HEALTHCARE ACCREDITATION HANDBOOK: A PRACTICAL GUIDE
2nd Edition

EDITORS

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"this book is dedicated to all healthcare professionals worldwide who believe in and practice incremental and continuous improvement on a daily basis...it is also presented with love and admiration to our spouses, children and families for their unwavering support and encouragements."
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The International Society for Quality in HealthCare defines Accreditation as “a self-assessment and external peer assessment process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system.”

This handbook elicits the different constituents forming the right tools to gain a comprehensive and easy tactic to deeply understand and easily achieve accreditation. It also explains why accreditation is growing to be the universal language for delivering standardized, high quality healthcare services.

The selection of the topics for each chapter is directed toward meeting the specific objective of providing a blend of an easy to understand theory and practice application in a smooth writing style for both, national and international readers.

Unlike licensure and certification which are also methods of evaluation, assessing and rewarding organizations (and individuals) for quality, accreditation requires rigorous acceptance, vigilant continuous willingness of the healthcare organization in quantifiable self assessment, and objective self criticism in the ultimate objective of achieving a never ending performance improvement. Accreditation greatly contributes in accurately managing an organization’s expectations, forecasting its financial and non-financial outcomes, and facilitating successful budgeting.

Ample comprehensive information about several American and International accrediting bodies is given. These organizations have different historical backgrounds, goals, survey processes. However they all share the fact of providing benefits to the various healthcare facilities that they assist in their endeavours for achieving accreditation. Once successfully achieved, an accreditation status provides consumers with standardized, objective information about the quality of these organizations.

On the international scene, an increasing number of healthcare organizations are seeking to obtain accreditation. This brings about a delicate issue to consider, the conflict of interest. In other words, “should accrediting agencies act as consultants as well as...
surveyors?” Recommendations to this newly rising concern along with some recommendations on qualifications and competence of surveyors are stated.

Striving to become an accredited organization should be accompanied by a vicious awareness of every minute detail of the accreditation process, thus, avoiding unhappy expectations. Comprehensive clues, hints, past evidences about the preparation phase are presented to enhance acquaintance with the process. In addition, the Joint Commission’s Organization Survey Preparation Guide is presented in its entirety to boost the preparation process.

The reader will be exposed to different accreditation standards setting scenarios, and will witness the tailoring of accreditation standards accordingly with the unique and different backgrounds in which they originated.

The accreditation phase with its three constituting subprocesses: (1) preparation for the survey; (2) survey process; and (3) evaluation, is thoroughly discussed. The handbook illicitly portrays the sequential steps of this phase, so that its actual occurrence looks like a déjà vu.

The accreditation movement is flourishing worldwide as a result of the global growth in the exchange of health services. It will prospectively evolve as a means for an international classification and recognition of hospitals. Patients, providers, and the public do feel the need to better understand the purpose and outcome of the accreditation process. Accreditation previously known as a private and voluntary process, is swiftly evolving towards public regulation, and is rapidly leaning to become compulsory. Hospital and other types of health care organizations must be on guard. Hospital accreditation and ambulatory health care accreditation are comprehensively presented giving the reader an approachable contact with the subjects gathering all needed information from a multitude of references.

Unique and rarely encountered accreditation assessment tools and forms are listed in one chapter. These can guide and help any healthcare organization to assess its preparedness and correct delinquencies throughout its system by pinpointing to the problematic areas using the before mentioned tools.

Patient safety solutions and the latest discussions for establishing a safe organizational culture are portrayed.

Al-Assaf and Seval, Akgun
1. Certification, Licensure and Accreditation

A. F. Al-Assaf, MD, MPH

In today’s health care arena, a number of issues are being raised that have received more attention either from the health care consumers or the media. The 1990s can easily be dubbed the period of “performance measurement”. Wheter as a provider, a consumer or a purchaser, each was looking for ways to satisfy the other through measuring and reporting on care outcomes. Accountability was at stake in that period. Several third-party organizations attempted to produce certain measure to report on these care outcomes. In the United States, a number of “indicators” were developed and measured and “report cards” were assembled on the health care organization of the nation. All of these activities were done in the effort to measure performance. In the international arena, WHO organized and facilitated a number of activities related to quality assessment, performance improvement and outcome measurement. A large number of countries and institutions participated in these activities and initiatives. And at the end, all agreed that there had to be an organized mechanism to account for quality, continuous measurement and improved performance in health care organizations. In order to do this a mechanism for certification, licensure or accreditation should be put in place.

It is not the scope of this chapter however to discuss all of these three mechanisms (licensure, certification and accreditation) in details. In this chapter only accreditation will be explored in more details. A definition of certification and licensure will be presented, and a modest comparison between the three mechanisms will be attempted. A detailed exploration of accreditation will take the majority of discussion of this chapter. The process and the methodology of accreditation will be discussed and a system for its implementation is presented.

Certification and Licensure

It is very easy for a lay person to get confused with the terms and mechanisms of certification, licensure and accreditation. In general, certification, licensure and accreditation are all methods of evaluation and are also methods of assessing and rewarding organizations (and individuals) for quality. Accreditation is the only method however that requires a health care organization to follow a rigorous set of performance standards and be subject to a comprehensive process of self-assessment in addition to external evaluation. Both licensure and certification follow the same principle of assessment whereby an organization must demonstrate to the granting
agency its capability and proof that it has met the standards prescribed by that granting agency. The difference between the three is therefore based on the rigor of the assessment process and whether the evaluation is comprehensive to all aspects of the organization. It is believed that in the case of accreditation, the process and the standards are more rigorous and more comprehensive in nature.

Therefore, certification can be defined as a process of assessing the degree by which a facility, product, unit or professional attains minimum standards. It is specific to the nature of the assessment, and the entity is “certified” as a special agency for the purpose of providing a specific service or activity. For example, an organization may be certified as a provider of care to a special population or as a training facility. Similarly, an individual may be able to pass a certain examination and become certified.

Certification for an individual could be certification to be an auditor or an accountant or a trainer. Therefore certification is established for a specific purpose and is organized in order for the certified entity to engage in that specific activity on a prospective basis. Certification is an “add on” to the roles and responsibilities of an entity. For example, an organization, which is certified as a sports medicine centre, would still be able to provide services in other areas if it chose to do so and as long as the other services did not require additional certification or licensure. Also, certification may not give the entity the permission to practice a certain activity or provide a certain service, especially if that activity or service requires a license. Therefore in most cases, certification is not governed by law and is usually voluntary. It is used primarily as an added credential to an entity’s qualifications and portfolio. Of course, certification has a set of minimum guidelines that must be met by the entity to be certified. It is also governed by a granting agency similar to accreditation and lasts a set time before renewal is necessary. Renewal however is usually automatic as long as the organization is paying its dues and is in good standing. Certification would seldom be revoked or withdrawn, and an entity would in most instances have to provide documentation that it still met the standards of the certifying agency. Unlike accreditation, a re-certification on-site survey may not be necessary.

Licensure is somewhat more like certification than accreditation. Again it is targeted at all entities, individuals, organizations or groups. Licensure can therefore be similarly defined as the process of assessing the extent that a facility, organization, or professional has attained minimum requirements. Again, licensure is a prospective process. The licensed entity is given such a privilege in order to be able to engage in a certain activity. Unlike certification, however, without a license, an entity is prohibited from practicing the activity for which a license is needed. Failure to license renders an entity in violation of the law. Therefore licensure is usually a government-sponsored activity that is put in place to control the practice of
a profession or an act that has the potential of risk to the recipient or the beneficiary. For example, if an organization is licensed as a mental health centre then it may function only as a mental health centre unless it has another license that specifies otherwise. Licensure is also limited by time and is usually renewable annually and may only require the payment of dues and maintenance of good standing in the community. Licensure, however, is closely monitored for potential violations. It can be revoked or suspended if a violation is committed by an entity and can only be reinstated by the same governing agency (which is usually composed of peers). Although licensure can be voluntary, without it an entity cannot perform the specific activity for which licensure is mandatory. An obvious example would be a physician without a valid license, who may not see patients. Therefore technically speaking, qualified physicians are not obliged to get a license unless they intend to practice their profession.

What is Accreditation?

Accreditation is applied primarily to organizations rather than individuals, departments or units. Accreditation is a rigorous and comprehensive evaluation process through which an external accrediting body assesses the quality of the key systems and processes that make up a health care organization. Accreditation also includes an assessment of the care and service health care organizations are delivering in important areas such as preventive services and client satisfaction. Accreditation was developed in response to the need for standardized, objective information about the quality of health care organizations. Almost all accreditation programs are voluntary. Organizations seek accreditation for different reasons but most do so in an effort to increase market share and to win customer satisfaction and professional reputation. In all cases accreditation is voluntary.

The International Society of Quality in Health Care (1998) defines accreditation as:

…a self-assessment and external peer review process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system. Quality standards and the external peer review process are directed by nationally recognized autonomous, independent accrediting agencies with a commitment to improve the quality of health care for the public.

The Canadian Council on Health Services Accreditation (CCHSA) describes accreditation as one of the few and most effective measures that
health service organizations can use to accurately assess their level of performance. It is a peer review and a self-assessment process that focuses on ways to continuously improve the health care system.

Each health service organization’s performance is assessed against a set of national standards set by the accrediting organization in collaboration with key players in the health care system and related stakeholders. The assessment is designed to address processes; outcomes and structures, with the focus on continuous improvement within the health service delivery system.

The value of accreditation is in the internal self-assessment that an organization undergoes in preparation for the survey visit and in the consultative peer review process, which is part of the on-site survey visit. The principle of self-assessment is the fundamental basis of accreditation. It serves as the mechanism by which an organization can assess its own performance, on an ongoing basis, against a set of nationally developed standards.

The on-site survey represents an opportunity for the health service organization to receive advice and have its performance validated by external reviewers. The survey is planned in partnership with the health care organization and recognizes areas of excellence as well as areas for improvement. (CCHSA, 1998)

There is a number of accrediting organizations that have been established on the international scene. Some of these organizations are sponsored by the government of a specific country whiles others are primarily private not-for-profit organizations that have the support of national governments and key health care players in that system. In the US, there are four major accrediting agencies; each is independent and each has a specific emphasis. For example, hospitals in the US are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) while ambulatory care organizations are accredited by either the Accrediting Association for Ambulatory Health Care (AAAHC), or by Utilization Review Accrediting Commission (URAC) or yet by the JCAHO. Managed care organizations are accredited by such organizations as the National Committee on Quality Assurance (NCQA) or by any of the other three agencies, JCAHO, AAAHC or URAC.

On the international scene, accreditation is handled primarily by a government agency or a quasi-government agency such as the Canadian Council on Health Services Accreditation (CCHSA) or its Australian, Japanese, Indonesian, Austrian or Argentine counterparts. In all cases however, these accrediting organizations are governed by a board of both experts and independent agencies that represent other sectors in the health care system such as the private sector and academia.
According to AAAHC (1999), the certificate of accreditation is the most visible result of the assessment process. The ultimate value of accreditation, however, lies in the ongoing self-analysis, peer review and consultation the health care organization gains as it continues its participation in the programme. Organizations that seek accreditation first perform an internal (self) evaluation of all of their services and activities. Standards obtained from the desired accrediting organization are used to perform this internal assessment. Depending on the results of this assessment the organization may feel ready to invite the accrediting organization for the on-site external evaluation. During the survey, a team of senior health care professionals experienced in both clinical and administrative aspects, representing the accrediting organization, evaluates each and every aspect of the health care organization’s care and service activities and units. The team then scores each standard according to the result of its on-site evaluation. When they have completed their survey, the team of surveyors makes an accreditation recommendation, which is then reviewed by the accrediting organization’s board of directors, which makes the final decision. Accreditation may be awarded for six months, one year, two years or three years depending on the level of compliance with the standards.

As per URAC (1999), accredited organizations must continue to remain in compliance with the applicable standards throughout the accreditation cycle. Accreditation status may be rescinded if an accredited company is unable to comply with the accrediting organization’s standards. There are periodic and unannounced on-site visits scheduled by the accrediting organization throughout the accreditation cycle. The purpose of these visits is to make sure that the accredited organization is continuing its compliance with the accreditation standards.

