# Table of Contents

INTRODUCTION.................................................................................................................................................. 3  
THE ACCREDITATION CYCLE............................................................................................................................... 3
BEFORE THE SURVEY ........................................................................................................................................ 4
  CONTRACTING AND REQUIRED INFORMATION ............................................................................................ 4
  SURVEY LOCATIONS ....................................................................................................................................... 5
  SURVEY TEAM SIZE AND COMPOSITION ........................................................................................................ 5
  LEAD SURVEYOR (TEAM LEADER) .................................................................................................................. 5
  SURVEY PLAN PREPARATION ........................................................................................................................... 6
DURING THE SURVEY ....................................................................................................................................... 6
  OPENING MEETING ......................................................................................................................................... 6
  DOCUMENT REVIEW ........................................................................................................................................ 6
  INTERVIEWS AND BUILDING VISITS .............................................................................................................. 7
  PATIENT CENTRED SURVEY ............................................................................................................................ 8
  PATIENT CARE REVIEW .................................................................................................................................. 9
  INTERVIEWS ...................................................................................................................................................... 9
  CLOSING MEETING .......................................................................................................................................... 9

THE SURVEY REPORT ..................................................................................................................................... 9
  NON-CONFORMITIES: CATEGORY 1 (MAJOR) .................................................................................................... 9
  NON-CONFORMITIES: CATEGORY 2 (MINOR) ................................................................................................ 10
  OBSERVATIONS ............................................................................................................................................... 10
  OPPORTUNITIES FOR IMPROVEMENT ............................................................................................................ 10

AFTER THE SURVEY ....................................................................................................................................... 10
  CORRECTIVE ACTION PLANS ........................................................................................................................ 10
  APPLICANT HOSPITALS .................................................................................................................................. 11
  DNV ACCREDITED HOSPITALS ......................................................................................................................... 11

DECLARATION OF ACCREDITATION ................................................................................................................ 12

USE OF ACCREDITATION .................................................................................................................................. 12

SUSPENSION OR WITHDRAWAL OF ACCREDITATION ....................................................................................... 12
  SUSPENSION ................................................................................................................................................... 13
  WITHDRAWAL ............................................................................................................................................... 13

CHANGES IN ACCREDITATION REQUIREMENTS .............................................................................................. 14
INTRODUCTION
DNV International Accreditation for Hospitals is a programme offered by DNV Healthcare and is designed to support the development and continual improvement of healthcare quality and patient safety in hospitals. It also addresses general safety for workers, patients and other visitors within hospitals. This document explains the DNV International Accreditation process and is intended to guide hospitals that are either in the programme or are considering entering it.

The requirements of the DNV International Accreditation for Hospitals Standard are based upon those used by DNV in the USA and which have been approved by the US Government's Centers for Medicare and Medicaid (CMS). The international requirements are adapted so that they may be implemented by any hospital, independent of their location, national regulatory requirements, and local culture.

These Accreditation Guidelines are intended for hospitals that are considering applying for DNV International Accreditation as well as for those that are currently accredited by DNV Healthcare under our International Program. When a hospital has applied for but not yet been awarded DNV International accreditation, it is referred to as an “Applicant Hospital”. When a hospital is currently accredited by DNV, it is referred to as a “DNV Accredited Hospital”.

THE ACCREDITATION CYCLE
A DNV International Accreditation survey will consist of a survey for compliance with the International Accreditation standards and compliance with or certification to the ISO 9001 Quality Management System within three years of initial DNV International Accreditation. Compliance to ISO 9001 requirements must be done through DNV Healthcare as part of the accreditation survey. Certification to ISO 9001 can be achieved either through DNV Healthcare or by another Accredited Certification Body as outlined in International Accreditation Standard QM.1, SR 1-3.

Continuing DNV accreditation will require a successful annual survey that validates continuing compliance with DNV International Accreditation standards as well as continued ISO 9001 compliance or certification following the ISO 9001 three-year grace period described in the above introduction.

