
Cardiorespiratory arrest	Cardiorespiratory arrest, cardiocirculatory arrest (CCA) or cardiac arrest (CA) refers to the cessation of mechanical cardiac activity, confirmed by the absence of a pulse and apnoea or agonal breathing (gasping) (French Society of Cardiology).
Care channel	Arrangement regarding the patient's medical care and its funding, which underpins the patient's trajectory in the healthcare system, thus facilitating access to care and ensuring its continuity.
Care pathway	The proper, timely sequence of different professional skills directly or indirectly linked to the patient's care: consultations, technical or laboratory procedures, medicinal and non-medicinal treatments, handling of acute episodes (decompensation, exacerbation), other care (in particular medico-social, but also social care). The approach consists in improving the coordination of professional interventions through good practices during the acute phases of the disease or condition as well as in the patient's overall long-term care. This notion of care pathway therefore focuses on the good practices of each healthcare professional as well as the development of anticipatory actions, coordination, and the exchange of information among all the players involved.
Carer	A person who provides assistance with some or all aspects of daily life on a regular and frequent basis, on a non-professional basis: – a family carer provides assistance to a person with a disability. – a close carer provides assistance to an elderly person who is losing their independence.
Confidentiality	Any person cared for by a healthcare professional/facility/department, or a professional/organisation dedicated to prevention or healthcare is entitled to privacy and confidentiality with respect to the information about them. Excluding the exceptions expressly laid down by law, this confidentiality covers all patient-related information which has come to the knowledge of the professional, any staff member of these facilities/services/organisations or any other person in contact, through their activities, with these facilities or organisations. It is required of all professionals working in the healthcare system.
Control of risks	Actions designed to implement risk management decisions. The control of risks may involve their monitoring, their reassessment, and modifications to comply with the decisions made.

Term	Definition
Continuous improvement	Regular activity making it possible to increase the ability to meet requirements. The defining of objectives and search for improvement opportunities is a permanent process that makes use of audit findings/conclusions, data analyses, management reviews or other means, and which generally involves the implementation of corrective or preventive actions.
Continuous improvement Programme (Pacte) Teamwork	Programme aimed at making patient safety a team priority, integrated into professional practices, in order to reduce the occurrence of adverse events through teamwork, and to ensure the safe organisation of patient care by turning the team into a safety barrier.
Controlled Atmosphere Zone	An area that has defined the control of particulate and microbial contamination in the environment and that is constructed and used to reduce the introduction, multiplication or persistence of contaminants.
Crisis situation	Situation putting persons or an organisation at risk and requiring appropriate, urgent decisions (crisis scale: minor incident, major incident or serious accident, catastrophic event).
Critical care	Critical care involves treating patients who have or are likely to have one or more acute failures that directly threaten their life or functional prognosis and may require the use of one or more support methods (artificial ventilation, dialysis, extracorporeal membrane oxygenation (ECMO), etc.). (Decree No. 2022-690 of 26 April 2022)
Dashboard	Brings together a selection of key indicators providing periodic data on several dimensions of a policy or programme. Its purpose is to monitor the progress of the policy or programme and assess the relevance of the policy or effectiveness of the programme. As management tools, dashboards bring together and summarise indicators to present them to the management team in a useful form and support decision-making.
Digital medical devices for professional use	These are digital tools with a medical purpose (and therefore CE marking), used in routine care by healthcare professionals as an aid to screening, diagnosis, medical decision-making and therapeutic decision-making. Some examples: Various systems to assist with screening, diagnosis and medical and therapeutic decision-making already exist in a wide range of fields of application. Examples include systems to assist with the detection of: • pulmonary nodules or tuberculosis from chest X-rays; • cancerous nodules from mammograms; • melanomas from images of skin lesions; • bone fractures from X-rays; • diabetic retinopathy from fundus examinations; • polyps during colonoscopy. Other DMNs for professional use can assist in the accuracy and performance of certain procedures, for example by helping to contour a tumour for radiotherapy or by helping to identify prescriptions with a high iatrogenic risk for a patient.
Discharge letter or liaison letter	An essential item for the safety of patient care. The discharge letter comprises a summary of the main information relating to the patient's stay, as well as useful information for the continuity of care between the hospital and community practice (or a downstream entity). It is intended for the patient ("discharge letter" handed to the patient) and/or the healthcare professionals who will care for the patient after the hospital stay, whether in the community or in another healthcare organisation (liaison letter).
Document management	Set of general rules that mainly define how documents are prepared and updated; the management of references (source documentation); the defining of identification/classification criteria; the drafting of procedures for the verification, validation and supply of documents; provisions concerning the security of the documents' contents. For effective document management, it is necessary to establish a functional typology, define the document management plan and specify the IT system.

Term	Definition
Early discharge from the maternity ward	Early discharge is defined as any discharge from maternity: • during the first 72 hours after a vaginal delivery; • during the first 96 hours after a caesarean section. The criteria for discharge from the maternity ward and the support arrangements after discharge are based on several factors: • the interests of the mother and child (the wishes of the mother or couple, return home to favourable environmental and social conditions and according to medical indications); • the time required for the newborn to adapt to extrauterine life to ensure that there is no risk (or only a limited risk) of complications for the child; • maintaining an organisation and circuit for neonatal screening tests that have proven their effectiveness proven their effectiveness; • use of locally available health resources, with a focus on network organisation networks. The standard length of stay was defined as a hospitalisation period of • 72 to 96 hours after a vaginal delivery; • 96 to 120 hours after a caesarean section.
Early prenatal consultation	Early prenatal consultations allow women, as soon as they declare their pregnancy, to meet alone or as a couple with a midwife or doctor, whether privately, at a maternal and child health centre or at the maternity ward. This consultation is mandatory.Its purpose is to enable the healthcare professional to assess, together with the pregnant woman or the couple, the support needs during pregnancy. It takes into account the psychological and emotional aspects, as well as the social environment of the pregnancy. It is a consultation based on listening and sharing. No physical examination is carried out. In fact, it is not a medical consultation (Ministry of Labour, Health, Solidarity and Families and Article L. 2122-1 of the Public Health Code).
Early postnatal consultation	To better support new mothers in the weeks following the birth, an early postnatal consultation has been offered to them systematically since 2022. It can be carried out by a midwife or doctor between the 4th and 8th week after the birth. The aim of this consultation is to: • identify the early signs of postpartum depression (depression or anxiety, fatigue, mood swings, etc.); • identify any risk factors that may expose parents to this depression (isolation, stressful events, etc.); • to prevent and detect situations of vulnerability. • to assess the possible needs of the woman or couple in terms of support. The healthcare professional may suggest a second consultation between the 10th and 14th week after the birth, in order to continue support if they deem it necessary or at the request of the parent(s).
Eco-responsible care	Care that, while offering the same quality and safety for the patient, has less impact on the environment. (Ameli).
Elderly persons	The definition of an elderly person depends on the context. Ageing is a gradual process. Thus, frailty – rather than civil age – helps to better identify those who fall within the scope of geriatrics, even if the commonly accepted limit is 75 years of age. Thus, entering old age does not refer to any particular age but to a state of functional incapacity experienced subjectively or objectively according to the statements of older persons themselves. Older people constitute a population: • specific due to the frequency of multiple pathologies and, for the oldest among them, the increased prevalence of physical, mental or socio-economic frailty and the risk of loss of autonomy and dependence; • Heterogeneous, more often hospitalised, for longer periods and more frequently passing through the emergency department. In the certification framework, a patient is considered elderly if they are over 75 years of age
Electroconvulsive therapy (ECT)	Consists of delivering an electrical stimulus through the brain to induce a brief seizure that is controlled in its form, intensity, and duration. The ECT session is performed under general anaesthesia for a few minutes without intubation, with curarisation and under electroencephalographic monitoring. (Vidal)
Emergency department (ED)	An emergency department (ED) is a hospital department dedicated to the immediate care of patients requiring unscheduled medical attention due to an accident, sudden illness or a deterioration in their health. Operating 24 hours a day, 7 days a week, it is equipped to assess, treat and refer patients according to the severity of their condition. Some require rapid treatment or even hospitalisation, while others may be referred to a GP. The SAU may be part of a public or private institution and works in collaboration with the SAMU/SMUR (emergency medical service) to manage life-threatening emergencies. The department has premises divided into three areas: 1° a reception and triage area; 2° an examination and treatment area with a room and resuscitation equipment. 3° A very short-stay observation area comprising three to five individual cubicles per 10,000 visits per year to the department, allowing for rapid observation of patients before a decision is made on discharge or admission (Public Health Code).