Of course each accrediting organization has a different system for accreditation and a different set of accreditation decisions. JCAHO for example, has seven levels of accreditation, namely:
- accredited with commendation or with excellence
- accredited with recommendations for improvement
- accredited without recommendations for improvement (accredited)
- provisional accreditation
- conditional accreditation
- preliminary non-accreditation
- adverse decision in appeal.

NCQA (1999) on the other hand has the following five levels for accreditation of managed care organizations:
- excellent
- commendable
- accredited
Historical Perspectives and Trends on Accreditation

Accreditation was originated in the US as a mechanism to insure compliance to a set of standards in order for professionals to expect a certain level of quality in a health care organization. During the early 1900s a new awareness of quality in medical education was brought to the US government’s attention through a report published by a notable physician, Abraham Flexner. According to this report, US medical schools at that time were functioning without any real guidelines or any specific standards that they had to meet. Therefore, the standards of medical education were extremely variable from the very good to those that were barely considered adequate. It was at this same era that a group of US surgeons represented by the American College of Surgeons put together a list of minimum standards for hospital operating rooms. The purpose was to have these hospital operating rooms comply with these standards in order to be “certified” by this group as an acceptable operating room. This programme was known as the hospital standardization programme. The programme was established as a reactive measure against the wide variations that existed then between the different hospital operating rooms. Its purpose was, of course, to minimize this variation and to ensure a certain level of quality in order for these rooms to host surgical operations. This programme is considered the precursor of the accreditation system that US hospitals currently have.

Following this initiative by the American College of Surgeons and still leading the efforts of standardization, the same organization got together with a group of other professional organizations to form the then called Joint Commission on Accreditation of Hospitals (JCAH) in 1951. JCAH published its first standards for hospital accreditation in 1952 and rapidly became the hallmark for quality in US (and Canadian) hospitals. Of course this list of standards has grown considerably over the years and now the accreditation manual for hospitals boasts hundreds of standards and over 300 pages.

Accreditation standards not only grew in quantity but also in focus, setting and quality. When first developed, these standards were primarily structure standards—standards related to either the physical structure of a hospital or its human resources. More process-oriented standards were introduced to manual and later outcome-related standards were also added. The current list includes more process standards than structure and has over the years included such areas as patients’ rights and responsibilities, leadership and ethics, therefore moving away from distinct “departments” to
functions. The focus of accreditation has also changed over the years. Hospitals were the first to be accredited but now, ambulatory care facilities, nursing homes, rehabilitation facilities, mental health facilities and home health organizations as well as managed care organizations are also surveyed for accreditation. Another change in accreditation is that not only the Joint Commission is responsible for all accreditation activities but other agencies started forming for the same purpose and not only in the USA but also in other countries as well.

In late 1987, the Joint Commission changed its name to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). They explained that the change of name was a reflection of their current involvement since their services has expanded considerably to include other health care organizations. Also, and because of pressure indirectly exerted by the US government and consumer demands, accreditation criteria started to emphasize not only compliance with a certain set of standards but also on mechanisms for continuous improvement of performance. So, a health care organization may have met the structure and process accreditation standards but it must also demonstrate a proven path and experience in the continuous pursuit of improvement. Moreover, certain accrediting organizations such as the National Committee on Quality Assurance (NCQA), the premier accrediting organization for managed care plans in the US and most probably the world, are pushing their constituents to “close the loop” on improvements. These organizations, in order to receive accreditation, must demonstrate their capabilities and experience in improving certain patient outcomes and that they are able to maintain and continuously improve such outcome through frequent monitoring and re-measurement. Therefore, accreditation as we see it now is not only a quality assurance activity but also a quality improvement effort.

More and more organizations and countries are becoming interested in accreditation. The International Society of Quality in Health Care has organized a group of international representatives, and this group has met at least annually since 1996 in order to design a system for international accreditation. This group has also received the attention of major health care organizations around the world including accrediting organizations from the US, Canada, UK and Australia. Similarly, WHO began its efforts to increase awareness of different countries in the six WHO regions on accreditation. In 1998 WHO’s South-East Asia Region held an inter-country meeting on accreditation in Indonesia with representatives from the countries of that Region. The East Mediterranean Region organized a similar activity in 1999 in Limasol, Cyprus. Again, almost all of the countries of that region sent their representatives to that meeting. The outcome of the meeting included a number of recommendations for member countries to organize specific activities towards introducing accreditation in these countries. The WHO
Regional Office for the Eastern Mediterranean is working with those countries that showed interest in accreditation to design a system and a mechanism for implementing such a programme in their health care systems.

**Why Accreditation?**

For more than four decades, accreditation has been the highest form of public recognition a health care organization could receive for the quality of care it provides. Accreditation offers quantitative as well as intangible benefits to a health care organization besides public recognition. Accreditation can actually enhance the organization’s strategic management decision-making process (AAAHC, 1999).

The purpose of accreditation can be summarized into the following categories:

- demand of the customer
- a forum for measuring performance
- standardization and variance control
- benchmarking
- report cards
- quality improvement
- positive competition
- reward and recognition
- efficiency.

**Effectiveness**

Let us discuss each of the above reasons for making accreditation an important process to adopt by a country and by organizations to seek:

Health care consumers are becoming increasingly aware of the different requirements a health care organization must meet in order to be considered a quality organization. They are also becoming interested in learning about the status of care provided by an organization judged by its peers or professional experts. Accreditation provides just the answers and the assurances that health consumers are asking for. Accreditation provides for a mechanism for an objective unbiased peer review of a health organization. It provides the consumer a set of measures by which they can judge a health care organization in comparison with similar organizations. With the seal of approval, accreditation also provides the consumer a level of comfort ensuring that a health care organization has been checked and is considered a quality organization since it has passed a rigorous set of evaluation processes. In essence, accreditation could be defined as the
process of assessing the quality of an organization for the purpose of providing comparative information to the customer.

Accreditation standards are developed to be as quantifiable as possible. These standards follow the various functions and units health care organizations perform and possess. Standards are developed and are updated annually by a group of experts that are related directly to the process of care and to the structure of services rendered by the health care organization. These standards are therefore developed to measure the performance of the health care organization in the aspects of care and services it claims to provide. Compliance with these standards is a proxy measure of the performance of such an organization. Of course compliance may have to be substantial for the health care organization to receive the seal of approval from the accrediting organization. In this way accreditation can work as a measure of the performance of the organization, especially in such areas as structure and process.

One of the main activities of accreditation is to set standards that a health care organization must meet. Experts usually develop these standards rigorously. It is with these standards that the accreditation agency is able to measure the quality of the health care organization they want to evaluate for accreditation. Therefore, these standards soon become the yardsticks by which performance is measured and accreditation is achieved. Standardization is important in order that objectivity can be assured in the evaluation process. It is also a mechanism for controlling outcomes and comparing performances. Meeting certain standards will render the health care organization “accreditable” and will decrease variation between its current performance and the desired one. Standardization is also useful in controlling cost by controlling expectations, predicting outcomes and facilitating effective budgeting.

Benchmarking and report card capabilities are two of the reasons why health care organizations should seek accreditation. These are also reasons why accreditation should be developed in order for companies to be compared with one another based on the findings of accreditation. Benchmarking is a process of identifying the best process, activity or outcome and to find ways to study them and emulate them in one own setting. Through the process of accreditation, health care organizations are encouraged to look for the best processes of other organizations in order to study these processes and learn about performing them so that they can be imported and implemented in that organization. Benchmarking is usually enhanced by the fact that most quality organizations are accredited. Similarly one of the reasons for accreditation is to list on the health care organization’s report card (outcome measures) that they are accredited. A report card that does not have accreditation listed on it is not a complete and
certainly not a credible report card. Therefore, organizations must seek accreditation and attain in order for them to list it on their report card.

According to the quality improvement cycle shown below, accreditation is involved in all of the steps of the cycle, including quality improvement. The process of accreditation emphasizes assessment but it also encourages improvement based on the outcome of such assessment. It also encourages organizations to initiate improvement projects. Most of the new accreditation standards call for health care organizations to demonstrate their capabilities of identifying improvement opportunities and initiating processes for improvement and development. Accreditation agencies respond positively to those organizations that demonstrate their experience in “closing the loop” from the identification and analyses of improvement opportunities to selection and implementation of actual improvements and then maintaining their sustainability. Therefore, accreditation will stimulate improvement efforts in health care organizations and will bring these organizations to a higher level of accountability.

Accreditation provides a mechanism for comparison between health care organizations. Those organizations that have achieved accreditation, especially “commendation” or “excellent” status, will have a positive image and will use that distinction to market their services accordingly. Accreditation can therefore be used as a tool for positive marketing and as a tool that enhances positive competition between health care organizations. Competition can be based on price or other factors. Competition based on quality as exemplified by the attainment of accreditation is a form of non-price competition and is a form of positive competition. This type of accreditation is in contrast with the type of competition exhibited by and between political candidates where they each try to find weaknesses in each other performance or character to attack. Positive competition on the other hand encourages benchmarking and identifying the positive attributes of your competitor in order for you to achieve even a better level of these attributes in your organization. It is a process of continuous search for excellence and a mechanism for emulating that excellence in ones own systems. Accreditation facilitates this process and encourages it.

As stated earlier, receiving accreditation is equivalent to receiving the seal of approval on the quality of one’s own organization. This recognition certificate is usually worthy of announcement and heavy marketing to promote it. It is both rewarding and beneficial to an organization and its employees. Accreditation can also be used as the mechanism for rewarding individuals who have worked hard in order for the organization to achieve it. It is also a method of recognition among peer organizations and proof of quality.

Quality has many dimensions. Two of these dimensions are related to the ability of an organization to attain its objectives in a timely and cost-
beneficial manner. Therefore the ability of an organization to use its resources in the optimum way is one of the important dimensions of quality. Similarly, an organization that can demonstrate its ability to achieve its goals and objectives in a timely manner is considered an effective organization and therefore has met another dimension of quality. Accreditation is somewhat similar to what quality is all about. Accreditation requires an organization to be effective and to use its resources most efficiently. In order for the health care organization to achieve accreditation it has to demonstrate its effectiveness and its efficiency through completed projects related to their mission, their objectives and their goals. Efficiency and effectiveness must be practiced and proof must be documented in order for an organization to receive accreditation.

The Benefits

Here are some of the benefits of accreditation according to JCAHO (1999), NCQA (1999) and AAAHC (1999):

- enhances community confidence
- provides a report card for the public
- offers an objective evaluation of the organization’s performance
- stimulates the organization’s quality improvement efforts
- aids in professional staff recruitment
- provides a staff education tool
- may be used to meet certain government certification requirements
- expedites third-party (insurance) payment
- often fulfills licensure requirements
- may favorably influence liability insurance premiums
- favorably influences managed care contract decisions
- finds new ways to improve the care and services they offer
- increases the organization’s efficiency and reduce costs
- develops better risk management programs
- motivates staff and instills pride and loyalty
- strengthens public relations and marketing efforts
- recruits and retains qualified professional staff members
- develops alliances with other provider groups and health care organizations.

Components of Accreditation

A typical system of accreditation (as seen below) is organized around four different components: administration, standards, communication and education, and surveying.
Administration

Of course such a system must have credibility, and this is usually attained through an upper management structure such as a board of directors or a governing board. The board most probably will consist of representatives of all of the major players in the health care system. For example, representatives from both the government and the private sector would be represented on the board. Professional organizations and societies may also be included on such a board. Certainly, this board would act as the top decision-making entity in the system of accreditation. It is responsible for evaluating survey reports for health care facilities and would render the final decision regarding eligibility for accreditation. Therefore this board is responsible for:

- Evaluation of surveyors' recommendations
- Verification of information
- The accreditation decision
- The appeal process
- Re-evaluation and periodic surveys
- Re-accreditation
- Accreditation violations/abrogation

The accrediting organization will have an administration. This component will have a number of activities and functions that are supportive and somewhat facilitative in nature. This component is usually responsible for providing leadership and administrative insight to the accreditation process. Specific functions include:

- Facilitating the application process
- Collecting of the application and survey fees
- Scheduling of the on-site survey
- Identification and contact of surveyors
- Travel arrangements of surveyors
- Secretarial and clerical support
- Help desk/customer service, etc…

Education and communication

The second component of the accrediting organization is education and communication. This component is primarily responsible for increasing awareness of the target organizations and their employees of the process and the standards of accreditation. Specifically, this component is responsible for:

- Seminars/workshops
- Conferences
- Consultations and advice
• Newsletters
• Web-site
• Direct mailings
• News releases
• Marketing.