Once ISO 9001 compliance or certification is achieved, continued compliance or certification will depend on annual ISO periodic surveys (limited in scope to full ISO 9001 compliance or Certification Survey) and a full ISO 9001 compliance or certification survey done triennially. The triennial ISO 9001 compliance or certification survey as well as the annual ISO 9001 Periodic Surveys, done in intervening years, will take place concurrently with the annual DNV International Accreditation survey.

For Applicant Hospitals surveys will typically take place according to the following schedule:

**Initial 3 Year Contract**
Year One: Pre-Assessment and year one Accreditation Survey;  
Year Two: International Accreditation Survey and ISO 9001 Pre-Assessment Survey;  
Year Three: International Accreditation Survey and ISO 9001 Stage 1 Certification.

**Second 3-Year Contract**
Year One: International Accreditation Survey and ISO 9001 Stage 2 Certification / compliance verification;  
Year Two: International Accreditation Survey and ISO Periodic Survey or Compliance;  
Year Three: International Accreditation Survey and ISO 9001 Periodic Survey.
Third 3-Year and All Subsequent Contracts
Year One: International Accreditation Survey and ISO 9001 Re-Certification or Continued Compliance;
Year Two: International Accreditation Survey and ISO Periodic Survey;
Year Three: International Accreditation Survey and ISO 9001 Periodic Survey.

Hospitals already certified to ISO 9001 and thus compliant with the International Accreditation standard QM.1, SR 1-3 and that wish to move towards an integrated audit that can result in certificates of compliance for both International Accreditation and ISO 9001 should discuss with local sales managers to discuss how this should be managed.

Failure to obtain ISO 9001 compliance or certification in this timeframe will result in Accreditation being withdrawn (see below).

BEFORE THE SURVEY

Managing Impartiality
DNV shall not Accredit Hospitals where DNV has provided management system consultancy within the last two years and will not provide consultancy services to DNV Accredited Hospitals if these services are directed towards maintenance or development of the accredited system.

Moreover, DNV shall not include members of the survey team that have assisted the Applicant Hospital in preparation for the survey or otherwise served in the capacity as a consultant or as a former or current employee of the Applicant Hospital within the last four years.

Contracting and Required Information
The Accreditation and Certification process begins when the Applicant Hospital submits a completed DNV International Accreditation for Hospitals Information Sheet (DIAS 002). Upon receipt of the completed information sheet DNV will review the information and provide the hospital with two copies of an Accreditation Proposal using a fee structure that is based on the Applicant Hospital's complexity and the services requested.

Once contracts have been signed then DNV will contact the Applicant Hospital to agree on a date for the pre-assessment. Once the hospital has confirmed in writing that the proposed dates are acceptable DNV will submit a hospital profile sheet to collect further information that is needed for the development of the survey plan. The information required will include:

- Accurate contact information for the hospital;
- Names of top leadership team;
- A description of the hospital location(s);
- A description of the patient services provided and information about their associated patient volumes;
- Number of in-patient beds
- Number of staff employed (FTE)
- Average daily census
- Any additional information available about the facility (e.g., the hospital’s web site, any media reports about the hospital, etc). If applicable).
Survey Locations

Hospitals that do not have off-campus provider-based locations or have a limited number shall have all departments, services, and locations (and that should be included in the scope statement) surveyed.

Hospitals that comprise of multiple provider-based locations will have the following surveyed:
- All hospital departments and services at the primary organization campus and on the campuses of other remote locations of the hospital;
- All satellite locations of the hospital;
- All inpatient care locations of the hospital;
- All out-patient surgery locations of the hospital;
- All locations where complex out-patient care is provided by the hospital.

In addition the surveyors shall survey a sample of other locations that provide other types of services than above. The focus of the survey team visits will vary from department to department as well as between sites.

Contracted patient care activities or patient services (such as dietary services, treatment services, diagnostic services, etc.) located on the hospital campuses or organisation-provider based locations shall be surveyed as part of the organisation for compliance with appropriate requirements.

Survey Team Size and Composition

DNV shall decide on the composition and size of the survey team. A typical full survey of a mid-size (200 bed) hospital might include 3 surveyors who will be at the hospital for 3 or 4 days but this will depend on a number of factors that include:

- Size of the facility to be surveyed, based on average daily census and number of employees;
- Complexity of services offered, including outpatient services;
- Type of survey to be conducted;
- Whether the facility has special care units or off-site clinics or locations;
- Whether the facility has a history of serious deficiencies or complaints.