Term	Definition
Emergency medical service (SAMU)	The SAMU is a hospital service responsible for providing medical and other health-related assistance in emergency situations. It operates through a call reception and dispatch centre (CRRA), accessible 24 hours a day by dialling 15, to respond to the urgent healthcare needs of the population (Public Health Code). The SAMU participates in the medical care of victims involved in exceptional situations, in accordance with defined emergency response plans. It also provides medical coordination for emergency situations (Public Health Code).
Emergency medical unit	Emergency medicine unit provide emergency medical services with specific requirements (participating in a joint regional medical team, holding authorisation to operate a mobile emergency and resuscitation service (SMUR) on the same site) and are not open 24 hours a day. Opening hours to the public cover at least twelve hours of continuous service, every day of the year. These are specified in the authorisation decision. During closing hours, the emergency medicine branch's headquarters displays a notice inviting people to call 15 for appropriate guidance (or a device allowing them to contact 15 directly). Medical and paramedical services are provided by the emergency medical centre outside of opening hours to ensure continuity of care (Public Health Code – SFMU).
Emergency preparedness plan	Each healthcare facility has a crisis plan, known as a "plan blanc d'établissement" (facility contingency plan), which enables it to immediately mobilise all available resources in the event of an influx of patients or to deal with an exceptional health situation (major pressure on emergency services and capacity, cyber attacks, epidemics, floods, exceptional accidents, power failures, etc.). It can be triggered by the director or manager of the establishment, who immediately informs the State representative in the department, or at the latter's request. The Director General of the ARS can also trigger the white plan at the territorial, departmental or regional level (after consulting the establishments and the GHT when they are concerned). The white plan incorporates the guidelines of the ORSAN scheme and lists the resources of healthcare establishments that can be mobilised. It defines the conditions for their use and, in particular, sets out the procedures for keeping the necessary staff on site or, where appropriate, recalling them when the situation warrants it. The stages for mobilising human and material resources are set out in a gradual and sectoral manner. Finally, the white plan specifies that each healthcare facility must set up an operational crisis unit responsible for managing the alert or crisis, led by the head of the facility or their representative. (Ministry of Labour, Health, Solidarity and Families).
Enhanced recovery after surgery (ERAS)	Set of measures (before, during and after a surgical operation) aimed at minimising the trauma suffered by the patient and thereby accelerating their recovery, both generally and in terms of the function of the body part operated on. It is classed as innovative care. The primary objective is to enable patients to return to their daily activities as quickly as possible and therefore recover more quickly.
e-Satis	French system for the measurement of hospitalised patient satisfaction and experience. The e-Satis indicator compiles, for each healthcare organisation, the patients' opinions on the quality of the various human, technical and logistical aspects of their care. The purpose is to help to improve the quality-of-care provision. Part of the HAS' role is to provide quality monitoring tools to healthcare organisations, so they can implement improvement actions in keeping with patients' expectations. The patients' responses also allow the calculation of a national indicator, which is published on QualiScope – the HAS online information service, thus providing an improvement lever.
Exceptional health situation	The concept of an "exceptional health situation" (EHS) encompasses all circumstances that could immediately and unpredictably lead to a significant increase in demand for healthcare (rapidly unfolding events such as terrorist attacks or serious accidents) or disrupt the organisation of healthcare provision (major events or gatherings). An exceptional health situation may also result from a slow-moving event (epidemic or climatic event that is exceptional in terms of its scale, duration, etc.) causing pressure on healthcare provision and for which initial management measures prove insufficient.
Excreta	In physiology, excreta are defined as all substances eliminated by the body. Faeces are the main reservoir of microorganisms, particularly antibiotic-resistant bacteria of digestive origin, and require strict management of excreta to eliminate cross-contamination. Urine and vomit may also contain microorganisms with a high potential for transmission, including those of digestive origin. Managing excreta requires wearing medical gloves and protective clothing, and practising hand hygiene when removing gloves. In the absence of single-use collection bags, bedpans must be transported with a lid and placed directly into the bedpan washer when full, without handling or rinsing, due to the risk of aerosolisation and environmental contamination.
Feedback	Approach aimed at detecting and analysing anomalies, discrepancies and any other event, whether positive or negative, by searching for causes and chains of causes and drawing lessons from them.

Term	Definition
Good practice guidelines (or professional guidelines)	Proposals developed according to an explicit method to help the healthcare professional and the patient find the most appropriate care in given clinical circumstances. They are produced by the HAS, health boards, learned societies, professional associations, etc.
Governance	Collaboration between the different bodies involved in the management of the healthcare organisation. Following the French HPST Act of 21 July 2009, governance off healthcare organisations is now based on stronger executive management, in close coordination with the Board of Governors, under the supervision of the Supervisory Board. With regard to the certification survey, governance involves the healthcare organisation's Management, the Chairperson of the Medical Committee and the Head of Care.
Healthcare-associated infections	A healthcare-associated infection (HAI) occurs during or following diagnostic, therapeutic, palliative, preventive or educational care; it was neither present nor incubating at the start of care. A healthcare associated infection is referred to as a nosocomial infection when it is contracted in a healthcare facility. The most common HAIs are urinary tract infections, pneumonia, surgical site infections and bacteraemia. Patients can become infected with their own microorganisms as a result of an invasive procedure and/or due to a particular vulnerability. Microorganisms can also originate from other patients (cross-transmission), staff or contamination of the hospital environment
Healthcare products	All products, substances, plants and devices presented as having curative, preventive, diagnostic, cosmetic, hygienic or dietary properties and which may be used in humans or animals with the aim of improving their health status and/or well-being.
Health simulation	Health simulation is a training method. It also enables the assessment and improvement of practices and risk management. It involves "the use of equipment, virtual reality or a standardised patient to reproduce healthcare situations or environments, to teach diagnostic and therapeutic procedures and to enable healthcare professionals or teams of professionals to rehearse processes, clinical situations or decision-making". It is based on the use of scenarios of varying complexity, which use simulation techniques to enable: • training in technical procedures (routine or exceptional), • the implementation of procedures (individual or team), • training in clinical diagnostic and/or therapeutic reasoning, • behaviour management (professional situations, teamwork, etc.). communication, etc.), • risk management (repetition of undesirable events, ability to cope with exceptional situations, etc.), • the simulation techniques chosen must be adapted to the identified educational objectives identified. Definition from the 2019 HAS "Health Simulation Guide"
Health crisis	Exceptional health situation encompassing all cyclical situations likely to generate, in an immediate and unpredictable way, a significant increase in care demand (rapidly occurring events such as a terrorist attack or serious accident) or a disruption in the organisation of the care provision. The Health Minister is responsible for organising and preparing the healthcare system and the required healthcare resources to gain knowledge on serious health threats, prevent them, protect the population from such threats, and care for victims.
HOP'EN "Digital hospital open to its environment"	The HOP'EN 2 programme, a major initiative in the 2023-2027 roadmap "Putting digital technology at the service of health", takes over from the HOP'EN and SUN-ES programmes to support the digital transformation of healthcare establishments and encourage the development of digital applications that improve patient care and simplify the lives of healthcare professionals. It complements other digital health initiatives led by the Ministry to cover all aspects of the digital transformation of the hospital sector: - Strengthening the IT security foundation and user identification with the programme CaRE and Hospiconnect systems; - Updating key hospital software involved in health data sharing, with phase 2 of the Ségur digital programme; - And finally, the transformation of practices and the development of digital uses, with this new HOPEN 2 programme.
Hospitalisation at Home (HAH)	Type of hospitalisation that makes it possible to avoid or shorten a hospital stay. It ensures continuous, coordinated medical and paramedical care in the patient's home. HAH care differs from the usual home-based care through its complexity, its duration and the frequency of the procedures. HAH facilities are healthcare organisations under the same obligations as hospitals housing patients.
Hospital tension	Caused by a mismatch between the influx of patients and the healthcare organisation's immediate patient-handling capacity. It can be generated by a structural and/or economic problem.