**Standards**

The third component is related to the setting and continuous updating of the accreditation standards and the scoring guidelines for measuring compliance to the standards. Specifically, this component will be responsible for:

• Organizing the domains (see below)/sections for the standards manual
• Developing and setting the accreditation standards and sub-standards
• Identifying the documentation requirements for evaluating compliance
• Establishing scoring guidelines
• Organizing and updating the standards manuals.

**Surveying**

The forth and last component of the accreditation organization is probably the most important: where the actual assessment of the health care organization is handled. This particular component is usually called the surveying component. Professionals working for this component will be responsible for:

• Selection of surveyors
• Training of surveyors
• Scheduling of surveyors/facilities
• The survey report and the score card
• The organizing of the site visit
• The surveyors’ recommendations.

**The core standards**

Depending on the accrediting organization’s emphasis, the areas for the development of standards may be different from one another. Also, the type of facility to be accredited has an effect on the type and the “domains” of standards to be developed by the accrediting organization. For example, the Accreditation Association for Ambulatory Health Care (AAAHC) developed standards in the following domains: rights of patients, governance, administration, quality of care, quality management and improvement, clinical records, professional improvement, facilities and environment.
For the National Committee on Quality Assurance (NCQA) there is a different focus. During an accreditation survey, managed care plans are reviewed against more than 60 different standards. Plans must also report their Health Employer and Data Information Set (HEDIS) results on 10 different measures and at least one member satisfaction survey. These standards and performance measures fall into five broad categories.

**Access and service**
Do health plan members have access to the care and service they need? For example, are doctors in the health plan free to discuss all treatment options available? Do patients report problems getting needed care? How well does the health plan follow up on grievances?

**Qualified providers**
Does the health plan assess each doctor’s qualifications and what health plan members say about their providers? For example, does the health plan regularly check the licenses and training of physicians? How do health plan members rate their personal doctors and nurses?

**Staying healthy**
Does the health plan help people maintain good health and avoid illness? Does it give its doctors guidelines about how to provide appropriate preventive health services? Are members receiving tests and screenings as appropriate?

**Getting better**
How well does the health plan care for people when they become sick? How does the health plan evaluate new medical procedures, drugs and devices to ensure that patients have access to safe and effective care?

**Living with illness**
How well does the health plan care for people with chronic conditions? Does the plan have programmes in place to assist patients in managing chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

**HEDIS**
NCQA (1999) is also the leader in the field of health plan performance measurement. NCQA manages the evolution of the principal performance measurement tool for managed care, the Health Plan Employer
Data and Information Set (HEDIS), a set of standardized measures used to compare health plans. “Today, through employer initiatives, national magazines and local newspapers, many consumers receive HEDIS data in the form of health plan report cards”.

HEDIS sets the standard in assessing how effectively health plans care for acute and chronic illnesses, and includes measures that address many of the nation’s most pressing health problems, such as cancer, heart disease, smoking and diabetes.

Internationally, healthcare facilities have several options to explore should the decision be made to seek accreditation. While some countries have an internal, governmental survey process, many are still in the formative stages of the accreditation process. There are currently two external accreditation survey options that are being utilized with increased frequency.

**Joint Commission International**

The US-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) launched joint Commission International (JCI) in 1999. JCI standards were developed with input from numerous international healthcare professionals and are based upon international consensus standards. JCI’s stated mission is to improve the safety and quality of healthcare in the international community. There are currently four JCI accreditation programs:

- International Standards for Hospitals
- International Clinical Lab Standards
- International Standards for the Care Continuum
- International Standards for Medical Transport Organizations

The JCI hospital survey team will include a physician and a nurse, with the addition of an administrator surveyor, at times. In addition to the evaluation of patient care services and patient safety issues, the surveyors will assess the overall effectiveness of communication throughout the organization, the processes related to management of information, the adequacy of the physical facility, the processes for ensuring competency of staff, and the preparedness of the facility to address disasters.

Survey activities include the following:

- Interview with Leadership
- Review of policies, procedures, plans, bylaws, and other Tour of the facility
Visit to clinical areas, including patient care areas, Pharmacy, Emergency Services, Laboratory, Rehabilitation Services, Radiology, as well as, areas where anesthesia and sedation are administered

Interview of the infection control practitioner(s) and evaluation of the infection control program

Review of staff qualifications and education

Evaluation of the quality improvement and patient safety program

Assessment of the organization’s information management program, to include review of documentation components in medical records

Given the overall focus on healthcare quality, JCI has adopted several required clinical, managerial, and other general quality monitors which are evaluated during the survey process. The required clinical monitors include:

- Patient assessment
- Antibiotic and other medication use
- Medication errors
- Blood and blood products administration
- Surgical procedures
- Radiology and Laboratory quality control programs
- Anesthesia use
- Infection Control surveillance and reporting
- Medical records – availability, content and use of same
- Clinical research

Required managerial monitors include:

- Processes related to procurement of supplies and medications
- Risk management
- Utilization management
- Patient, family, and staff satisfaction
  - Financial management
- Patient, family and staff safety-related risk reduction strategies and surveillance
- Reporting of those activities required by law and/or regulation
- Patient demographics and diagnoses

Required general measures monitors include:
• Use of data collection to identify areas in need of study and improvement
• Evaluation of implemented improvements through data collection and analysis

*International Organization for Standardization (ISO)*

Another option for accreditation is the International Organization for Standardization (ISO) system. ISO was founded in 1946 in order “to facilitate the international coordination and unification of industrial standards.” While ISO was originally oriented toward the electro technical industry, it has since broadened to encompass numerous other industries, to include healthcare.

The premise under which ISO was developed is that development of common standards provides a framework, which facilitates information and technology sharing and trade. Having uniform standards eliminates, on an international level, the technical barriers that would normally be in place due to differing regional practices, standards, cultural and language issues.

Participation in the ISO program is voluntary. The standards are developed by member consensus and market requirements. ISO standardization pertains to such issues as terminology, symbols, performance and safety requirements, protocols for computers, quantities and units. ISO standards are specific to a particular process or product.

ISO includes standards that encompass how an organization addresses customer satisfaction, regulatory requirements, and works to continually improve its performance. While ISO accreditation may not necessarily serve as a substitute for JCI accreditation, it will likely result in a less costly and more structured survey preparation process. Through the adoption of the ISO quality standards, an organization can anticipate improved compliance with record-keeping, documentation, and utilization of the overall quality program. ISO provides the structure for ongoing quality improvement throughout the organization.

The ISO paradigm differs from that of JCI in that its guiding principle is that the organization develops and defines its own unique quality program. Using the Quality Performance Wheel concept, an organization addresses program cost, performance measurement, and customer satisfaction in order to develop an effective quality program. Once the organization has developed a quality program that will meet financial, customer satisfaction and process and outcome goals, a system must be put into place to continuously monitor the effectiveness of the program.
ISO has received increased attention from the healthcare industry in recent years due, in large part, to concerns over rising healthcare costs coupled with serious concerns about patient safety. Advances in medical technology have leveraged organizations to balance the cost of being able to provide higher technical care with the resultant cost of recruiting and retaining staff competent to provide this increasingly complex healthcare. The need to develop a structured environment to support the processes related to the delivery of safe, high quality care is now an international imperative. Seeking and maintaining accreditation is a viable means to achieve this goal.

**The Accreditation Process**

The accreditation process consists of a “desktop review” of the application and a site visit. Through this process, applicant organizations submit evidence of compliance with accreditation standards, which is then verified by an accreditation reviewer.

Once the desktop review is complete, the organization may be asked to submit additional information and/or revisions to the application. After receipt and review of the additional documentation, an on-site visit will be scheduled. Applicants refer to a specific interpretation guide to prepare for the on-site verification. The processing time for an application, that is the time an application is received at an accrediting organization until the time the accreditation is granted, is approximately four to six months. The actual time frame will vary according to the type of accreditation applied for, the number of standards that are met versus not met upon desktop and on-site review, the number of applicant sites, and the number of applicants in the queue for accreditation, among other factors.

During the on-site visit, a team of surveyors meets with many representative groups from various parts of the health care organization to discuss the processes of care and support function within the organization, as well as, the quality improvement initiatives related to them. The survey team meets with the health care facility’s board of directors, senior administration, care teams and other supporting teams, such as human resources, environment and information management. Most important, the surveyors meet with clients and their families, who are interviewed about their understanding of the care received, their feelings about the quality of care/service, and their level of understanding of their role in the care and treatment process.

In addition, the survey team reviews documentation (for example, policies and procedures, minutes, care plans and clinical records) and visits key work areas to support their observations. In summary, the survey team is
invited by the organization to review the quality of care and services provided against nationally developed standards.

After the survey team completes its verification process a report including the accreditation recommendation is prepared and submitted to the accrediting organization for decision-making. The accrediting organization in turn analyses the report and discusses the recommendation, thus making its final decision regarding accreditation. The decision is verified by the accreditation organization’s governing board and is provided to the health care facility. If the decision is a denial for accreditation or any adverse decision, then the facility has the right to appeal that decision.

Conclusions

Accreditation has played a major role in the monitoring of health service organizations for over 40 years. The success of accreditation rests with the recognition of it as a voluntary, objective peer review process with self-assessment at its core. Its success also rests with the on-going participation of the multitude of professional groups who all work collectively and collaboratively to ensure that accreditation reflects the common goal of delivery of consistent, high quality care.

It is a process that has the potential of insuring continuous improvement, and institutionalization of quality. Sustaining quality activities are enhanced with certain incentives and accreditation is an example of such incentives. In this era of performance measurements and accountability, a mechanism that encourages compliance to standards such as accreditation is exactly what this era needs. It is no wonder that countries around the world are becoming increasingly and seriously interested in such an activity.
REFERENCES


2. The Leading Accreditation Bodies of Healthcare Organizations

N. Rayan, MHA

Objectively evaluating and improving processes in a healthcare facility is fundamental to provide optimal patient care. Accreditation organizations guarantee recognition for a healthcare facility’s dedication to performance and quality improvement. Ensuring and strengthening patient safety efforts are not the only benefits that result from accreditation. Counseling is also offered to educate staff members and upper management about good practices to improve business operations. Accreditation status strengthens the community’s confidence in the facility as a provider of quality healthcare services. Various accredit ing bodies throughout Europe, Canada, Australia and the U.S. in particular, are available for both counseling and evaluating healthcare entities.

Many of the above mentioned organizations are in charge of accrediting different types of healthcare facilities tailoring their services according to the applicant’s needs. Accreditation organizations have various histories, goals, survey processes. But they all offer tangible and intangible benefits to the healthcare facilities participating in the accreditation process.

Joint Commission for Accreditation of Healthcare Organizations

The most well known accreditation body in the United States is the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). The Joint Commission currently evaluates and accredits more than 15,000 health care organizations and programs in the United States. It is an independent, not-for-profit organization and is the nation’s predominant standards’ setting and accrediting body in health care. Since its creation in 1951, the Joint Commission’s comprehensive accreditation process evaluates an organization’s compliance with up to date standards in addition to other accreditation requirements. The goals of JCAHO are illustrated through its mission “to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.”

The Joint Commission assesses a number of types of healthcare organizations. They include but are not limited to general, psychiatric,
children’s and rehabilitation hospitals, critical access hospitals, medical equipment services, home care organizations, long term care facilities, behavioral health care organizations, addiction services, rehabilitation centers, group practices, office-based surgeries, other ambulatory care providers and independent or freestanding laboratories. JCAHO accreditation gives the organization a “deemed status” which allows organizations to receive reimbursement from Medicare and Medicaid and other agencies without undergoing a separate examination and application process by various governmental agencies. In addition to accrediting healthcare organizations, JCAHO also awards Disease-Specific Care (DSC) Certification to health plans, disease management service companies, hospitals and other care delivery settings that supply disease management and chronic care services.