Survey teams shall be composed to match the requirements and challenges of the hospital but will normally include a Clinical Surveyor, a Physical Environment Specialist and a Generalist Surveyor. All of the surveyors will be qualified as auditors or lead auditors for ISO 9001 and typically one surveyor will have knowledge of the local language, culture and legal and regulatory framework under which hospital operates.

Lead Surveyor (Team Leader)

The survey is conducted under the leadership of a Lead Surveyor (Team Leader) that has been designated by DNV. The Lead Surveyor is responsible for assuring that all survey activities are completed within the specified time frames and according to DNV’s policies and survey protocols. Responsibilities of the Lead Surveyor include:

- Preparation and communication of the survey plan to the hospital;
- Chairing the opening and closing meetings;
- Communicating with hospital leadership regarding survey progress and initial findings;
- Evaluating team progress and adjusting survey plans as needed;
- Coordination and preparation of the survey report and submission of report to DNV.
Survey Plan Preparation
A minimum of 2 weeks prior to the start of the survey a plan shall be prepared and this shall be sent to the hospital for review and comment. The plan shall ensure that compliance against the entire DNV International Accreditation for Hospitals standard can be assessed and that all departments, services, and locations are visited. Where possible it will have particular focus on areas or activities where there may be greatest risk in terms of patient safety or quality of care based on the experience of the Lead Surveyor, discussions with the hospital, previous survey results and any history of complaints or other investigations.

DURING THE SURVEY
The length of the Accreditation/Certification Survey and the number of survey team members are determined by the size and complexity of the Applicant Hospital and will be determined in the application process. Regardless of the size and complexity of the Applicant Hospital, the team will consist of at least two members; a Clinical Surveyor and a Physical Environment Specialist. The working language of the survey team will be English, translators will be used where necessary.

The following activities apply whether the survey is for an International Accreditation survey or a combined International Accreditation / ISO 9001 survey:

Opening Meeting
This will be led by the Lead Surveyor and will address the following issues:

- Introduction of survey team;
- Confirmation of survey objectives, scope and criteria;
- Confirmation of focus areas;
- Review of the survey plan;
- Agreement of meeting times and attendees;
- Clarification of method of reporting.

Participants at the opening meeting are typically executive and medical staff leadership and board members and others that will be directly involved in the survey activities. The opening meeting should take no more than 20-30 minutes depending on the questions raised by the hospital.

Document Review
The following documents or their equivalents should be made available for the morning of the first day of the survey (hard copies of the documents are preferred but computer access is also acceptable):

- Organizational Chart
- Organizational chart for nursing services
- A map/floor plan, indicating locations for patient care and treatment areas
- A list of current inpatients with each patient’s room number, age, primary diagnosis, attending physician, admission date, and other significant information as it applies to that patient.
- Current Surgical Schedule
- Most recent ISO certification report unless provided by DNV
- Most recent local healthcare accreditation report (if applicable)
- Bylaws of the Governing Body
- Minutes of the Governing Body
- Medical Staff Bylaws, Rules and Regulations
- Minutes of the Medical Executive Committee
- Organizational Plan for Patient Care/Scope of service for each department and patient care unit
- Minutes of the Quality Oversight/Management Review Committee – including Performance Improvement data for the previous 12 months
- Minutes from Environment of Care/Safety Committee
- Management plans for the physical environment and annual evaluations
- List of contracted services, companies and individuals - Surveyors will select a sample for review
- Nursing service plan of administrative authority/delineation of responsibilities for delivery of pt. care
- Infection Control Plan with risk assessment/hazard vulnerability analysis
- List of employees including name, title, unit, and hire date
- List of current patients who have had restraint or seclusion used during hospitalization
- List of patients discharged with the past 6 months who had restraint or seclusion used violent or self-destructive behaviour during their hospitalization
- Policies & Procedures:
  - Autopsies;
  - Blood & Blood Product Administration;
  - History and Physical Examination;
  - Informed Consent;
  - Medication Security;
  - Moderate Sedation;
  - Patient Assessment (Nursing, respiratory, nutritional services, etc.);
  - Pain Management;
  - Patient Care Planning/Interdisciplinary Treatment Plan;
  - Patient Grievance;
  - Procedural Verification Process (Practices ensuring the correct patient, site & procedure);
  - Restraint or Seclusion;
  - Verbal/Telephone Orders.