Term	Definition
Hydroalcoholic friction	The widespread use of hydroalcoholic friction, a technique that is both rapid and effective, helps to control the risk of cross-transmission of hand-borne microorganisms and thus contributes to reducing the rate of healthcare-associated infections and the spread of emerging multi-resistant and highly resistant bacteria. Hydroalcoholic friction involves applying a hydroalcoholic solution (HAS) to hands that appear clean (with no visible dirt) to reduce or inhibit the growth of microorganisms without the need for an external water source and without the need for rinsing or drying with hand towels. Hydroalcoholic friction is indicated before and after contact with the patient prior to an aseptic procedure, after risk of exposure to biological fluid and after contact with the patient's environment. To support healthcare facilities in promoting the use of HAH, the "consumption of hydroalcoholic solutions (ICSHA)" indicator is collected in the MCO, SMR, HAD, long-term care, dialysis and radiotherapy sectors. It provides an indirect measure of hand hygiene practices in healthcare facilities;
Iatrogenic dependency	It covers the main causes of functional and/or psychological decompensation during hospitalisation, which can sometimes lead to death: • Immobilisation syndrome: causing multi-systemic decompensation, in particular rapid loss of muscle mass, loss of independence and an increase in the rate of readmissions. Despite this, patients are sometimes confined to bed even though activity restrictions are not always medically justified and are sometimes too systematic. Trigger factors include: environment, inadequate care and support organisation, unjustified activity restrictions or bed rest, physical or chemical restraint, unjustified urinary catheters and probes, lack of adequate assistance with walking and/or transfers, untreated pain, etc.; • acute confusion: this increases the risk of functional decline, falls, length of hospitalisation and admission to an institution. Predisposing risk factors include: dementia or cognitive impairment, immobilisation aggravated by restraint, sensory impairment (hearing, vision), multiple comorbidities, malnutrition, polypharmacy, history of confusion, mood disorders (depression); • Undernutrition: this is linked to insufficient food intake and/or an increase in needs related to the disease. Malnutrition in older people is associated with increased mortality, complications (confusion, infection, loss of muscle mass, delayed healing, bedsores, etc.), admission to care homes and a decrease in independence and quality of life. • Falls: these cause injuries, trauma, post-fall syndrome with fear of falling again, loss of independence and increased length of hospital stay; • Incontinence: this is common and increases with hospitalisation. It is a risk factor for functional decline, falls, urinary tract infections and impaired quality of life. During hospitalisation, it is exacerbated by certain medications, dietary advice or inappropriate care, in particular the use of urinary protection, or even unjustified de novo bladder catheterisation; • Adverse drug reactions: 30 to 60% of adverse drug reactions are predictable and preventable. Iatrogenic drug reactions are a cause of emergency hospitalisations among people over 75. Polypharmacy is a risk factor for iatrogenic reactions. Older people are more exposed to the occurrence of adverse effects when using high-risk drugs (e.g. those that increase the risk of falls), particularly those with a narrow therapeutic margin, or drug interactions in the case of polypharmacy; • Suicide risk: Depression is one of the leading causes of suicide. However, depression is often underdiagnosed and undertreated in older people, particularly because of atypical presentations. Validated tools such as the GDS (Geriatric Depression Scale) exist to screen for depression in older people. Depression is not a 'normal sign of ageing' but a disorder that requires treatment. In the week before a suicide, older people often consult their family doctor. A previous suicide attempt is considered the main risk factor for subsequent suicide attempts. It has been shown that the older individuals get, the higher the risk that a new suicide attempt will result in a fatal outcome.
Identification of risks	Process used to find, list and characterise the various aspects of a risk. These aspects may include hazardous sources or phenomena, events, consequences and probability.
Identity vigilance	System dedicated to the surveillance and monitoring of risks associated with the identification of patients. It aims to ensure the accurate identification of patients throughout their hospital stay and in transfers of medical and administrative data. The objective is to guarantee quality and safety of care by ensuring the reliability of the data.
Ill-treatment	There is ill-treatment towards a person in a vulnerable situation when a gesture, words, actions or failure to act compromise or affect their rights, their basic needs and/or their health, and when this occurs within a relationship of trust, dependency, care or support. Ill-treatment can be occasional or chronic, deliberate or unintentional; it may stem from an individual or collective origin. Violence and negligence can come in many forms or be combined within these types of situations.
Indicator	Measurement tool making it possible to characterise an evolving situation, an action or the consequences of an action, in order to assess them and compare them at set intervals. Indicators must be defined in relation to a project's objectives.

Term	Definition
Informed consent	With the support of a healthcare professional and in view of the information and recommendations provided by the latter, each person makes the required decisions concerning their health. Every person has the right to refuse or not receive a treatment. Despite this, the patient continues to be followed-up by the physician, in particular for palliative care. The physician is required to respect the person's wishes, after having informed them of the consequences of their choices and their seriousness. If, by refusing or interrupting a treatment, the person puts their life in danger, they must reiterate their decision within a reasonable amount of time. The person may call on another member of the medical profession. The entire procedure is noted in the patient's medical record.
Innovative technological devices	These are tools with no medical purpose that do not meet the definition of medical devices but can enable institutions to improve their care organisation. However, particular attention must be paid to digital technologies that rely on artificial intelligence systems and can be used directly by healthcare teams. Some non-exhaustive examples Innovative technological tools can take different forms and have different purposes. Examples include tools to assist in the drafting of medical documents, tools to assist in the structuring of electronic medical records, and patient sorting software. Digital medical devices for remote medical monitoring, as defined in Article L. 162-48 of the Social Security Code, do not fall within the category of DMNs for professional use referred to here, as there is a specific national framework for their evaluation.
Intensive care unit	General intensive care units treat patients with acute life-threatening or functionally life-threatening conditions, sometimes requiring temporary replacement therapy. If the condition requires organ replacement therapy, the patient is transferred to intensive care. Multipurpose paediatric intensive care units care for patients under the age of eighteen. The intensive care unit may also specialise in cardiology, neurology, vascular medicine or haematology. Paediatric multi-purpose intensive care units provide care for patients under the age of 18. "Special multi-purpose intensive care units" (subject to authorisation) are not directly attached to an intensive care unit, but establishments must have a formal agreement with a referral intensive care unit in case of need for transfer. Intensive care units may be specialised in areas such as cardiology, vascular neurology and haematology.
Interoperability (of IT systems)	Capacity of a product or IT system to operate with other current/future products or systems. In other words, this is the ability of the systems to operate together and "communicate" with one another. To allow this communication, a common language must be used. Making systems interoperable basically means enabling them to speak a common language so they can work together.
Interventional radiology	Interventional radiology covers all invasive medical procedures aimed at diagnosing and/or treating a condition and performed under the guidance and control of imaging equipment. It concerns various medical specialities (surgeons, radiologists, neuroradiologists, cardiologists, gastroenterologists, etc.). (French Society of Radiology and the Federation of Interventional Radiology).
Ionising radiation	Ionising radiation is a form of energy released by atoms and propagated in the form of electromagnetic waves (gamma or X-rays) or particles (neutrons, beta or alpha particles). The spontaneous decay of atoms is called radioactivity, and the excess energy produced is a form of ionising radiation. Unstable elements that decay and emit ionising radiation are called radionuclides. (WHO).
Labile blood products	Products derived from a donor's blood, intended for transfusion into patients. They include whole blood, plasma and blood cells of human origin. These products can be divided into autologous products (intended for the donor), and allogeneic products (intended for a person other than the donor). The list and characteristics of labile blood products that can be distributed or delivered for therapeutic purposes are established by decision of the French National Agency for Medicines and Health Products Safety on the advice of the French Blood Establishment. In fact, they are not governed by the same rules since stable blood products are considered to be medicinal products.
Leadership	Leadership is a mechanism whereby one person influences a group of people to achieve a common goal. Leadership is inseparable from management in its ability to mobilise and unite professionals around shared objectives, including the priority of quality and safety of care. While management must demonstrate leadership, it must also create the conditions for widely shared leadership that respects everyone. Leadership must therefore be found at all levels of the organisation and act at the team level, i.e. as close as possible to the field, where actions are implemented. Leadership creates the conditions for their deployment and sustainability by recognising and valuing professionals, as well as by supporting initiatives to improve teamwork, the quality of care and the quality of life at work.