In order to receive accreditation, an organization must undergo a thorough examination of the quality of their services, where certain standards are measured and must be maintained. Joint Commission standards address the organization’s level of performance in critical functional areas, such as supporting patient rights, patient treatment, and infection control. Standards also provide performance expectations for the structure (physical and human resources) and processes that affect the safety and quality of patient care. If an organization provides the necessary elements, patients will most likely experience good outcomes. The Joint Commission develops its standards with the contributions of health care specialists, providers, measurement professionals, purchasers and consumers.

JCAHO assesses standards in an unbiased manner with the help of specific, measurable objectives. In 1997, the Joint Commission launched its ORYX® proposal, which includes outcomes and other performance measurement data into the accreditation process. The Joint Commission’s primary goal is to recognize, rather than develop, stable measures that support both the objectives of the ORYX initiative as well as process improvement of an organization.

The accreditation process is thorough and comprises many steps. The JCAHO survey process includes a team of highly qualified surveyors who measure organizational performance against approximately 700 different standards. The evaluations include: a pre-survey process, document review, interviews with various individuals and observations of clinical activities. As a policy of JCAHO, site visits are scheduled a month to two in advance and the organizations are requested to have a coordinator who will schedule meetings with pertinent hospital staff members. There are over 100,000 highly qualified surveyors of JCAHO. The Joint Commission is administered by twenty nine Board of Commissioners including nurses, physicians, consumers, medical directors, administrators, providers,
employers, a labor representative, health plan leaders, quality experts, ethicists, a health insurance administrator and educators. The Board of Commissioners utilizes interdisciplinary experiences in healthcare and business to provide JCAHO with many different points of view. The Joint Commission’s corporate members are the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association and the American Medical Association.

There are many benefits for an organization that seeks JCAHO accreditation status. The Joint Commission accreditation is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards. In addition to accreditation, an organization can obtain the Gold Seal of Approval™. To earn and maintain the Joint Commission’s Gold Seal of Approval™, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years. Laboratories must be surveyed every two years.

Besides quality measurement and performance improvement that JCAHO provides a healthcare organization with, other advantages are at stake. Accreditation strengthens community confidence in the quality and safety of patient care. Quality improvements that are implemented in accordance to JCAHO standards improve risk management and reduce incident reports in general. This will, in turn, reduce liability insurance premiums. In addition to being required for Medicaid and Medicare reimbursement, accreditation is becoming a prerequisite to eligibility for insurance reimbursement and participation in managed healthcare plans. An accredited organization witnesses dramatic improvements in its daily operations. As mentioned before, accreditation helps in managing and strengthening patient safety efforts. It provides managerial, administrative, and counseling advice leading to improving the business transactions and enhancing staff education.

Performance improvement measures require a high commitment and costly preparations. The short-lived costs however may be a good investment for the organization owing to the many benefits that accreditation can provide for an organization on the long run. Another dilemma that the Joint Commission may face is that organizations may simply prepare for each expected survey instead of maintaining a quality environment. Recent changes that JCAHO have made did encourage maintaining an ongoing culture of quality. In this regard, the Shared Visions-New Pathways® initiative turns the focus of the accreditation process on operational systems critical to the safety and quality of patient care, encouraging continuous improvement of the operational systems in the ultimate objective of improving the quality and safety of patient care.
The National Commission for Quality Assurance (NCQA) is an independent, not-for-profit organization whose purpose is to improve the quality of healthcare by providing accountability for healthcare organizations. NCQA grants accreditation to managed care organizations. During the accreditation process, the NCQA assesses the quality of the systems and processes that define health plans. The NCQA examines service plans and the care they deliver in areas such as preventive care. In an attempt to help patients make more informed decisions about the health plans they choose, NCQA began accrediting managed care organizations (MCOs) in 1991. Accreditation provides consumers with standardized, objective information about the quality of these organizations. Employers, consumers, regulators and health plans all refer to NCQA's accreditation as a credible reference in evaluating health plan quality. NCQA regularly revises and updates its accreditation standards, tackling red flagged health care issues and resolving them.

The accreditation program helps to fulfill the mission of NCQA which is to “improve the quality of healthcare by generating useful, understandable information about the health care quality to help the consumer and employer make an informed choice.” NCQA generates information and feedback to practitioners, and other healthcare workers about various health plans to identify areas that need improvement.

Several health plan areas are assessed during the accreditation process. One of these is the presence of quality improvement in three domains. The first domain is program structure and operations of the organization. Here, surveyors look for the presence of a quality improvement committee and the reviewing processes that are on the agenda of the quality improvement committee. The second examined domain is the availability of healthcare practitioners and services. The last domain comprises member satisfaction, adherence to practice guidelines.

Once an organization applies for accreditation with NCQA, the organization completes an Interactive Survey System (ISS). The ISS allows the organization to submit its self-survey information electronically, to streamline the initial process and make it faster. Once initial self-survey scores are viewed and the organization is prepared, an on site survey can be conducted. Like most other accreditation bodies, teams of physicians, as well as other experts conduct accreditation surveys. Once an on site survey has been conducted and all the relevant information is collected, an independent oversight committee analyzes the teams’ findings and the organization’s clinical performance. An accreditation status is then assigned based on performance. “Excellent”, which is the highest level of
accreditation, is only granted to health plans that demonstrate quality that meets or exceeds NCQA requirements. The plans must also achieve the highest levels of nationally standardized health indicators, determined by HEDIS program, which reflects a series of measures of population health and overall effectiveness of healthcare and is developed by NCQA. A score of “Commendable” indicates that the health plan demonstrated levels of service and quality that meet or exceed NCQA standards. A status of “Accredited” indicates that the health plan meets most of NCQA’s basic requirements. If the health plan only meets some, but not all of NCQA standards, they receive “Provisional” accreditation. A health plan is denied accreditation if they did not meet NCQA’s requirements during its review.

A managed care plan that receives high levels of accreditation from NCQA can enjoy many benefits. Employers and independent consumers visit NCQA websites to search for info about health quality. Federal employees, dependents and retiree’s receive information about the quality of health plans through the annual Federal Employees Health Benefits Guide, a booklet distributed in order to help guide health plan selection. NCQA also has an online Health Plan Report Card, which serves as a reference that illustrates the NCQA status of all surveyed health plans. Many major employers purchase health plans based on NCQA accreditation including IBM, AT&T and Coca-Cola. Not only are ¾ of all HMO enrollees in NCQA accredited plans, but accreditation provides organizational benefits as well. Participating commercial health plans generally experience improvement across a wide range of clinical quality measures with the help of NCQA.

**Accreditation Association for Ambulatory Healthcare**

Accreditation through the Accreditation Association for Ambulatory Healthcare (AAAHC) is a voluntary process through which a healthcare organization can measure the quality of its services and performance against nationally recognized standards. The Accreditation Association focuses on improving quality in a variety of healthcare settings including ambulatory care settings, and office based surgery. Developed in 1979, the association’s purpose is to “encourage and assist ambulatory health care organizations, to provide the highest achievable level of care for recipients in the most efficient and economically sound manner.” The American Association for Ambulatory Healthcare improves quality of healthcare organizations through surveying, on site review, peer assessment and providing education for ambulatory healthcare providers. AAAHC accreditation has many advantages. Accreditation is a symbol to others that an organization provides high-quality care in accordance with a set of nationally recognized standards. It can also provide confidence to members of the community and gives ambulatory care centers a competitive advantage. In addition to the
benefits accreditation has to the organizations reputation, accreditation can satisfy regulatory requirements for licensure or certification, and can be used for improving third-party reimbursement and insurance premium reduction. Several states such as California and Florida have already recognized AAAHC accreditation as a way to meet certain state laws and regulations. AAAHC has also been granted Medicare deemed status for Acute Surgery Centers.

AAAHC accreditation can be used for many different settings in the ambulatory healthcare arena. The Accreditation Association (AAAHC) is the most recognized accrediting organization for ambulatory health care organizations. The surveyors are experts in ambulatory settings who provide consultative feedback on what each organization’s processes are and methods for improvement. One type of ambulatory care setting examined by the Association is managed care organizations. The Accreditation Association’s managed care standards are developed with from members of the industry. Standards include the evaluation of functional areas such as enrollee communications systems, grievance resolution systems, utilization management, quality management and improvement, and provider credentialing systems. In addition to managed care, the Association accredits office based surgery centers. The program was developed in 2001, for organizations that have no more than 4 physicians or dentists and no more than 2 operating rooms. The association also accredits lithotripsy organizations. The Accreditation Association joined the American Lithotripsy Society (ALS) to create a joint accreditation program, the Accreditation Program for Lithotripsy Organizations (APLO). This collaboration offers ambulatory health care organizations that provide lithotripsy services, a more comprehensive approach to achieving accreditation.

The process of accreditation compares areas of performance of the organization to AAAHC standards. The accreditation process involves self-assessment by the organization, as well as a thorough review by the Accreditation Association’s surveyors. In order to prepare for a survey, the organization first obtains a copy of the standards, which are published in the Accreditation Handbook for Ambulatory Health Care and submits an application for survey. The Accreditation Association standards are divided into 250 major standards that apply to all organizations seeking accreditation, and 375 adjunct standards that apply to organizations based on the services they provide. A few of the core standards that apply to all organizations include rights of patients, governance, administration, quality of care provided, quality management and improvement, clinical records, and environment. A few of the adjunct standards that apply to organizations are based on the types of services they provided, including surgical services, overnight care, emergency services, immediate/urgent care services,
diagnostic imaging services and health education to name a few. Once the standards have been reviewed and the application has been submitted, a surveyor will conduct an on-site examination. The surveyors are volunteer practitioners, such as, physicians, dentists, podiatrists, pharmacists, nurses and administrators, who are regularly involved in ambulatory health care. The on-site survey includes a complete examination of compliance of the organization with the Accreditation Association Standards, including a review of any separate entities that have a close relationship with the organization seeking accreditation. After the on-site survey is complete, surveyors hold a brief conference at which they present their findings to the organizations' representatives. The organization will be given the opportunity to comment on both the findings and the entire survey process.

Length of accreditation varies from three years to six months depending on the level of compliance with AAAHC standards. The longest-term accreditation offered is three years. The AAAHC awards an organization accreditation for three years when the organization is concluded to be in substantial compliance with the standards. The committee must not have any doubts about the accuracy of the survey findings or the organization’s commitment to providing high-quality care and services as reflected in the standards. The AAAHC will award an organization accreditation for one year when a majority of the organization’s operations are acceptable but other areas need more time to be improved. The AAAHC awards an organization a six-month term of accreditation fewer than two circumstances. First of all, if the AAAHC concludes that the organization is in substantial compliance with the standards but it is not eligible for a longer term of accreditation because the organization does not meet certain requirements, e.g., the organization has not been operational for six months. The AAAHC may also award a six-month term of accreditation to an organization that meets many requirements, but continued compliance with the standards is not sufficiently well established to grant a longer term of accreditation. If the AAAHC is not ready to award accreditation, they can defer decision when the organization’s operations do not meet the standards, but the organization demonstrates the commitment and capability to correct identified deficiencies within six months. Finally if the AAAHC concludes that the organization is not in substantial compliance with the standards, they can deny accreditation.

Organizations that are awarded accreditation are required to maintain AAAHC standards. Organizations must undergo full, regular surveys at least once every three years in order to avoid a lapse in accreditation status.

Utilization Review Accreditation Commission
In the 1980’s, a standardized method of standardizing and reviewing utilization review techniques was needed in order to ensure that health care measures were medically necessary for patient care. This was in light of insurance and managed care companies placing increasing constraints on the delivery of patient care. The Utilization Review Accreditation Committee (URAC) implemented a mission to cover “a large range of service functions found in various health care settings including the accreditation of integrated systems such as health plans to smaller organizations offering specialty services.” Today, URAC has over 16 accreditation and certification programs for different areas in health care. URAC is an independent, nonprofit organization. URAC offers a wide range of quality benchmarking programs and services that keep healthcare organizations updated about changes in standards in the health care system.