If the survey shall assess compliance with ISO 9001 requirements then the following documents will also be incorporated into this document review process:

- Control of Documents;
- Control of Records;
- Control of Non-Conformity;
- Internal Reviews (Internal Audits);
- Corrective Action;
- Preventive Action;
- Quality Manual;
- Quality Policy;
- Quality Objectives;
- Management Reviews.

**Interviews and building visits**
The survey will include a series of activities that will include:

- Review of previous survey results and implementation of associated action plans;
- Interviews with leadership, management staff, physicians, and board members;
- Interviews with patients;
- Building tour (4-12 hours, dependent on Applicant Hospital size);
Interviews with individuals who oversee core processes (e.g. patient safety, infection control, etc.);
- Human Resources interview to verify compliance with staff requirements;
- Medical Staff credentialing session to verify compliance with Medical Staff requirements;
- Additional document review if deemed necessary by survey findings.

The survey team shall observe the care environment to obtain information about how the care delivery system works and how the organisation’s departments work together to provide care. The surveyors will review services provided, conduct interviews, and review records and policies/procedures by stationing themselves as physically close to patient care as possible. While completing a chart review the surveyor will as far as possible observe patient care, the environment, staff interactions with patients, safety hazards, infection control practices, or any other activity that affects patient care or staff performance.

**Patient Centred Survey**

Much of the International Accreditation survey will take a patient centred approach that will employ a tracer methodology. This methodology involves surveyors selecting sample records and then following the patient care and other process(es) to verify various aspects of the organization as they are applied against the DNV International Accreditation standard and ISO 9001 standards and organisation policies. The hospital can expect visits to multiple areas that include but are not limited to patient care units, ancillary services, human resources/personnel office, medical staff office, purchasing, bio-med/clinical engineering and/or facilities management. The Tracer methodology process may identify performance issues as a result of reviewing an individual patient’s case, in one or more steps in the process or perhaps the interfaces between steps that affect the care of the patient/family as well as staff and organisation performance.

A sample of patients will be selected that reflects as well as possible the patient population and the services provided. The surveyors will perform the selection following a review of the patient lists as well as inspection of various patient logs. The majority of patients that are selected will be in the hospital during the survey (i.e., open records) such that surveyors have the possibility to validate the information obtained through record reviews with observations and patient and staff interviews. There may be situations where closed records are needed to supplement the open records reviewed (e.g., too few open records, complaint investigations, etc), surveyors will use their professional judgment in these situations and select a sample size that will enable them to make compliance determinations and verify consistency. If it is necessary to remove a patient from the sample during the survey, (e.g., the patient refuses to participate in an interview), the surveyors will replace the patient with another who fits a similar profile. This will be done as soon as possible in the survey.

The number of clinical records selected for review will typically be based on the organisation’s Average Daily Census (ADC) and in most cases it will be sufficient to see a number equivalent to 10% of the ADC in a hospital with an ADC of 180 or more. For smaller hospitals the sample will not be fewer than 10 inpatient records.

If a complaint is being investigated during the survey, the survey team will include patients who have been identified as part of the complaint in the sample. Issues or concerns identified through complaints may be an area of focus when selecting the patient sample.
**Patient Care Review**
A comprehensive review of care and services received by patients in the sample will be part of the survey. A comprehensive review includes observations of care/services provided to the patient, patient and/or family interview(s), staff interview(s), and medical record review. After consent is obtained from the patient, the surveyors will observe sample patients receiving treatments (e.g., intravenous therapy, tube feedings and wound dressing changes) and observe the care provided in a variety of treatment settings, as necessary, to determine if patient needs are met.

**Interviews**
Interviews provide a method to collect information, and to verify and validate information obtained through observations. Informal interviews will be conducted throughout the survey. The surveyors will use the information obtained from interviews to determine what additional observations, interviews, and record reviews are necessary. Records of all interviews will be maintained by the surveyors.