Term	Definition
Local perinatal centre	Facilities that are not authorised to practise obstetrics may carry out prenatal and postnatal activities under the name of a local perinatal centre. These centres benefit, by agreement, from the support of a healthcare facility that practises obstetrics. The local perinatal centre provides prenatal and postnatal consultations, early prenatal and postnatal interviews, birth preparation classes, newborn care education and family planning consultations. The CPP is part of a regional organisation coordinated with other perinatal care providers in the area, ensuring that women, couples and newborns have access to a graduated care pathway that integrates a range of health, social and medico-social services. The CPP therefore enters into a partnership agreement with the partner maternity units serving its territory, which provides for, in particular: • the distribution of roles among partners in terms of pregnancy monitoring, according to patient profiles; • the criteria for referring pregnant women to the partner maternity unit, including in emergencies; • the conditions under which the partner maternity unit provides staff (midwives, gynaecologists-obstetricians, paediatricians, paediatric nurses, etc.) to support the CPP's scheduled activities; • For CPPs that organise 24-hour midwifery care to respond to calls (excluding emergencies) from patients and to help refer them in close collaboration with the SAMU-SMUR (emergency medical service): the conditions under which the partner maternity ward contributes to the midwife on-call rota; • the conditions for the participation of CPP staff in the activities of the partner maternity ward, with the aim in particular of maintaining their experience in the management of childbirth and the care of newborns; • the conditions for organising the training of CPP staff, as necessary, in conjunction with that of the staff of the partner maternity ward; • the conditions for organising and the frequency of consultation meetings between the CPP and the partner maternity ward. As far as possible, the CPP must be able to access and present situations to the medical, psychological and social staff of its partner maternity ward. The CPP also establishes, through agreements, the conditions for coordinated work with maternal and child protection services, local emergency medical services, mental health services for children, adolescents and adults, addiction services, local medical and social structures, local professional health communities, mobile healthcare access services, sexual health centres, specific regional perinatal services (formerly the perinatal network), etc.
Management of beds	The optimal management of the capacity to handle a given activity volume or target, while respecting quality criteria (quality of care, waiting times, durations, schedule reliability, etc.), under resource constraints. The management of beds promotes smoother flows in care pathways for patients hospitalised for scheduled or non-scheduled procedures, in order to provide hospitalisation "at the right place" and for the right amount of time, by locating available hospital beds and ensuring the fluidity of the transfer.
Mandatory health vigilance	Concerns the use of healthcare products (pharmaceuticals, medicinal products, blood products, medical devices, biological products, cosmetics, reagents), as well as assisted reproductive technology, the mandatory external reporting of serious care-related adverse events such as care-related infections and significant radioprotection events. The different types of vigilance involve continuous data collection, data analysis and the dissemination of standardised data concerning adverse health events. They are used for alert, management and risk prevention purposes.
Mechanical restraint	Utilisation of any means, methods, equipment or clothing to prevent or limit the voluntary movements of all or part of the body for safety purposes, for a patient whose behaviour generates serious risks for their own integrity or that of others.
Medical call assistant	The ARM is the first link in the pre-hospital emergency chain. A specially trained professional, they receive, assess and direct telephone calls according to the request (urgent medical assistance handled by the emergency medical service or unscheduled care needs) in an emergency and distress situation. They prioritise calls and refer them to the emergency medical service's coordinating doctor or the general medicine department of the healthcare access service, based on pre-established protocols. They manage the flow and resources defined by the coordinating doctor, ensuring traceability until the end of the patient's care. To improve the quality of medical dispatch within emergency medical call centres (SAMU-helpline 15), a diploma course is now compulsory to practise as a medical dispatch assistant (Ministry of Labour, Health, Solidarity and Families).
Medical call record	Contains all the information collected by the call handling centre concerning the patient, the measures taken and the follow-up provided, for any medical, medico-social or health case brought to the attention of the emergency call centre (SAMU, helpline 15). The call handling record becomes a medical call record following triage by a physician.

Term	Definition
Medical devices	A medical device (MD) is any instrument, apparatus, equipment, material, product (except for products of human origin), including accessories and software, used alone or in combination, for medical purposes in humans, and whose main intended action is not achieved by pharmacological, immunological or metabolic means. To ensure material vigilance, manufacturers and healthcare professionals must report immediately to the ANSM* any incidents or risks of incidents that have occurred as a result of the use of a medical device. Similarly, users (consumers, healthcare professionals, etc.) are strongly encouraged to report any incidents they encounter following the use of a medical device, including when these incidents result from misuse. **Implantable medical devices** Implantable MDs are intended to be implanted in the human body or to replace tissue through surgery (e.g. hip prosthesis, intraocular implant, dental implant, implantable pacemaker, stent, brain neurostimulation system, etc.). The implanted device remains in place after the procedure for a period of at least thirty days. **Invasive medical devices** Invasive medical devices partially or completely penetrate the body, either through a body orifice or through the body surface (central catheter, arterial catheter, peripheral catheter, urinary catheter, etc.). **Reusable thermosensitive invasive medical devices** These are MDs intended for use on a patient for diagnostic purposes and which have undergone reprocessing (cleaning, disinfection) for reuse. *ANSM - Ministry of Health and Access to Healthcare
Medical radiodiagnostics	This encompasses all techniques for morphological exploration of the human body using X-rays produced by electrical generators. Playing a major role in the field of medical imaging, it includes various specialities (conventional radiology, interventional radiology, computed tomography, angiography and mammography) and a wide variety of examinations (chest X-ray, chest-abdominal-pelvic CT scan, etc.).
Medical regulation	Medical regulation is provided by hospital or private practice regulating doctors, working closely with medical regulation assistants, who are the first point of contact for callers. The aim of this regulation is to provide a response that is proportionate to the situation: triggering emergency services, initiating emergency procedures, referring the patient to the appropriate care pathway, providing medical advice (HAS). As part of this mission, the SAMU may call upon the following services under its control: • mobile emergency and resuscitation units; • departmental fire and rescue services; • private medical transport providers; • private doctors and paramedics; • any other medical resources available in the area (access to health centres, etc.). The participation of private resources, under the responsibility of the SAMU medical dispatch centre, is determined by agreement (Public Health Code).
Medication error	Omission or unintentional performance of a procedure during a care process involving medication, which may give rise to a risk or an adverse event for the patient. The medication error may have actually occurred or be potential (detected before administration to the patient).
Medication for human use	Any substance or composition presented as having curative or preventive properties in relation to human diseases, as well as any substance or composition that can be used in humans or administered to them for the purpose of establishing a medical diagnosis or restoring, correcting or modifying their physiological functions by exerting a pharmacological, immunological or metabolic action. Dietary products containing chemical or biological substances that are not themselves foodstuffs but whose presence confers on these products either special properties sought after in dietary therapy or test meal properties are also considered to be medicines. (Public Health Code).
Medication reconciliation	Formal process whereby all the medicinal products taken or to be taken by the patient are taken into consideration for any new prescription. This process involves the patient and is based on information-sharing and coordination between professionals. It prevents or corrects medication errors by promoting the transmission of accurate and comprehensive patient medication information among healthcare professionals at points of transition, i.e. hospital admission, discharge and transfers.