The URAC accredits many types of health care organizations depending on the functions they carry out. Each of the different accreditation programs review the entire organization, such as the health plan standards, or focus on quality within a single functional area in an organization, such as case management or credentialing. Any organization that meets the standards, including hospitals, Health Maintenance Organizations and other provider groups can seek accreditation. Accreditation adds value to these programs by acting as an external symbol of quality, and by promoting quality improvement within the organization as part of the accreditation process.

In order to receive accreditation, the health organization must meet certain standards. A committee of experts who represent providers, health care organizations, insurers, and the public develops URAC standards. URAC measures standards that apply to certain types of health organizations or basic, core standards. URAC accreditation programs include accreditation for case management, claims processing, consumer directed health, credentials verification, disease management, health plan assessment, HIPAA privacy and security and independent review. The Core standards are the foundation of URAC accreditation. These standards address major organizational functions critical for any health care organization, including: organizational structure, staff qualifications, training and management, oversight of delegated activities, quality management, and consumer protection. All URAC-accredited companies need to meet the basic requirements of the Core Standards, in addition to the function-specific requirements for the specific accreditation program.

Organizations applying for accreditation participate in a process that includes substantial review occurring in four phases. The first phase consists of completing the application forms and supplying supporting documentation, which can take several months. After the preliminary paperwork is done, the applicant's documentation is analyzed and URAC
reviewers compare components to the URAC standards. The applicant’s
documentation can include formal policies and procedures, organizational
charts, position descriptions, contracts, sample template letters, and program
descriptions and plans for departments such as quality management and
credentialing. The onsite review is then conducted in which the accreditation
review team conducts an onsite review to verify compliance with the
standards. Management is then interviewed about the organization's
programs and the staff is observed performing its daily duties. Audits are
also conducted while personnel and credentialing files are analyzed. Finally,
education and quality management programs are reviewed. During the
onsite visit, URAC reviewers also share "best practices" and provide other
helpful guidance to members of the organization they are surveying.

After the on site survey is complete, two URAC committees review
the information collected from the organization. The committee review
process begins with a written summary documenting the findings of the
desktop and onsite reviews which is submitted to URAC Accreditation
Committee for evaluation while discussion with the review team is
conducted if needed. The Executive Committee then makes a final
accreditation determination. A full two-year accreditation is awarded to
applicants who successfully meet all requirements. Conditional
accreditations may also be awarded to applicants who have appropriate
documentation, but have not implemented certain policies and procedures
according to URAC standards. Provisional accreditation may also be
awarded to companies that have not yet implemented their program or have
not had at least six months of operational experience at the time of the onsite
review. Organizations can be deemed as unable to meet URAC standards
and are either placed on corrective action status, denied accreditation, or
choose to withdraw. Follow-up activities for organizations receiving
Conditional or Provisional status or corrective action may need to be
completed and submissions of additional or revised documentation need to
be provided before another onsite review. When these follow-up activities
are complete, a follow-up executive summary is submitted to URAC
committees and the organization may receive Full Accreditation.

Besides giving organizations a view on their quality performance,
accreditation provides updated standards, which motivate health care
workers to remain, informed about current changes in health care oversight
and delivery. With the help of URAC standards, states can make sure that
companies remain in compliance with national standards without the burden
of having to revise legislative and regulatory language. Some states will
even "recognize" URAC accreditation, meaning that the accreditation can be
used to meet state regulatory requirements instead of separate reporting to
the state.
Commission for Accreditation of Rehabilitation Facilities

Since its development in 1966, The Commission for Accreditation of Rehabilitation Facilities (CARF) has promoted quality and optimal outcomes through its consultative based accreditation process. CARF’s vision is “to respond to the environment of rehabilitative care through their programs and services.” CARF accreditation examines processes in the organization, assesses their strengths and weaknesses and provides a foundation for improvement. In addition to the organizational benefits of accreditation, insurance companies also value CARF accreditation. In acknowledgement of their commitment to improve performance and quality providers accredited by CARF may be eligible to receive discounts on their insurance premiums.

CARF is an international, private organization that focuses on accreditation in the areas of rehabilitation, employment, child and family, community, and aging services. The CARF organization currently accredits more than 4,800 providers in more than 17,000 locations in the United States, Canada, Western Europe, and South America. Fees from accreditation surveys, sales of publications, grants from public entities, and fees from workshops and conferences finance CARF, which is a nonprofit organization.

The accreditation process examines the facility against a set of standards specific to the type of organization desiring accreditation. An 11-member Board of Directors, who approve basic policies, including standards development and the accreditation process, develop the standards. The CARF standards, which are listed in their manual, pertain to important dimensions of quality. CARF standards are developed and revised through a series of leadership panels, national advisory committees, focus groups, and field reviews. The process of standard development is unique because it provides opportunities for consumers to be actively involved.

CARF’s dedication to the rehabilitation field among many others ensures that the standards for rehabilitation remain up to date. Although CARF’s standards are responsive to the unique needs of specialized programs in medical rehabilitation, there are a group of fundamental principles apply to all programs. These principles are the basis for all CARF standards. The first area is service design and delivery which must be patient focused. There must be designated, qualified, competent personnel providing services. The program must be easily accessible for the provision of rendered services. Positive outcomes should be present. There must be adequate participation of the patients in the course of their care and decision making. There must be a system of accountability that objectively measures the success of the program. Finally there must be sufficient communication.
between the organization and the stakeholders about program’s performance.

The accreditation process requires at least a year of preparation prior to the on-site survey and a commitment to maintain quality performance. Once an organization is approved for the accreditation process, they are assigned a resource specialist who provides them with guidance and a description of standards. The organization must implement and use the standards for at least six months before the survey. A survey team then determines the organization’s conformance to all applicable standards with an on-site visit. They observe services, interview with people served by the organization, and review relevant documentation. Surveyors also consult organizational personnel. Six to eight weeks after the survey, the organization is notified of the accreditation outcome and receives a final survey report. Depending on the organization’s evaluation, they receive several different levels of accreditation. The highest level of accreditation is awarded when the organization satisfies each of the CARF accreditation conditions and demonstrates substantial conformance to the standards. This designation lasts three years. A One-Year Accreditation is awarded when the organization upholds each of the CARF accreditation conditions and conforms to most of the standards. There can be significant areas of deficiency in relation to some of the standards, but there must be reason to believe that the organization is able to correct the deficiencies. Provisional Accreditation is given after a One-Year Accreditation expires, but the organization still functions on a level comparable to the One-Year level. Nonaccreditation status is given when the organization has major insufficiencies in many areas of the standards. Some of these insufficiencies involve the serious questions regarding the benefits of services such as welfare, or safety of those served. The organization will also not receive accreditation if they fail to satisfy one or more of the CARF accreditation conditions.

CARF accreditation not only assesses quality improvement, but the process ensures an evaluation of performance improvement as well. Ninety days after notification of accreditation award, the organization then submits a Quality Improvement Plan outlining the actions that have been or will be taken in response to the recommendations made in the survey report.

There are many advantages to CARF accreditation besides recognition of quality achievement. The accreditation process is focused on valuable peer review, networking, and sharing ideas. CARF's does not merely inspect the facilities, but it uses a consultative approach to teach the organizations throughout the inspection process. The final report received by the organization contains suggestions for improving services, and recommendations for improvement. This information can help the organization prepare a quality improvement plan to address the
recommendations throughout the future of the organization, allowing them to improve their structure and operations.

**American College of Pathologists Accreditation**

One area of healthcare that is of particular importance is the laboratory services provided by pathologists. *The College of American Pathologists (CAP)* has implemented an accreditation body that supports quality improvement for patient safety and outcomes for laboratory and pathology services. The goal of the CAP Laboratory Accreditation Program is to implement quality improvement through education, standard setting, and ensuring laboratories meet or exceed regulatory requirements. CAP provides standards and recognizes those who meet these standards upon successful completion of the inspection process. Once a laboratory is awarded CAP accreditation, it becomes part of a group of more than 6,000 laboratories around the world that have met those standards as well.

The CAP program is based on numerous accreditation standards that are translated into detailed and focused checklist questions. Surveyors use the checklists, which provide a quality practice outline for laboratories to follow, as a guide to assess the overall management and operation of the laboratory. The inspection measures the ability of pathology services, including appropriate consultation services to meet the needs of patients and their physicians. Specific areas assessed are proper identification, collection (when applicable), transportation, storage, processing, and examination of clinical specimens with subsequent reporting of results. When pertinent, pathology services may also include examination of patients in consultation cases and active participation in prevention, diagnosis, and management of patients. Each laboratory should also provide proper educational and scientific opportunities for the medical and technical staff.

The inspection process is rigorous with a processed measuring of specific standards of care. The standards measured during the inspection include the director’s roles, qualifications and responsibilities. It is also important that the facilities have sufficient upheld resources and safety standards. There must be a measurable process in place for quality control and performance improvement, which can include steps such as proficiency testing. Inspection requirements form both internal and external reviews must be conducted and consistent with CAP standards, which are listed, in a comprehensive checklist that is tailored to specific types of laboratories. These checklists include items that cover areas in quality control, surgical pathology reports, interlaboratory comparisons, equipment maintenance, and laboratory safety, just to name a few. These checklists can be many pages long and cover extensive details.
During the inspection process, laboratories will be inspected using the checklist version of standards sent to them at the time of application/reapplication. The customized checklists are sent with a Self-Evaluation, Re-application and Lab Inspection Packet. There are three methods of testing that surveyors typically use when evaluating facilities. With the first method, the inspector of a particular section selects an instrument or analyzes and asks the laboratory staff to demonstrate how things work, replicating a training session. The second method involves a comprehensive look at a selective group of analyses. This is based on the assumption that if few areas are thoroughly examined and eventually are found to maintain high standards, the organization then shows an overall commitment to quality. The third method is tracking a specimen from its collection till issuing its report and may be beyond this point. This is a commonly used General Laboratories and Blood Banks’ inspector. The idea is to observe the level of compliance the technicians demonstrate with the policies and training materials, while asking them some related questions.

The CAP Laboratory Accreditation Program is useful in meeting the needs of a variety of laboratory settings ranging from complex university medical centers to physician office laboratories. The Centers for Medicare & Medicaid Services (CMS) has granted the CAP Laboratory Accreditation Program authority for accrediting laboratories. It is also recognized by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and is used to meet many state certification requirements. Over 83% of the top major teaching and large community hospitals choose CAP as their accrediting agency. CAP Laboratory Accreditation Program uses multi-disciplinary teams of practicing laboratory professionals as inspectors who deal with laboratory issues on a daily basis. Their advice is educational for the laboratories being inspected due to their unique qualifications. The advantages for CAP accreditation are not only to inform consumers, but the process educates organizations on proven processes and quality improvement mechanisms.

Community Health Accreditation Program

Home healthcare in the United States is becoming increasingly important. The growing elderly population contributes to the demand of long-term care services. The Community Health Accreditation Program (CHAP) was established to ensure the safety and high quality of these organizations. Developed in 1965, CHAP is an independent, non-profit accrediting body implemented to distinguish that a community or home health organization has voluntarily sustained optimal standards. In 1992, CHAP was granted “deeming authority” by the Centers for Medicare and Medicaid Services (CMS) for home health and for hospice in 1999. CHAP
has the authority to survey agencies providing home health and hospice services and to determine whether they meet the Medicare Conditions of Participation in place of state surveys.

An advantage of CHAP accreditation is that the standards objectively validate the excellence of community health care practice through consistent measurement of the delivery of quality services. The presence of a regulatory body motivates community and home health providers to achieve continuous improvement by adhering to certain standards. This in turn helps assist the public in the selection of community health services and providers by demonstrating their achievements. CHAP’s mission statement is to “be an innovative, effective leader providing quality accreditation services to community-based organizations.”