The surveyors will conduct patient interviews regarding their knowledge of their plan of care, the implementation of the plan, and the quality of the services received. Other topics for patient or family interviews may include patient rights, advanced directives, and the facility’s grievance/complaint procedure. Interviews with patients will be conducted in private and with the patient’s prior permission.

The surveyors will interview staff to gather information about the staff’s knowledge of the patient's needs, plan of care, and progress toward goals. Problems or concerns identified during a patient or family interview will be addressed in the staff interview in order to validate the patient’s perception or to gather additional information. Telephone interviews will be conducted if necessary, but the preference is for in-person interviews.

**Closing Meeting**
The closing meeting is chaired by the Lead Surveyor and the purpose is to orally present and discuss all the findings of the survey so that the hospital understands the findings and what implications these may have. Individual patients or staff will not be identified during the close out. The hospitals management decides who shall attend the closing meeting but this will typically include the executive leadership team, medical and nursing leaders and others responsible for core processes. Where the hospital believes that the Surveyors have misunderstood an issue the hospital can present new information for consideration immediately after the closing meeting.

**THE SURVEY REPORT**
DNV will provide final survey report(s) for both International Accreditation and ISO 9001 (if requested) to the organisation within 10 working days of the last date of the survey. The report shall document the findings that were discussed at the closing meeting with a focus on non-conformities (NCs). NCs will be sited when objective evidence exists that a requirement has not been addressed (intent), a practice differs from the defined system (implementation), or the system is not effective (effectiveness). The NCs will be split into two categories:

**Non-Conformities: Category 1 (major)**
An NC will be categorised as major (NC1) when there is either:

- An absence of one or more required system elements or a situation which raises significant doubt that the services will meet specified requirements;
A group of category 2 non-conformities indicating inadequate implementation or effectiveness of the system relevant to a requirement of the standard;
A category 2 non-conformity that is persistent (or not corrected as agreed by the hospital) shall be up-graded to category 1;
A situation that on the basis of available objective evidence may directly lead to unacceptable risk of patient harm or does not meet minimum standards of care.

Non-Conformities: Category 2 (minor)
NC will be categorised as minor (NC2) when the hospital has a lapse of either discipline or control during the implementation of system/procedural requirements, which does not indicate a system breakdown or raise doubt that services will meet requirements. Overall system requirement is defined, implemented and effective.

Observations
An observation is not a NC, but something that could lead to a NC if allowed to continue uncorrected; or an existing condition without adequate supporting evidence to verify that it constitutes a NC.

Opportunities for Improvement
An opportunity for improvement relates to areas and/or processes of the hospital which may meet the minimum requirements for International Accreditation but which could be improved. An opportunity for improvement may be a system or performance related and is normally addressed based on the experience of the surveyor team, knowledge of international best practice from other hospitals or from practices within other units/departments of the hospital.

AFTER THE SURVEY
Corrective Action Plans
Following receipt of the written report(s) the hospital shall prepare a Corrective Action Plan(s) (CAP) to address the nonconformities. The CAP must:

1) Identify the root cause that led to the nonconformity;
2) Identify the actions taken to correct the nonconformity in the affected areas and/or processes;
3) Identify other areas and/or processes (if applicable) that have the potential to be affected by the same nonconformity;
4) Identify the process or system changes that will be made to ensure that the nonconformity does not recur;
5) Identify the timeframe for the implementation of the corrective action measure(s);
6) Identify the person responsible for implementing the corrective action measure(s); and,
7) Identify the performance measure(s) and/or other supporting evidence that will be monitored to ensure the effectiveness of the corrective action(s) taken.

For Applicant Hospitals there is no requirement for a CAP to be submitted to DNV following pre-assessment, however they are required to submit a CAP to DNV for technical review within 30 working days of receiving the survey report for the initial accreditation survey. All other Hospitals that have already achieved International Accreditation and that have had NC raised during a survey are required to submit a CAP within 10 working days of receiving the survey report. The CAP will be reviewed by technical staff for completeness and to ensure that the actions are appropriate, sufficient...
and timely. Within 10 working days of receiving the CAP DNV will either inform the hospital that it has been approved by the technical review or it will be returned with requests for additional action or information and with timelines attached. For hospitals that have NCs raised then the requirements for addressing the different categories of NCs will depend on whether they are an Applicant Hospital or a hospital that already holds DNV International Accreditation.