Term	Definition
Mobile emergency unit (SMUR)	SMURs are units attached to a healthcare facility authorised to practise emergency medicine. In the context of emergency medical assistance, the SMUR's mission is to: • to provide, at all times and in all locations, care for patients whose condition requires urgent medical and resuscitation care, mainly outside the healthcare facility to which they are attached. Where appropriate, and after assessment by the SAMU, a decision is then made to transport the patient, depending on their condition, to a healthcare facility ("primary transport"); • to ensure the transfer between two healthcare facilities of a patient requiring monitoring and/or medical care during the journey ("secondary transport"). To carry out these tasks, a distinction is made between the mobile emergency and resuscitation unit, comprising a doctor, a nurse and a paramedic, and the smaller team (paramedic and nurse). It is the SAMU dispatch doctor who, depending on the patient's condition and the teams already deployed, activates the appropriate emergency resources for the situation. The SMUR responds using mobile hospital units (UMH), vehicles specially equipped with complete resuscitation equipment to provide the necessary medical and resuscitation care (Public Health Code). Paediatric SMURs exist for the emergency care and transport of children, including newborns and infants. SMURs may have branches, i.e. remote locations, operating continuously or intermittently and set up on a permanent or seasonal basis, in order to meet a need (coverage of the territory, treatment of lifethreatening emergencies). The existence of these branches is regulated (Public Health Code – SFMU-SUF).
Morbidity-Mortality review (MMR)	A collective, retrospective, systemic analysis of cases involving death, a complication, or an event that could have caused harm to the patient. Its purpose is the implementation and follow-up of actions to improve the quality and safety of patient care.
Multidisciplinary consultation meetings	Meetings dedicated to discussions among specialists from several disciplines on diagnostic and therapeutic strategies in oncology. The MDT meeting is organised by a healthcare organisation, a group of organisations or an oncology network, within the framework of cancer coordination centres (3C). The regular assessment of MDT meetings is expected to show a continuous improvement in the quality of care and clinical benefit for patients. Such meetings are also developing in other specialities.
National health identity and secondary identification	The national health identity is a key reference point in the Ma Santé 2022 roadmap, enabling digital identification of patients in information systems. Mandatory since 1 January 2021, it ensures reliable identification of patients by healthcare professionals. Combined with an identity vigilance approach, the INS improves the quality and safety of care. Secondary identification procedures, including physical identification devices and regular checks, ensure that care is administered to the right patient
Nurse organiser de reception (IOA	The main tasks of the reception coordinator (IOA) are to provide a personalised welcome to patients and their companions on arrival, to define care priorities based on the needs expressed and/or observed, and then, based on these, to decide on the appropriate place of care. At this point, the severity of the health problem is determined using a validated triage scale. The IOA is responsible for the initial assessment of each patient who arrives at an emergency department. Their actions aim to improve the quality of care for patients and their companions from the moment they arrive. It is therefore essential to use triage when the flow of patients exceeds the capacity for immediate care. The reception nurse may, at any time, if necessary, seek the advice or assistance of another nurse and an emergency doctor.
Organ or tissue donation	When we talk about organ or tissue donation, we are referring to the wishes of the person from whom the donation will be taken. When we talk about removal, we are referring to the medical procedure that is made possible by the donation. In France, removal cannot be performed on a person who was against donation (Biomedicine agency). The act of removal can only be carried out in authorised establishments that are subject to the relevant rules of good practice. However, all healthcare establishments, whether authorised or not, participate in the process of identifying and removing organs by joining removal networks. The donor is the person from whom the organs and/or tissues have been removed.
Organisational model	The organisational model is a calculation tool used to determine staffing requirements in the absence of regulatory references. Several factors must be taken into account when constructing it: • calculation of the annual working obligation (by staff category: day shift, night shift, flexible hours, fixed hours); • methods for calculating the required workforce (taking into account foreseeable variations in activity) and available full-time equivalents (FTEs), • a work cycle, the relevance of which has been assessed (e.g. through a satisfaction survey, a presentation to the Social and Economic Committee, etc.), which ensures that the business can operate and that employees can achieve a good work-life balance, • the scope of intervention (e.g. the division) and within each scope: • staffing levels and FTEs consistent with medical departments - specifying ranges of bed numbers by category of professional, daytime, weekend and night-time, depending on the workload, level of activity, • rules for staff allocation and management of absences, replacements, leave compensation, etc. (validation of leave within ad hoc deadlines).

Term	Definition
ORSAN system	The ORSAN system organises and adapts healthcare at regional level in order to take all necessary measures to ensure that sick people receive appropriate care. It is intended to be implemented on an exceptional basis, mainly at regional level. It comprises five components that are used to organise healthcare when one of five situations likely to impact the healthcare system arises: • mass reception of uninfected victims (‘ORSAN AMAVI’); • treatment of large numbers of patients following a climatic event (‘ORSAN CLIM’); • management of an epidemic or pandemic on national territory, which may include the organisation of an exceptional vaccination campaign by the health system (‘ORSAN EPI-VAC’); • management of a known or emerging biological risk (‘ORSAN BIO’); • management of an NRC risk (‘ORSAN NRC’). In terms of resources, this involves: • firstly, reorganising the provision of care in the three sectors (outpatient, hospital and medico-social) in order to be able to reallocate resources in line with the priorities identified; • secondly, strengthening local resources (recalling hospital staff, • secondly, strengthening local resources (recalling hospital staff, reinforcing the availability of outpatient care, opening additional beds, etc.); • if local resources are no longer sufficient, national resources can be deployed, in particular replacement healthcare professionals, retired professionals, non-practising professionals and students (Ministry of Labour, Health, Solidarity and Families).
Palliative care	Treatment of patients whose condition does not respond to curative treatment and by which “active and continuous care is provided by an interdisciplinary team within a healthcare organisation or at home. This care is aimed at relieving pain, alleviating mental distress, safeguarding the patient's dignity and supporting their family”.
Parenthood	Parentihood refers to all the ways of being and experiencing parenthood. It is a process that combines the various dimensions of parenting: material, psychological, moral, cultural and social. It describes the bond between an adult and a child, regardless of the family structure in which it exists, with the aim of ensuring the care, development and education of the child. This adult/child relationship involves a set of functions, rights and obligations (moral, material, legal, educational, cultural) exercised in the best interests of the child by virtue of a bond provided for by law (parental authority). It is part of the social and educational environment in which the family and the child live (Ministry of Social Affairs and Health, 2012). The parenthood project corresponds to the project of becoming a parent. It corresponds to the expression of the project to health professionals even before the start of pregnancy. This differs from the birth project, which is formalised during pregnancy.
Patient experience	All interactions and situations experienced by a person or their family and friends during their healthcare journey. These interactions are shaped both by the organisation of this journey and by the life history of the person concerned. In other words, experience is the perception that patients have of their experiences throughout their care journey. It is influenced by all the people involved and by the care environment.
Patient expertise	Set of skills and knowledge (knowledge, know-how, communication skills, interpersonal skills) built up from their experiences (experience of a health situation, experience of care or support, use of a service, a place, a technical object). The knowledge of patients/people receiving support/carers is gradually developed, in particular by taking a step back from their experiences and through discussions with their peers. In individual care relationships, patient expertise improves medical decisions and care. It complements medical, nursing and academic expertise. The expertise acquired by patients enables them to participate more actively in shared decision-making with their doctors, helping to define their treatment goals, assess the benefits and risks of different options, and choose the care plan that best suits their situation. At the collective level, patient expertise improves the organisation of care and healthcare services, as well as the relationship between those receiving care or support and healthcare professionals. Within an institution, it can be mobilised in a number of activities: peer support, prevention/awareness-raising initiatives, design of goods and services, care pathways, professional training, medical research, etc. People with such "expertise" who engage with the healthcare system in a partnership approach to health are most often referred to as "patient partners" (or more specifically, patient resource partners, patient trainer partners, patient researcher partners, etc.), even though the terminology is not yet fully established (the term "expert patient" is often used in therapeutic education , for example
“Patient safety" checklist	Tool to improve practices by improving the sharing of information and cross-checking all of the items considered to be essential before, during and after an interventional procedure.
Patient record	This is where the formalised, up-to-date administrative, medical and paramedical information for each patient admitted, for any reason whatsoever, is compiled and kept.
Patient Reported Experience Measures (PREMs)	"Measures of the experience reported by patients". PREMs are questionnaires used to assess patient experience, particularly in healthcare units or technical facilities. They focus, for example, on communication with professionals, coordination, access to healthcare services, understanding medical information, respect for dignity and confidentiality, etc.