CHAP accreditation is available to organizations providing various services including home health, hospice, home medical equipment, home pharmacy, infusion therapy, nursing, private duty services, home care aide services, public health, supplemental staffing services and community nursing centers. The process of accreditation includes several steps. The first step is applying for the accreditation process. When the application is processed, the organization begins a self study, which addresses both the business and service delivery aspect of the applicant’s organization. This self-evaluation tool allows the organization to examine their day to day processes. Once the Self Study is turned in, the CHAP staff will review the documents for completeness and begin analysis of the content. The next step is the site visit, which is performed by the surveyors. The objective of the visit is to provide professional assistance while ensuring compliance with the CHAP Standards of Excellence and other regulatory requirements. The emphasized concepts are those of operational management, continuous quality improvement, adequate levels of resources, consumer satisfaction and outcomes, long-term viability of the organization, and promoting public recognition of the quality of services and products provided. A Site Visit Report is then developed, which is the legal document that states the organization’s level of compliance with the CHAP Standards. The Board of Review reviews the Site Visit Report and all supporting documents.

The review stresses on mentioning corrective actions. The site visit team gives its recommendations regarding accreditation status of the organization. Once the recommendations are made, accreditation status is determined, which range from accreditation to denial or revocation of accreditation.

The frequency of visits varies with the type of status the organization seeks to attain. Visits to Medicare home health and hospice organizations will be unannounced if agency applies for “deemed status.” The Board of Review and CHAP Staff in accordance with the “CHAP Site Visit Survey Frequency Guidelines” will schedule visits within the expected time frames.
as determined. Non-Medicare certified organizations may have prior knowledge of the date of scheduled visit. There are many types of visits that are made by CHAP. There are initial site visits which include the completion of the self studies, annual site visits, 1\textsuperscript{st}, 2\textsuperscript{nd} and 3\textsuperscript{rd} year cycles including the Self Studies, focus visits and complaint investigation visits. Full site visits are conducted at the initiation of accreditation and again at the first site visit scheduled in a new 3 year cycle. More concise site visits, focus on previously cited required actions and specific key standards during years 2 and 3.

CHAP not only measures quality standards and awards accreditation, but they ensure that high standards are maintained by the organization. The CHAP Standards of Excellence provide guidance and criteria for the evaluation of an organization, which are based on four-key “Underlying Principles”, which drive each set of the CHAP Standards. The first principle is that organization’s structure and function consistently supports its consumer-oriented philosophy, mission, and purpose. The second principle states that the organization must consistently provide high-quality services and products. The third principle affirms that adequate human, financial, and physical resources are provided in order to accomplish the stated mission and purpose. The fourth principle testifies that the organization is well positioned for long-term viability.

Benefits of accreditation by CHAP include management consultation of the highest quality, access to a broad network of professional resources, and guidance critical to building intra and inter-organizational collaboration and strength.

Healthcare Facilities Accreditation Program (AOA)\textit{The American Osteopathic Association (AOA)} represents over 54,000 physicians in the United States, which serves as the primary certification and accreditation body for all osteopathic physicians, osteopathic medical schools and healthcare facilities. The AOA supports the Healthcare Facilities Accreditation Program (HFAP) as part of their association. Since its development in 1945, this accreditation body functions to provide an objective review of medical facilities in the field of Osteopathic Medicine. HFAP is recognized as an accreditation body by insurance carriers, managed care organizations, federal and state governments. It is one of only two voluntary accreditation programs in the United States that is authorized to survey hospitals under Medicare, the Center for Medicare & Medicaid Services (CMS). CMS has given the AOA program “deeming authority” to conduct accreditation surveys of acute care hospitals and hospital laboratories. In addition to hospital settings, accreditation requirements have also been developed for ambulatory care/surgery, mental health, substance abuse, and physical rehabilitation medical facilities.
The program is also recognized as an alternative to accreditation by CMS and JCAHO.

**Malcolm Baldrige Award**

The Malcolm Baldrige award is presented by the President of the United States to healthcare organizations that apply and pass a rigorous review in different areas of its medical services. This award was established by the congress in 1987 to recognize organizations in the U.S. for their achievements in quality and performance and to raise awareness about the importance of quality in different industrial sectors. Three awards are given each year to healthcare organizations as well as other business categories.

Malcolm Baldrige was the Secretary of Commerce from 1981 until his tragic death in a rodeo accident in 1987. He was an advocate of quality management and took a personal interest in the quality improvement act, which was eventually named after him in honor of his contributions. The Malcolm Baldrige award is not only recognized as a standard of achievement in the United States, but around the world. Criteria for achieving one of these awards is focused around the organization's never ending efforts to improve its overall performance adding value to its customers.

Seven categories make up the award criteria for Malcolm Baldrige award: (1) senior executives’ leadership and good citizenship; (2) strategic planning; (3) customer’s and market’s focus and share; (4) ability to measure and manage data and information to support the organization’s direction and processes; (5) human resources or workforce and their adequate alignment with the organizational objectives; (6) process management; and finally (7) the overall business results measuring organizational performance and improvement in key business areas such as customer satisfaction, operational performance and relative performance as compared with other organizations’ performances.

The healthcare award was introduced in 1999 to promote quality education and services in any for-profit or not-for-profit organization including hospitals, HMOs, healthcare practitioner offices and health insurance companies.

Malcolm Baldrige applicants receive a 50-page document where written assessment of the organizations weaknesses, strengths and opportunities for improvement should be registered. These assessments measure individual items of quality and score them on a 10% scoring range and compare the organizations score relative to other applicants. A four stage evaluation process is then undergone by the organization which includes an independent review; a consensus review; a site visit review; and finally the Board of Examiners select recommended award recipients.
During the independent and consensus review, a panel of judges who attribute scores and present their reports based on the quality criteria met reviews applications. The judges then decide if the organization is eligible for a site visit. During the site visit review, the judges verify that application information is correct and recommendations are made whether or not the applicant will be selected for recommendation for the award.

Award recipients receive national recommendation for their achievements in quality improvement. This bring about an enhanced organization’s productivity, increased employees’ and customers’ satisfaction, and improved profitability according to studies done by the National Institute of Standards and Technology (www.nist.gov).

**Australian Council on Healthcare Standards**

*The Australian Council on Healthcare Standards (ACHS)* is one of the most recognized accrediting bodies for healthcare organizations in Australia. Since its implementation in 1974, ACHS has been an authority in the review, measurement and implementation of quality improvement processes in healthcare facilities around the country. Standards for evaluation, assessment and accreditation are determined by a council drawn from important bodies in health and representatives of the Commonwealth government, State governments and consumers. Its mission which is to “be recognized nationally and internationally as the leading Australian organization that independently assesses performance in order to promote and improve quality and safety in health care” guides ACHS and is accomplished by its accreditation processes through performance evaluation, quality education and standard setting.

ACHS continuously works with consumers and healthcare professionals to develop standards that are applicable in contemporary healthcare settings. The standards are tailored to the type of organization they are assessing. ACHS standards may be applied to all health care organizations including, hospitals, nursing homes, outpatient surgery centers, community health services, and ambulance services. There are four basic principles all standards are centered around. Those principles are: (1) positive outcomes; (2) leadership; (3) commitment to quality improvement; and (4) a culture that encourages “best practice” processes.

*Healthcare standards* are separated into two main components: (1) continuum of care; and (2) leadership and management. These standards measure quality throughout the patient’s care process. On another hand, *infrastructure standards* measure the competency of the support services needed to provide quality care.

Five major functions of the healthcare organization are examined. Each comprises a list of standards, and a list of criteria that must be met.
These functions are: (1) leadership; (2) human resource management; (3) information management; (4) safe practice and safe environment; and (5) performance improvement. Each of these categories is ranked by levels of achievement ranging from little achievement (LA) to outstanding achievement (OA).

Organizations seeking accreditation must go through the Evaluation and Quality Improvement Program (EquIP). This program involves a four-year process during which the organization conducts a self-assessment, and an organization-wide survey and periodic review conducted by peers in the healthcare industry. Accreditation is awarded to those organizations that meet ACHS standards.

There are many benefits in obtaining ACHE accreditation. ACHS standards are recognized throughout the world, and ACHS accreditation acts as a “stamp of approval” to notify consumers and other stakeholders that the healthcare organization has met high quality standards of patient care. This improves both quality processes and outcomes within the organization.

**Quality Health New Zealand**

*Quality Health New Zealand* is an accreditation body that was established to help improve compliance with standards and performance of health care and disability services. Clients include District Health Boards, hospitals, rest homes, mental health services, community and home care services, hospices, disability services, primary care services, Maori health providers and not-for-profit health organizations. Quality Health New Zealand is part of an international organization of national health accreditation bodies. Participation is voluntary, independent of government, and based on peer assessment by health professionals and requires commitment by the organization’s management to performance improvement activities.

The program takes about three years of on-site education, planning, organizational self-assessment, initial on site preview, accreditation survey, post-survey quality action planning, progress visits and continuous quality improvement. Quality Health New Zealand provides assessment for acute care centers, long term care centers, private surgical centers, as well as hospice, community health centers, home support and primary care centers plus not-for-profit health organizations.

Healthcare organizations are assessed against a set of standards for service delivery. These standards cover areas such as accessibility, patients’ assessment, client service/care planning, and implementation of client service/care, in addition to evaluation of and follow-up on outcomes. One distinctive aspect of Quality Health New Zealand is its focus on public health standards during the organizational assessment. These standards
include health promotion and protection, and should be integrated in all of the organization’s services/departments.

To receive accreditation, healthcare organizations should be compliant with a multitude of quality standards. Surveyors assess several performance measures during their inspections such as access to services, appropriateness of decision-making, continuity of care, effectiveness, efficiency, responsiveness and safety.

There are three main components of the survey. The first is the “Client Service Plan”. Each organization is given a Client Service Manager who develops a Client Service Plan specific to the organization. This plan details dimensions of the survey which include planning and staff education, on site visit, on site preview, a self-assessment and consequently a quality action plan, survey, and a follow-up visit.

The second step of the survey is the “Self Assessment”. It is not the same self-assessment performed in the above component. During this phase, the organizations compare their performance against those of the Quality Health New Zealand Standards. This provides a basic measurement against which the organization measures their progress and achievements. Before the organizations’ first survey takes place, it will receive an “On Site Preview” to help them in assessing their progress towards achieving the standards in areas demanding an improvement.

During the “Actual Survey”, the surveyors examine validation of the organization’s commitment to quality improvement. Surveyors examine this through review of documentation, interviews with the governing body, managers, committees and service teams, observations, assessments of client care and service examined through health records review, discussions with clients and families, meeting with groups of stakeholders to check on any additional comments. The surveyors then provide feedback to the chief executive and senior management at the end of the survey and provide feedback to the staff of the organization as well.

A seven point numerical rating scale assesses performance of the organization. This scale provides an objective measurement of performance. A report of performance is then provided to the organization which is then required to draft a “Quality Action Plan” (QAP) that specifically addresses the recommendations or corrective actions suggested within a specific timeframe.

Organizations that successfully achieve Quality Health New Zealand Accreditation receive a Certificate of Accreditation which lasts about three years as long as the organization continues to participate in the program. A Quality Health surveyor performs progress visits at least once while the organization is accredited. These visits are designed to support ongoing quality improvements, ensure standards are being maintained or exceeded,
review the organization’s achievements and outcomes in relation to its quality action plan, and assist with interpreting the intent of the standards.

Quality Health New Zealand helps organizations compare their accreditation results with similar organizations across the country using the Quality Health New Zealand’s comparative reporting indicator. Quality Health New Zealand provides many advantages to healthcare facilities by helping them to improve their overall performance and outcomes, develop strong leadership, enhance teamwork among staff, develop effective clinical and management systems throughout the organization, focus on quality care for clients and meet the Ministry of Health certification requirements. Quality Health’s Accreditation Seal is the symbol of New Zealand’s a reputable, respected and trusted quality program for health services. Accredited services can display the Quality Health Accreditation seal and Quality Health symbol with its own marketing and promotional actives.