Applicant Hospitals

All NC1s are required to be addressed according to all 7 steps identified in the CAP and objective evidence shall be verified by DNV. DNVs follow-up shall normally be performed on-site in order to perform proper verification of effective implementation and to close the NC1. In exceptional cases, and with justification, follow-up may be performed off-site as a desk review. This may be applicable where the team leader considers that solely documentary evidence is sufficient to close the NC1. The scope and extent of the follow-up survey will be determined based upon the complexity of the nonconformity and one or more surveyors will be assigned to the follow-up survey. When possible, members of the survey team that conducted the survey when the nonconformity was issued will be assigned. When this is not feasible, DNV will assign a surveyor that is familiar with the process and has the qualifications to validate compliance. Objective evidence that the NC1s have been addressed shall be available for verification by DNV within 90 working days of the Survey Report being submitted to the hospital. Only under exceptional circumstances will DNV extend this period and only if requested by the hospital when submitting their CAP.

If the applicant hospital is unable to demonstrate that all non-conformities have been closed within the 90 day period following the initial survey, and if no extensions to this period have been granted then the applicant hospital will be required to undergo a complete initial survey before the Accreditation process can proceed.

Hospitals that have NC2s identified during the survey shall be required to implement a plan for corrective actions that includes all 7 points given above and with a timeline not exceeding 90 working days from when the survey report was submitted to the hospital. DNVs follow-up shall normally be performed off-site, based on received documentation. However, based on the judgement of the team leader, an on-site follow-up may be decided appropriate for NC2s. This may be applicable in case of multiple NC2s and in cases where only documentary evidence is deemed insufficient.

Additional costs incurred by DNV due to follow-up activities will charged to the hospital in line with the DNV day rates of the original DNV International Accreditation Contract and travel charged at cost.

Once all NC1s have been closed and all NC2s have been satisfactorily addressed in a CAP that has also been approved following DNV technical review then documentation will be submitted to the Accreditation Committee.

DNV Accredited Hospitals

All NC1s are required to be addressed according to all 7 steps identified in the CAP and objective evidence shall be verified by DNV. DNVs follow-up shall normally be performed on-site in order to perform proper verification of effective implementation and to close the NC1. In exceptional cases, and with justification, follow-up may be performed off-site as a desk review. This may be applicable where the team leader considers that solely documentary evidence is sufficient to close the NC1. The scope and extent of the follow-up survey will be determined based upon the complexity of the nonconformity and one or
more surveyors will be assigned to the follow-up survey. When possible, members of the survey team that conducted the survey when the nonconformity was issued will be assigned. When this is not feasible, DNV will assign a surveyor that is familiar with the process and has the qualifications to validate compliance. Objective evidence that the NC1s have been addressed shall be available for verification by DNV within 30 working days of the survey report being submitted to the hospital. Only under exceptional circumstances will DNV extend this period and only if requested by the hospital when submitting their CAP.

Hospitals that have NC2s identified during the survey shall be required to implement a plan for corrective actions that includes all 7 points given above and with a timeline not exceeding 30 working days from when the survey report was submitted to the hospital. DNVs follow-up shall normally be performed off-site, based on received documentation. However, based on the judgement of the team leader, an on-site follow-up may be decided appropriate for NC2s. This may be applicable in case of multiple NC2s and in cases where only documentary evidence is deemed insufficient.

Additional costs incurred by DNV due to follow-up activities will charged to the hospital in line with the DNV day rates of the original DNV International Accreditation Contract and travel charged at cost.

Hospitals that do not have objective evidence that all NCs have been addressed ready with 30 days of receiving the survey report (or longer where an exception has been granted by DNV) may have DNV International Accreditation withdrawn.