Term	Definition
Patient Reported Outcome Measures (PROMs)	"Measures of outcomes reported by patients". PROMS are tools used to assess the results perceived by the patient regarding their state of health (symptoms, physical and psychological functioning) and quality of life (ability to perform certain tasks, etc.). These measures are generally based on standardised questionnaires. Professionals can gain a more comprehensive view of the impact of treatments and interventions on patients' lives and monitor changes in a patient's health status. They make it possible to measure changes before and after treatment, surgery or other medical interventions and to evaluate the effectiveness of these interventions from the patients' perspective.
Patient satisfaction assessment	Data providing insight into the patients' opinions on the various human, technical and logistical aspects of their care. The regular measurement of patient satisfaction has been mandatory since the French order of 24 April 1996 relative to the reform of public and private hospitalisation.
Personal protective equipment	Personal protective equipment refers to the following barrier measures: • wearing gloves; • face protection (mask/goggles); • clothing protection. This equipment is used alone or in combination and protects healthcare professionals from the risk of exposure to microorganisms: • during contact with mucous membranes or broken skin; • in the event of contact or risk of contact/spray/aerosolisation of biological products of human origin.
Personalised care plan (PCP)	Action plan concerning elderly persons in a frail condition or with one or more chronic conditions, requiring coordinated work by local players. It involves promoting care by a multiprofessional team within a framework of non-hierarchical cooperation. The action plan follows on from an overall assessment of the person's medical, psychological and social situation in order to identify problematic situations. It gives rise to follow-up and reassessment. In cancer care, the personalised care plan is a summary document that must be given to the patient following discussion of the treatment proposal resulting from the MDT meeting. It contains the therapeutic programme including the various cancer therapies (surgery, medicinal treatments, radiotherapy, radiology and interventional endoscopy, etc.) as well as the supportive care scheduled following an assessment of needs carried out jointly between the patient and the care team. This PCP sets out the patient's support and its sequence over time.
Person in a vulnerable situation	Vulnerability is related to individual factors and/or environmental factors. With regard to ill-treatment, a person feels they are in, or are actually in, a vulnerable situation where they find themselves having difficulty defending themselves or not being able to do so at all, or making the ill-treatment towards them stop or exercise their rights due to their age (in the case of a minor), their health status, their disability, an unsuitable or violent environment, a precarious situation or toxic relationship. Individual factors relating to gender, sexual orientation, race, ethnic origin or nationality can result in an increased risk of vulnerability.
Pharmaceutical analysis	Pharmaceutical analysis of the prescription or pharmaceutical analysis related to a request for a medicinal product subject to optional medical prescription is an integral part of the dispensing procedure, and allows dosages, doses, treatment courses, administration methods and regimens, absence of contraindications, drug interactions and drug redundancy to be checked.
Post-resuscitation syndrome	PICS (post-intensive care syndrome) refers to a range of symptoms that appear within 12 months of hospitalisation in intensive care, or even later. These symptoms persist for several months or even years after leaving intensive care and have a major impact on patients' quality of life, independence and social and professional reintegration. PICS encompasses a variety of symptoms, often associated with each other, which may include: • physical: neuromuscular damage (muscle weakness acquired in intensive care), ENT, pulmonary, renal, osteoarticular or skin damage; • psychological/psychiatric: anxiety, depression or post-traumatic stress disorder; • cognitive: mainly including difficulties with memory, concentration, attention and executive dysfunction. (HAS, 2023). Paediatric intensive care syndrome (PICS-P) can have repercussions on children, but also on their families. In neonatal resuscitation units, neonatal intensive care units and neonatal units, the developmental care provided helps to prevent the onset of post-resuscitation syndrome in children.
Prevention	The set of medical, medico-social and healthcare resources dedicated to preventing the occurrence of a disease (primary prevention) or preventing its spread (secondary prevention).
Prevention plan	Overall prevention approach which makes it possible to detect the specific risk factors for each activity and involves the implementation of appropriate means of prevention. It applies to professionals working in a healthcare organisation (hospital or clinic) who are potentially exposed to risks of infection, chemicals, physical risks, psychosocial risks or repetitive strain injury.

Term	Definition
Procedure	Specified way of conducting an activity or a process.
Process	Set of correlated or interactive activities that transform inputs into outputs.
Psychosocial rehabilitation	A set of approaches aimed at promoting the recovery of people living with mental health issues. It is part of a care approach focused on independence, quality of life and the patient's active participation in their treatment. It works on several levels: • Clinical: symptom management and treatment adjustment • Functional: support for cognitive and relational abilities and independence in daily life, • Social: access to housing, training, employment, and citizenship. Rehabilitation is based on validated tools (cognitive remediation, social skills training, therapeutic education, job coaching, etc.) and often involves a multidisciplinary approach with the possible participation of "peer support".
Psychosocial rehabilitation care	All the actions implemented with people suffering from mental disorders within a process aimed at promoting their autonomy and independence in the community.
Quality approach	All the actions that the establishment carries out to develop the satisfaction of its customers. The quality approach is based on various factors: taking into account needs; involvement of the management to involve all staff in this process; collective reflection on the resources needed; support of staff in the implementation of quality actions; provision of quality measurement tools. Decisions are based on facts, precise and objective information.
Quality and safety of care indicator (IQSS)	Tools for improving the quality and safety of patient care, for comparing organisations and aiding decision-making developed by the HAS. The indicators are also used to meet users' transparency requirements.
Quality improvement	Aspect of quality management focused on increasing the ability to meet quality requirements.
Quality management	Ability to meet stated and implicit needs, through the engagement of the hospital and healthcare professionals in systematic, permanent actions to improve the benefit provided to patients. The concept of quality management is linked to that of continuous improvement of quality. It corresponds to a mode of management of the healthcare organisation which, to achieve the strategic objectives it has set itself, includes a continuous quality improvement approach rolled out across all sectors.
Quality of life at work (QLW)	Quality of life at work has a direct impact on the quality and safety of care. The process of improving quality of life at work identifies and brings together actions that reconcile improvements in the working environment and conditions (including health and safety) with the overall performance of the institution. This approach encompasses all actions that improve working conditions: work organisation, giving meaning to work, supporting professionals through organisational change, listening to and valuing the opinions and initiatives of medical and nursing teams, and supporting teamwork
Quality policy	General quality guidelines and objectives expressed by management and formalised in a written document. The quality policy thus defines the guidelines and objectives pursued in terms of beneficiary satisfaction.
Radioprotection	Set of prevention/surveillance rules, procedures and means aimed at preventing or reducing the harmful effects of ionising radiation, whether direct or indirect, on persons and on the environment.
Radiotherapy	Radiotherapy is a medical technique that uses ionising radiation to destroy cancerous tumour cells. Its aim is to deliver the prescribed dose of radiation to the tumour as accurately as possible, while sparing the surrounding healthy tissue as much as possible. (IRSN).
Regional Health Project (PRS)	The PRS is a set of priorities that the regional health agency implements with its partners to improve the health of the region's inhabitants, promote their daily access to healthcare, and combat social and territorial inequalities in health.
Relative urgency	A relative emergency requires treatment, but time is not a predominant factor. The patient's life is not in imminent danger. This relative emergency reflects an assessment at a given moment in time and may change at any time. Indeed, the patient's condition may deteriorate rapidly and become a life-threatening emergency. Thus, a relative emergency requires regular monitoring of the patient's clinical condition