**Health Quality Service for UK and internationally**

The Health Quality Service (HQS) is the oldest established health accreditation service in the United Kingdom and Europe. Through its consulting services, developing healthcare standards and assessing processes, the Health Quality Service works with international healthcare organizations to improve quality. HQS tailor programs and services to meet the specific needs of the organization they are evaluating. The types of healthcare sectors they evaluate range from public, private, and voluntary healthcare services. HQS provides assistance to healthcare organizations in improving its physical resources and preparing the staff for any obstacle/challenge they may encounter during a survey or audit. Clients include acute care hospitals, community health, mental health, learning disabilities, palliative care, residential and nursing homes, general practitioners and primary healthcare services. HQS was originally known as the Kings Fund Organizational Audit and in 2000 became an independent charity. Since January 2005 HQS has been part of CHKS Ltd, a company specializing in knowledge management systems for healthcare. This merging allowed the clinical benchmarking expertise of CHKS Ltd to be combined with HQS’s knowledge about running quality accreditation programs.

HQS prepares accreditation standards for local and international healthcare organizations. Standards are developed for a wide array of healthcare services. The first list of international standards was implemented in 2003 and has since been revised and republished in 2005. Standards are based on current UK best practice while using internationally recognized terminology to communicate those standards. The international standards are customized to reflect local requirements including organizational
structures, service configurations, laws, culture and practices. Those standards incorporate the criteria from the ISO9001: 2000 widely recognized international standards provided by the International Organization for Standardization.

The accreditation review process for international applicants and United Kingdom applicants share some similarities with that occurring in the United States. Preparations for the review take 12 months. The healthcare organization seeking accreditation first conducts a baseline assessment. The information from the assessment determines the areas that need improvement. After few more self-assessments, progress with implementing the standards is measured. The applicant then selects a project manager to co-ordinate activities across the organization. The project manager will supervise the training of staff members, receive a project manager manual, and coordinate communications between the organization and HQS through their client manager.

Members of survey teams then conduct a peer review process. These teams consist of senior health care professionals who are chosen for their experience, knowledge and credibility as well as their appropriateness to the type of organization and services they provide. The number of surveyors in the team and length of the survey depends on the size of the organization being reviewed. During the actual survey, information is gathered from the organizations documentation and interviews with staff members and patients. Observations of work processes are made in critical sample service areas. Twenty to thirty days after the onsite survey, a draft and a comprehensive report of the surveyors' findings are sent back to the client providing the organization with an action plan. This action plan includes a detailed assessment of its performance against HQS standards, identification of problem areas, and encouragement for areas that have reached standards of best practice and suggestions and recommendations for future improvement. If an organization is awarded accreditation, they remain accredited for a period of three years from the date of the peer review survey. The organization receives a certificate and plaque of accreditation. HQS remains involved with the organization’s quality improvement efforts by continuing to monitor their performance. They do this by ensuring standards are being maintained and to reviewing the organization’s achievements in relation to its action plan.

HQS recognition has many advantages for the healthcare organization as well as providing recognition. Over 75 per cent of clients who have completed evaluation questionnaires over the last two years, have confirmed the HQS program has brought many organizational benefits. These benefits include preparation for inspection by statutory inspectors, a framework for meeting the requirements of clinical governance as well as a foundation for
meeting the requirements of controls assurance; it acts as an effective self-assessment tool and raised awareness of policies and procedures.

**Conclusions**

Accrediting bodies provide organizations with advices, evaluations and incentives that they actually can benefit from in order to improve their current performance. Reports based on these evaluations can keep staff members informed about weaknesses and strengths of the healthcare facility and would act as a framework for implementing improvements.

The survey process offers valuable recommendations for staff members and managers. The benefits from accreditation can also be acknowledged in an overall improvement in patient care and service delivery. The extensive survey process provides priceless guidance and corrective instructions to the various departments in a healthcare facility. The continuous monitoring offered by most of the accrediting bodies ensures that staff members stay informed about up to date quality standards and acts as a motivator to maintain the healthcare facility’s running contingently with applied guidelines.

Healthcare facilities that are taking the initiative to monitor their processes will hopefully act as an example to other organizations. Continuous evaluation by accrediting bodies ensures that those improvement measures remain endorsed.

**REFERENCES**


3. Synopsis on the Accreditation Survey Phase

*T. Anbar, MPH*

The *Survey phase* of the accreditation process is a systematic and independent assessment of the healthcare organization’s compliance to standards. The collected information during the *survey process*, the second sub-process of the survey phase, highlights the healthcare organization capability of providing good quality care. The survey process focuses on the performance and measurement of clinical outcomes rather than limiting the evaluation to capabilities and routine processes only.

Before, during and after the survey the healthcare organization is usually very busy and engaged in different important activities to make this survey a successful experience that will result in a positive outcome. It is therefore up to the organization to make every effort to prepare well for the survey and perform well during it. It is a long and hard process but it is worth it at the end.

**The Survey Phase**

The survey phase can be divided into three separate sub-phases, namely:
- Preparation for the Survey
- Survey process
- Evaluation.

**Preparation for survey**

The preparation for the survey includes all preparatory activities carried out by both the accrediting body and the healthcare organization. The main elements of the preparation stage pertaining to the accrediting body are:
- assigning a survey team
- preparing an agenda.

**Assigning Survey team:**

The survey process involves visits by a small group of external professional reviewers who evaluate an organization's performance against specific standards. These external reviewers are called surveyors. The surveyors' responsibilities are:
• to survey all aspects of the facility for compliance to the accreditation standards
• to provide the surveyed organization with an opportunity to improve its quality system
  ► to report nonconformities
  ► to report potential problems and necessary improvements
  ► to identify areas where improvement is possible
• to confirm the implementation effectiveness of policies and procedures
• to provide educational consultation to the organization in relations to the standards.

The size of the survey team depends on the size, the nature and complexity of the health care organization being surveyed. Usually, survey team consists of one each; a physician, a nurse and an administrator. Small institutions are usually reviewed by teams of two surveyors, which may vary depending on the accrediting body; some prefer a nurse-manager team, others a doctor-nurse team. A leader is assigned for the team to facilitate coordination between accrediting body and healthcare organization, and among team members themselves. Surveyors are selected by the accrediting body well in advance of the survey. These are then subjected to training in conducting surveys, interpreting standards, interviewing skills, quantitative methodologies and in teambuilding and leadership skills. The success of a survey process highly depends on surveyors’ skills. Their feedback is the key for the final decision of the accrediting body. The surveyor’s skills should include but are not be limited to:

Professional Credibility:
• Credentials and qualifications
• Comprehensive and good understanding of the healthcare system

Leadership:
• Ability to work in a team
• Capability to enhance and transfer knowledge

Communication skills:
• Verbal and nonverbal communication (listening and writing skills…)

Analytical Capacity:
• Ability to observe and judge objectively
• System thinking
Personal Attributes:

- Interpersonal relations objective, adaptable, consultative, and sensitive (to cultures and audiences)
- Creative
- Unbiased and neutral.

Surveyors should be excessively trained and experienced in the field of healthcare, they should be holding adequate professional degrees. They must be knowledgeable about quality improvement concepts. Surveyors usually undergo an orientation program before surveying in the field, and continue to receive an ongoing education.

The selection process of the Australian Council on Healthcare Standards surveyors’ workforce ensures the latter have at least five years of managerial experience and an excellent understanding of accepted medical industry standards and best practice. According to JCAHO, the surveyors must receive regular training on the implemented standards, the survey process and the scoring guidelines. The training tools include Annual Training Conference, role playing exercises, web based training, conference calls and study guides. The Joint Commission is also considered the only accrediting organization that certifies its surveyors through Surveyor Certification Examination that monitors their competencies.

Preparing an agenda:

An agenda is a timetable or audit plan that describes the arrangement of the survey visit; i.e. date, schedule, number of surveyors, duration of the survey. The agenda will be delivered to the HCO ahead of time, it will help the organization to identify staff members who shall be involved in the survey activities and documents that should be prepared and made easily accessible by surveyors. But the surveyors might ask to visit areas or access documents that were not previously planned on the agenda.

The agenda is prepared by the accrediting body after the receipt of the application for survey from the healthcare organization. Based on the size and complexity of the healthcare organization, the survey agenda is prepared to be comprehensive so that all major units and departments of the organization are surveyed and their services are assessed. Once drafted, it is sent to the healthcare organization for their review and feedback before it is finalized. The healthcare organization may find it useful at this stage to inquire about who should participate in each of the surveyors’ activities and what should be prepared for that activity. After the inquiry period and further revisions, the agenda is finalized and communicated back to the healthcare organization for internal distribution and use in the preparation process. It is rarely the case that an agenda is changed after this point unless there is a change of the assigned surveyors or a major alteration of the accreditation
plan has occurred. In this case the healthcare organization is given the choice to accept or reject the new modified agenda.

The duration of the survey varies according to the size, nature, complexity and diversity of health care services of the organization being surveyed. It ranges from one day for small hospitals to three days or four days for larger ones.

**Health Care Network Central Office and Practitioner Site Survey: Two Surveyors (An Illustrative Example)**

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<th>Day One</th>
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<tr>
<td><strong>Both Surveyors</strong></td>
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<td><strong>Both Surveyors</strong></td>
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<td>First Surveyor</td>
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<td>9:00-10:00 AM</td>
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<td>Second Surveyor</td>
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| Both Surveyors           |
| 12:00-1:00 PM            | Lunch |
| 1:00-2:00 PM             | Competency review   |
| 2:00-3:00 PM             | Credentials/privileges review |
| 3:00-4:00 PM             | Performance improvement oversight group interview |
| 4:00-4:30 PM             | Team meeting       |
| 4:30-5:00 PM             | Daily briefing |

<table>
<thead>
<tr>
<th>Days Three &amp; Four Up to four practitioner sites per day, as required</th>
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<tr>
<td><strong>First Surveyor</strong></td>
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<td>1:15-4:00 PM</td>
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**Day Five Survey closing activities may occur as early as Day Three.**
**Timing of activities is dependent on the number of practitioner sites selected for survey**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>Both Surveyors</td>
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<tr>
<td>8:30-9:00 AM</td>
<td>Daily briefing</td>
</tr>
<tr>
<td>9:00-11:00 AM</td>
<td>Team meeting to integrate survey findings</td>
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<tr>
<td>11:00 AM-12:00 PM</td>
<td>Network closing conference</td>
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The Survey Process

The survey is the second sub-process. At this point, the surveyor has already searched for information about the audited processes and has prepared a questionnaire or a checklist about the questions that shall be asked and the information to be gathered and verified. The main purpose of this sub-process is to gather information in order to score the standards and to write the report. It is important that surveyors in an accrediting body follow the same surveying methodology and tools in sake of the accreditation’s process consistency. Survey processes involve several components:

- Opening meeting/ceremony
- Leadership conference
- Information collection
- Staff interviews
- Documents’ review (policies, plans, medical records, and credentialing files)
- Facility tours
- Observations (especially in patient care areas)
- Daily debriefing meetings
- Exit meeting or final debriefing.

The opening meeting

The opening meeting includes surveyors and senior leadership and is supposed to introduce the participants to each other making the two parties feel more confident, comfortable with each other. The surveyors will present the methodology adopted in conducting the survey, review the agenda, get to know better the leaders and get a general overview of the organizational structure and the scope of care in the healthcare organization. This meeting may also include presentations made by the staff to demonstrate their achievements and improvements in major areas of the organization’s operations. The opening meeting should be held in a conference room large enough to fit the number of surveyors and senior staff attending the meeting. The room arrangement should be attentively dealt with ahead of time, since it affects the level of communication whether formal or informal. In such an occasion, an informal atmosphere is preferred, and the meeting table should be U-shaped.
Leadership conference

In this meeting, that follows the opening meeting, key leaders are asked to meet with the surveyors to present the organization’s strategic plan and to help the surveyors emphasize the leadership involvement and commitment in quality patient care. The surveyors might ask specific questions related to leaders’ insight of performance improvement activities, use of information, oversight of existing contracts and subcontracts as well as their involvement in the accreditation process as such. Top management may also be asked about certain policies, by-laws and plans already existing at the organization and in particular those related to patient safety.

Information collection

Surveyors will verify the organization’s achievements in relation to standards’ implementation. The method used here is documentation review whereby each chapter’s leader should be well prepared to submit any documentation related to his/her responsibilities. Surveyors may require reviewing policies/procedures’ manuals, hospital plans, quality improvement plans, evidence of compliance and specific performance indicators/monitors.