**DECLARATION OF ACCREDITATION**

Hospitals that achieve the status of being a DNV International Accreditation status shall be recognised by the issuance of an Accreditation Certificate. The Accreditation Certificate shall be issued only after a successful initial or re-accreditation process that will be judged by:

- Approval of the survey report by DNV technical review;
- Approval of the Hospital CAP by DNV technical review;
- Closure of all NC1s;
- All NC2s have been adequately addressed in the CAP.

The DNV International Accreditation is valid for three years and in order to maintain accreditation the hospital will be subject to annual surveys for assessment of continual compliance with the DNV International Accreditation Requirements for Hospitals.

**USE OF ACCREDITATION**

DNV Accredited Hospitals may use the DNV International Accreditation mark on letters, documents and other promotional material including the hospital web-sites. Hospitals shall be careful not to make or permit misleading statement regarding its Accreditation and the Accreditation Mark must not be shown on a product or product packaging, samples of products or test certificates for products. The Accreditation Mark shall never be shown as larger than Hospital's own logo and the Accreditation Mark shall always be shown in its entirety.

**SUSPENSION OR WITHDRAWAL OF ACCREDITATION**

Where the hospital operates outside of the agreed conditions of the DNV International Accreditation Programme there are 2 stages of consequences: A time limited invalidation (suspension) or a permanent invalidation (Withdrawal).
**Suspension**

DNV may initiate suspension in cases where:

- DNV becomes aware through surveys, external investigations, complaints or other activities, that the provision of care or other services by the Hospital poses an extreme, immediate and unacceptable risk to the safety of patients, staff or visitors;
- The Hospital fails to submit a required CAP within 10 working days of receiving a DNV Survey Report;
- Objective evidence is not made available to DNV, within the timelines given in the approved CAP, that the corrective actions described in the CAP have been fully implemented;
- The Hospital Management system does not reflect the current organisation and processes, e.g. as a result of changes, acquisitions, diversification etc;
- The Hospital fails to maintain a quality management system compliant with ISO 9001 within three years of initial DNV International Accreditation;
- Periodic surveys and reaccreditation surveys are not allowed to be conducted according to required frequency or as scheduled;
- The Hospital violates terms of the signed accreditation agreement, including non-payment of fees or refusal of access;
- DNV judges that the Hospital has made false public claims regarding its DNV International (e.g., accreditation is used in a way that is unjustifiable or deceptive in advertising.);
- Information from stakeholders that could affect the status of DNV International Accreditation (e.g., non-compliance to regulatory/statutory requirements);

DNV may also choose to only give the Hospital a warning that suspension is being considered, but when DNV decides that suspension of DNV International Accreditation is appropriate the Hospital will be informed in writing. This letter will describe the situation that has led to suspension as well as the requirements and timelines that must be met to have DNV International Accreditation reinstated. The hospital will have 10 working days from receiving the notification letter to respond or to appeal the decision. During suspension both the hospital and DNV shall inform enquirers that this is the case and use of all advertising matter containing a reference to DNV International Accreditation are prohibited during time of suspension. DNV International Accreditation shall not be suspended for a period longer than 6 months.

Verification that the requirements have been met may require additional on-site surveys that will be charged to the hospital based on the rates and costs used in the original accreditation contract.

**Withdrawal**

DNV International Accreditation will be withdrawn from the hospital if:

- The customer does not meet the conditions of suspension
- A suspension is not considered to be an adequate action

Any decision to withdraw a certificate shall be communicated through a formal letter. The Hospital shall be required to terminate any use of the Accreditation mark and any reference to DNV International Accreditation and return Accreditation certificate(s) and copies to DNV.

The customer hospital will be informed of its right to appeal.
CHANGES IN ACCREDITATION REQUIREMENTS

DNV Accredited Hospitals will have the opportunity to comment on proposed change(s) or additional requirement(s) for a period of no less than thirty (30) working days prior to the effective date of the change(s) or additional requirements.

DNV shall provide notice to all DNV Accredited Hospitals upon any changes or additional requirements in the International Accreditation Programme. The notice shall contain a description of the change(s) or additional requirement(s), the effective date(s) of the change(s) or additional requirement(s) and the action(s) required of DNV Accredited Hospitals to meet the changes. A grace period of one year will normally be provided for hospitals to implement any required changes.