Term	Definition
Remote medical monitoring	A telemedicine procedure aimed at enabling a medical professional to remotely interpret the data required for the medical follow-up of a patient and, where applicable, take decisions relating to this patient's care. Data recording and transmission may be automated or carried out by the patient themselves or by a healthcare professional.
Repository of operational resources (ROR)	Tool describing the healthcare resources for a region, providing exhaustive information on the healthcare provision within and outside the region, covering community practice as well as hospital resources in the health and medico-social fields and, in the longer term, the social field.
Resuscitation unit	The fundamental mission of the intensive care unit is to treat patients whose lives are at risk due to potentially reversible acute organ failure, often caused by multiple factors. This treatment therefore requires cross-functional and multidisciplinary organisation and access within the healthcare facility to a wide range of skills and techniques for diagnosis, monitoring and treatment (SRLF). There are many causes of vital organ failure, such as severe infection (septic shock), drug poisoning, multiple trauma, coma, acute renal failure, acute respiratory failure, after cardiac arrest, or in the postoperative period following major surgery such as cardiac or digestive surgery (SFAR). There are adult, paediatric and neonatal intensive care units. The paediatric intensive care unit treats patients under the age of 18
Risk	Takes account of two factors, such as the likelihood of occurrence of a hazardous event, and the seriousness of its consequences.
Risk Carrier Event (RPE)	When the EIAS has had no consequences or when the consequences could have been avoided or limited (EIAS said to be recovered) (synonyms: near miss, near hit, close call, a great escape, quasi-accident, quasi-event, etc.). (HAS)
Risk management	Risk management is an approach aimed at ensuring the safety of patients and that of the care provided to them, and in particular reducing the risk of occurrence of adverse events for the patients and the seriousness of their consequences.
Safety	State under which the risk for persons is minimised; this state is achieved through a safety procedure making it possible to identify and manage the various sources of risks.
Sectors of activity	Units of work. The sectors of activity are defined by the establishment. The HAD is a unit of work. It is therefore, within this framework, considered as a sector of activity.
Serious adverse event associated with healthcare (SAEH)	A serious adverse event associated with care provided during investigations, treatments, cosmetic medical procedures or preventive measures is an unexpected event in view of the person's state of health and pathology, the consequences of which are death, life-threatening situations, the probable occurrence of a permanent functional deficit, including a congenital anomaly or malformation (regulatory definition - Article R 1413-67 of the PHC)
Shared medical record (DMP)	My Health Space is a personal, secure digital space offered by the National Health Insurance Scheme and the Department of Health, which aims to become the digital health record for all insured persons. Thanks to this service, everyone can actively participate in monitoring and maintaining their health. The medical record allows each patient to find all their health information (treatments, test results, radiology reports, prescriptions, vaccination records) in one secure and easily accessible place. They are free to add any documents that may be useful for their care. Their general practitioner, and all other healthcare professionals who treat them, as well as social and medico-social organisations, can also add to it. Users can also fill in their medical profile with information about their medical history, allergies, pregnancy, etc. Their general practitioner, all other healthcare professionals who treat them, and social and medico-social organisations can also contribute to it. Users can also add personal information to their medical profile, such as allergies and family history, or record their medical measurements (weight, height, blood pressure, blood sugar, etc.). They can also store their advance directives, i.e. their end-of-life wishes, to ensure that medical decisions concerning them are in line with their wishes and values. The medical file can be shared with the healthcare professionals of their choice who need it to provide better medical care and avoid unnecessary tests.
Short-stay hospitalisation unit (UHCD)	The short-stay unit (UHCD) may be integrated into or adjacent to the emergency department. It is intended to accommodate patients for less than 24 hours who require clinical monitoring or additional care after their initial treatment, before a final decision is made on the patient's destination (return home or hospitalisation).

Term	Definition
Social care assistant	Professional caregiver, certified. Most often, they work for a personal services organisation.
Social precariousness	The absence of one or more forms of security, particularly job security, enabling individuals and families to fulfil their professional, family and social obligations and enjoy their fundamental rights. (Economic, Social and Environmental Council).
Stakeholders (or interested parties)	In all cases, the stakeholder represents an economic interest, a professional interest or an interest held by an association. The following are thus recognised as stakeholders: with respect to interests held by associations: patient associations, with respect to economic interests: any economic player operating in the field of health products, with respect to professional interests: learned societies, unions of healthcare professionals, specialist boards, national healthcare professional boards, which include all or part of the three previous categories.
Standard	Structured set of information or reference system associated with a field of knowledge, particularly in view of a practice or study, and in which there are details concerning definitions, solutions, practices or other aspects relating to that field of knowledge.
Standard precautions	These form the basis for preventing the cross-transmission of microorganisms. They have proven their effectiveness and represent the first line of defence to be observed. It is essential that all healthcare professionals are familiar with and apply them for all care, in all settings, for all patients regardless of their infection status. As the foundation of healthcare-associated infection prevention, standard precautions are taught, promoted and implemented continuously in all healthcare settings. They must be applied in a reasoned and judicious manner to ensure that care is provided with the utmost safety.
Sustainable development	Concept aimed at meeting current needs without compromising the ability of future generations to meet their own needs.
Teamwork	The team plays an essential role in terms of the quality and safety of care. The team is a group of professionals who are committed to working together on a common project centred on the patient. The team is made up of professionals with complementary skills that the patient needs. The team enables the institution's quality and safety policy to be implemented in the field. The teamwork approach draws on the teams' experience of their work and its organisation to design and implement concrete improvements, which may take the form of simple organisational innovations but which have a very direct and positive impact on quality of life at work and quality of care.
Telecare	"Telecare is a form of remote healthcare practice using information and communication technologies. It connects a patient with one or more pharmacists or medical assistants in the exercise of their duties as set out in this code." (Article L6316-2 of the PHC). The healthcare professions that can provide telecare are pharmacists and medical assistants: – Hearing aid specialists – Dieticians – Prosthetists – Occupational therapists – Nurses – Medical radiographers – Physiotherapists – Ocularists – Opticians – Orthopaedic technicians – Speech therapists – Orthopaedic technicians – Orthoptists – Chiropodists-podiatrists – Pharmacists – Podiatrists – Psychomotor therapists – Medical laboratory technicians
Teleconsultation	A telemedicine procedure that allows a medical professional to consult with a patient remotely. A healthcare professional may be present with the patient and, where appropriate, assist the medical professional during the teleconsultation. Psychologists (...) may also be present with the patient.
Tele-expertise	A telemedicine act that allows a medical professional to remotely seek the opinion of one or more medical professionals based on their training or specific skills, using medical information related to the care of a patient.

Term	Definition
Telehealth	Form of remote medical practice based of the use of information and communication technologies. Its purpose is to improve access to care (particularly in remote areas) and patients' quality of life by enabling them to get care and be followed up where they live. Telehealth covers telemedicine, carried out by medical professionals, and telecare, carried out by pharmacists or medical auxiliaries.
Telemedicine	"Telemedicine is a form of remote medical practice using information and communication technologies. It connects a medical professional with one or more healthcare professionals, either with each other or with the patient and, where appropriate, other professionals providing care to the patient." It enables a diagnosis to be made, preventive or post-treatment follow-up to be provided for a patient at risk, specialist advice to be sought, a treatment decision to be prepared, products to be prescribed, services or procedures to be prescribed or performed, or the condition of patients to be monitored." (Article L6316-1 of the PHC). There are three medical professions that can perform telemedicine procedures: dental surgeons, doctors and midwives. 5 telemedicine procedures "Telemedicine as defined in Article L6316-1 refers to medical procedures performed remotely using information and communication technology." Telemedicine procedures include: 1° Teleconsultation, which allows a medical professional to consult with a patient remotely. A healthcare professional may be present with the patient and, where appropriate, assist the medical professional during the teleconsultation. Psychologists (...) may also be present with the patient; 2° Tele-expertise, which enables a medical professional to remotely seek the opinion of one or more medical professionals on the basis of their training or specific skills, based on medical information related to the care of a patient; 3° Remote medical monitoring, which enables a medical professional to remotely interpret the data necessary for the medical follow-up of a patient and, where appropriate, to make decisions regarding the care of that patient. The recording and transmission of data may be automated or carried out by the patient themselves or by a healthcare professional; 4° Medical tele-assistance, which enables a medical professional to remotely assist another healthcare professional during the performance of a procedure; 5° Medical response provided within the framework of medical regulation (...)." (Article R6316-1 of the PHC).
Territorial hospital group (GHT)	Its purpose is to enable healthcare organisations to implement a common, scaled strategy for patient care, with the aim of ensuring equal access to safe, high-quality care. It ensures the rationalisation of management methods through the pooling of functions or transfer of activities between healthcare organisations. In each group, the participating healthcare organisations define a shared medical project that guarantees a local care provision offer as well as access to benchmark and alternative offerings.
Territorial Mental Health Project (PTSM)	Established by the Health System Modernisation Act of 26 January 2016 (Art. 69), the PTSM is a tool aimed at improving access, quality and coordination of mental health care pathways in each region. Developed collectively by health, medico-social and social actors in the region, the PTSM aims to organise the early detection of mental disorders, the development of diagnoses, and access to care and support, based on the latest scientific data and best professional practices.
Traceability	Possibility of retrieving a list of specified information relating to one or more components of the system from a system in order to explain its failures.
Transition	A process of transformation during which a system moves from one state of equilibrium to another. Whether ecological, energy-related, social, solidarity-based, economic, democratic, digital or managerial, transition is characterised by a profound transformation of systems. (Ministry for Ecological and Solidarity Transition)
Trusted person	Any adult may designate a trusted person, who may be a parent, a relative or the attending physician, who will be consulted in the event that the adult is unable to express their wishes and receive the information necessary for this purpose. The trusted person reports on the wishes of the adult. Their testimony takes precedence over any other testimony. If the adult so wishes, the trusted person accompanies them in their dealings, attends medical consultations to help them make decisions and helps them to understand their rights if they encounter difficulties. The appointment is made in writing and co-signed by the appointed person. It is valid for an unlimited period, unless the adult or the trusted person decides otherwise. It can be revised and revoked at any time. (Public Health Code)

Term	Definition
Unreasonable therapeutic obstinacy	The acts referred to in Article L. 1110-5 [prevention, investigation, treatment and care] must not be implemented or continued when they result from unreasonable obstinacy. When they appear unnecessary, disproportionate or when they have no effect other than the artificial maintenance of life, they may be suspended or not undertaken, in accordance with the patient's wishes and, if the patient is unable to express their wishes, following a collegial procedure defined by regulation (Article L. 1110-5-1 of the PHC). LATA (limitation or cessation of active treatment) aims to avoid unreasonable obstinacy. It may be requested by the patient or the healthcare professional if the patient is unable to express their wishes. The decision must be based on advance directives, the testimony of the trusted person or relatives, and requires a collegial procedure. It must be justified and recorded in the medical file
User representative	Representatives of healthcare system users defend and embody the principles of democracy in healthcare. User representatives sitting on hospital boards (public and private) are members of approved healthcare associations appointed by the director general of the regional health agency (Articles L1114-1 and R1112-81 of the Public Health Code). The main mission of the RU is to ensure that the needs and concerns of users are taken into account in the planning, delivery and evaluation of health services, thereby helping to promote a patient-centred approach and guarantee the quality of care. The missions of the RUs can be divided into four main areas: - Listening, supporting and providing recourse for users, - Acting as an intermediary between users and management, - Partnering with the organisation/structure and making proposals in all areas that impact the quality of care, treatment and consideration of users (training on user rights, involvement in establishment, service and communication projects, participation in architectural projects, etc.) - Key player and driving force behind the CDU As part of the users' committee, their role is to ensure that users' rights are respected and to contribute to improving the quality of the healthcare system, specifically the care system. In this dual capacity, the users' committee, more specifically: - examines complaints and claims addressed to the institution, as well as the responses provided, ensuring that everyone is informed of the avenues of appeal and mediation available to them - receives a summary of the discharge questionnaires and satisfaction surveys carried out by the establishment - receives a presentation of serious adverse events that have occurred in the establishment and the actions taken by the establishment to remedy them and prevent their recurrence - is involved in the institution's quality and safety policy and may issue proposals on these topics - produces an annual report each year, which is sent to the institution's governing bodies and the regional health agency - may propose a user project (integrated into the Establishment Project) aimed at meeting the needs and expectations of users in terms of reception, quality and safety of their care, as well as respect for their rights - may contribute to the evaluation of professional practices and the continuous improvement of services, taking into account patient feedback - participates in the institution's certification process and in monitoring the resulting actions
Vital emergency	A life-threatening situation (severe haemorrhage, severe asthma, upper airway obstruction, severe allergic reaction, heart disease with cardiac arrest, profound tachycardia or bradycardia, etc.) in which the patient's life is in imminent danger without rapid and appropriate care. Life-threatening situations are defined in terms of: • neurological: coma: the patient does not respond to painful stimuli; • Respiratory: respiratory arrest, abnormal breathing frequency or amplitude, upper airway obstruction: inability to speak, patient's mouth open, hands-on neck; • Circulatory: unmeasurable blood pressure, no proximal pulse. Professionals can explain how the team is organised to deal with life-threatening emergencies in the following cases: • choking: in the event of choking, act quickly by slapping the person on the back, or even abdominal thrusts; • Bleeding: when blood is spurting or flowing continuously, pressure should be applied on the wound to stop the bleeding; • unconsciousness: if the person is unconscious and their chest is rising regularly, it is important to clear their airways and place them in the recovery position; cardiopulmonary resuscitation is necessary; • Cardiac arrest: if the person is unconscious and not breathing normally, perform chest compressions and rescue breathing. Resuscitation should continue until normal breathing resumes or emergency services arrive. • Heart attack: A heart attack manifests itself as chest pain. The person may also show other signs such as difficulty breathing, sweating, nausea, etc. It is essential to ask the person questions so that the emergency services can assess the degree of urgency (see the Ministry of Health's "Responding to a medical emergency" information sheet).
Well-treatment	Culture inspiring individual actions and collective relations within a healthcare organisation or department. It aims to promote user well-being while keeping in mind the risk of ill-treatment.

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Federations, associations, and other organisations consulted

Agence de la biomédecine (French Biomedicine Agency)
Agence nationale d'appui à la performance (French National agency for the assessment of health and medico-social system performance)
Agence régionale de santé (French regional health agency)
Association des représentants des usagers dans les cliniques, les associations et les hôpitaux (Association of user representatives in clinics, non- profit organisations and hospitals)
Association française des directeurs des soins (French Healthcare Manager Association)
Association française des experts visiteurs de la HAS (French Association of HAS Surveyors)
Bureau de l'assurance qualité et de l'information médico-économique de l'hospitalisation privée (Bureau for quality assurance and medico-economic information in the private hospital sector)
Caisse nationale de l'assurance maladie des travailleurs salariés (French national health insurance fund for salaried workers)
*Conférence des directeurs de centre hospitalier (*Conference of hospital centre directors)
Conférence des directeurs d'hôpitaux MCO de la FEHAP (Conference of FEHAP (private non-profit) medical surgical and obstetric hospital directors)
Conférence des directeurs généraux de centre hospitalier universitaire et HCL (Conference of university hospital centre and HCL general directors)
Conférence des présidents de CME privé à but non lucratif (Conference of private non-profit medical committee chairs)
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Conférence des présidents de CME de CH (Conference of hospital centre medical committee chairs)
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