The documentation review session will help the surveyors to know and inspect about the healthcare organization’s day to day activities. When they encounter a new policy/ procedure they will expect to see the evidence of circulating this new policy/procedure to the related departments and training the staff on the implementation of this new policy. Moreover, they would also seek the evidence of the policy/procedure’s sustainable implementation.

Staff interviews

Surveyors conduct interviews with members of the staff, doctors, patients, patients’ families and/or patients’ advocates as is the case with JCAHO. The Joint Commission requires the organization to inform the public of the scheduled survey and invite them to provide the surveyors with any useful information.
Sample Public Notice (An Illustrative Example):

PUBLIC NOTICE

The Joint Commission on Accreditation of Healthcare Organizations will conduct an accreditation survey of:

________________on _________________

(insert hospital name)       (insert your survey date)

The purpose of this survey will be to evaluate the organization’s compliance with nationally established Joint Commission standards. The survey results will be used to determine whether, and the conditions under which, accreditation should be awarded to the organization.

Joint Commission standards deal with organization quality and safety-of-care issues, and the safety of the environment in which care, treatment, and services are provided. Anyone believing that he or she has pertinent and valid information about such matters may request a public information interview with the Joint Commission’s field representatives at the time of the survey. Information presented at the interview will be carefully evaluated for relevance to the accreditation process. Requests for a public information review must be made in writing and should be sent to the Joint Commission no later than five working days before the survey begins. The request must also indicate the nature of the information to be provided at the interview. Such requests should be addressed to:

Division of Accreditation Operations
Office of Quality Monitoring
Joint Commission on Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Or
Fax to: 630/792-5636
Or
E-mailed to complaint@jcaho.org

The Joint Commission’s Office of Quality Monitoring will acknowledge in writing or by telephone requests received 10 days before the survey begins. An Account Representative will contact the individual requesting the public information interview prior to survey, indicating the location, date, and time of the interview and the name of the surveyor who will conduct the interview.

This notice is posted in accordance with the Joint Commission’s requirements and may not be removed before the survey is complete.

Date Posted: __________________

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**Documents’ review: sample of medical records and other types of records**

Surveyors will review samples of patient medical record (a sample methodology is usually communicated to the healthcare organization at the first opening meeting and the requested records are pulled and made available to surveyors on the second or third day of the survey for assessment, evaluating the Clinical Information Service (CIS) staff’s management of these records for use in continuing patient care and research. Surveyors will review the documentation process, writing eligibility, patient communication, medication management, charts’ signatures, timeliness of patient assessment and patient care processes.

Besides medical records, accreditation organizations require surveyors to review credentialing files of professional staff; doctors, nurses and allied health professionals. Surveyors will choose a sample of the aforementioned be surveyed using a sampling methodology that is communicated to the HCO on the first day of the survey. These files are reviewed to document the organization’s compliance with respect to its health professionals’ licensure, education, qualification, training and experience. Timeliness, accuracy and diligence are considered main issues surveyors observe and review in the verification process.

It is good to identify a staff member, knowledgeable of these documents, and make him/her available to help the surveyors in their documents review sessions. Certain documents if not written in English need to be translated according to the surveyors’ convenience and/or have a translator readily available.

**Facility tours**

The surveyors will visit different areas in the hospital after their documents review in order to compare written plans and procedures with the actual occurrences. Usually they visit different patient care areas, inpatient and outpatient areas, emergency, operating room, anesthesia, X-ray, laboratory, endoscopy unit, renal/hemo-dialysis unit, kitchen, laundry, pharmacy and general storage. They will always look at and make sure that emergency plans are effectively implemented and safety measures/exits are available. It is advantageous when a healthcare organization identifies assigned staff members that may act as “guides/escorts” for each of the surveyors during their facility tours. The appointed staff member should be knowledgeable about the accreditation standards, approachable, and helpful.

An important factor for the healthcare organization’s participants to consider is acquiring a good perception and comprehension of the surveyors’...
questions in order to respond accurately avoiding traps that might be set by surveyors. At times interpreters are needed to facilitate communication when surveyors and surveyed don’t speak the same language. Frequently asked questions are:

- How do you monitor the services at...?
- What kinds of improvements have been implemented in...?
- Who is authorized to...?
- Who is responsible for...?
- Could you show me a record of...?
- What is the evidence that...?
- What do you do in case of....?
- What is your organization’s policy on...?
- How do you demonstrate that ... policy is implemented?
- What is the mission and vision of your organization?
- What is your role in improvements?
- How do you maintain patient safety?
- Demonstrate...safety procedure/process?
- What data do you collect?
- What do you do with it? Why?

Usually surveys are conducted during the day but few include night visits to trace out what happens during night shifts and the consistency of work during night shifts.

**Observations**

During the survey, surveyors and surveyed sit together in order to exchange information, compare findings and relate information together before feedback on the organization’s achievements is given. Special meeting areas/rooms should be prepared for this purpose. In this session surveyors may start the scoring for compliance with the standards. Surveyors may ask for additional information or may inquire about a selective policy, plan or monitor. These sessions are strictly confidential but surveyors might feel the need to invite certain staff members to help identify or provide specific information.

**Daily Debriefing and Exit Meeting**

On a daily basis, surveyors will ask key leaders of the organization before starting rounds and other activities to receive a debriefing about findings/observations of the previous day. During this session, surveyors will answer any question from staff and might ask for certain documents that they think are missing. This session presents an opportunity for the surveyors to communicate findings, observations and concerns to the leaders.
and perhaps give them a chance to correct them or refute them before the final meeting.

All accrediting bodies provide a feedback session at the end of the survey. The surveyors thank the staff for their cooperation and help in making their mission accomplishable. During this meeting each surveyor and/or team leader will give a summation of the findings, recommendations and guidance for future action. Certain surveyors might or might not feel comfortable communicating their final assessment to the organization including their recommendation or not for accreditation. Either way, this session is considered very important for the organization as it is the culmination of all of the hard work and strenuous months of preparation towards accreditation.

JCAHO’s New On-Site Survey Process survey will be conducted as follows:
1) Opening conference and orientation
2) Survey planning session
3) Individual tracer activity
4) System tracer activity (such as medication management, infection control, data use)
5) Proficiency testing validation and regulatory review (laboratory only)
6) Special issue resolution
7) Daily briefing
8) Competency assessment process
9) Medical staff credentialing and privileging
10) Environment of care session
11) Life safety code building tour
12) Leadership session
13) Chief executive officer exit briefing and
14) Organization exit conference.

The focus in the new process is on “tracer methodology”. About 50% to 60% of the survey time will be spent on tracer activities, where the surveyors will focus on how actually care is being delivered, rather than on policies and documents review. They will follow the standard’s implementation as they trace selected patients throughout their hospitalization and look at processes from admission to discharge. In this way they may “trace” a patient from the place where he/she was first seen by the facility personnel, including outpatient clinic, ER, reception, admission office, etc. Then reconstruct all of the steps the patient took throughout his/her hospital stay. That may include a visit to the imaging or radiology department, a visit to the lab, the ICU or the operating theater. During each step, a number of observations/encounters may be assessed by the surveyor, e.g. if the patient was seen at the ICU, nurses participating in
his/her care might be interviewed, the process of assessment/care revised, his/her physician asked a few questions regarding the patient’s care and perhaps the physician’s credentialing and privileging file will be reviewed as well. Good organizations appreciate this method for its efficiency and practicality in showing its genuine, professional, and ethical care processes.

**Evaluation**

Following each On-Site Survey, a summary of the surveyors’ findings is completed to provide the organization with a detailed assessment of its performance against the standards and criteria. This includes the identification of areas where performance is satisfactory, others where further action is required and suggestions/recommendations for improvement are given. This is called the evaluation phase. It consists of the following:

- scoring
- report writing
- appeal process
- final decision.

**Scoring**

The scoring method differs from one accrediting body to another. But most accrediting bodies do not only use Met\not Met in scoring the organization’s compliance; rather they use a scale of 3 or 5 points to show the degree of compliance. The New Zealand Council on Health Care Standards includes grades of: Minimally, Partially, or Substantially Achieved or Non Applicable. When it comes to JCAHO’s new survey decision scoring process, each standard is evaluated either "Compliant" or "not Compliant" based on scoring of the Elements of Performance (EP). A standard will be "not Compliant" if any of the EP is scored 0 (insufficient compliance) or 35% or more of its EP are scored 1 (Partial Compliance). When problems are identified, the surveyor will issue a "Requirement for Improvement" and the organization has 45 days to submit "Evidence of Standards Compliance". The scoring method is slightly different for JCAHO’s international subsidiary, JCI. The standards are scored using three scales; Not Met, Partially Met or Met. Each standard is either a “core” standard or a “non-core” standard. Each of these standards may have one or more “measurable elements” (ME). These are specific indicators for measuring compliance with standards. A score of zero is given for MEs that are not met, a score of 5 for those that are partially met and a score of 10 for those that are met. Each core standard should be fully met. Non-core
standards have to have an aggregate score of not less than 7. Other accrediting organizations use other methods and scales e.g. certain accrediting bodies use the scale of 0, 1, or 2.

**Report writing**

Usually the first draft of the report is written the same day or within 24 hours after survey. The final draft is submitted to the accrediting body for further evaluation and editing to be then presented to the surveyed organization for review and final rebuttal.

The format of the report varies according to accrediting body; some produce negative reports that show only areas of non-compliance, others create positive reports including constructive comments on the findings and highlighting areas of non-compliance. It goes without saying that surveyed organizations would prefer the second type of reports. JCAHO will make the performance report available for both the hospital and public. A complete directory of surveyed hospital is available through Quality Check™ on JCAHO’s website ([http://www.jcaho.org](http://www.jcaho.org)). The JCAHO Accreditation Report is composed of four sections:

- "Executive Summary’
  This is a summary of the accreditation decision and the follow-up activities (if any) needed by the organization, including timelines for those follow-up activities

- "Requirements for Improvement”
  This section includes standards with which the organization is not compliant

- The "Life Safety Code® Report”
  This section appears only if issues were identified in the organization's compliance with the Life Safety Code

- "Supplemental Findings”
  This section appears at the end of the report. Supplemental findings are standards with which the organization is compliant, but contain Elements of Performance that have been scored at the partial compliance level.

**Appeal process**

With some accrediting bodies, if the Accreditation Committee recommends the organization a denied accreditation, a draft of the report will be sent to the surveyed organization for further comments. The organization may either accept the findings or submit documentation within a specified time frame that supports its compliance with standards
and the accrediting body shall reconsider its first decision. This process is called the “internal” appeal process.

An external appeal process is initiated when the surveyed organization is not satisfied with the final decision. In this case, there are two options to be taken: either choose a mutually accepted “arbiter” or use the court system to resolve the matter.

**Final decision**

Based on the information included in the final report the accrediting body committee makes the final decision to accredit the organization or not; according to this decision the certificate will be issued. The certificate indicates that the accrediting body states publicly that the institution complies with a set of standards.

The Accreditation Certificate has two main aspects, the time span that it covers (generally 3 years) and the degree of compliance. Most accrediting bodies give accreditation certificates for three years. In Australia, after successful completion of several accreditation surveys, the hospital may get a longer time span. Different accreditation levels differ according to the accrediting bodies.

In the Joint Commission the accreditation states are:

- **Accreditation is awarded:**
  To a health care organization that is in compliance with all standards at the time of the on-site survey or has successfully addressed requirements for improvement in an Evidence of Standards Compliance (ESC) within 45 days following the survey

- **Provisional Accreditation:**
  Results when a health care organization fails to address successfully all the requirements for improvement in an ESC within 45 days following the survey, or fails to achieve an appropriate level of sustained compliance as determined by a Measure of Success result

- **Conditional Accreditation:**
  Results when a health care organization is not in substantial compliance with the standards, as usually evidenced by a count of the number of standards identified as not compliant at the time of survey. The threshold count is between two and three standard deviations above the mean number of non-compliant standards for organizations in that accreditation program. The organization must remedy identified problematic areas through preparation and submission of an ESC and subsequently undergo an on-site follow-up survey

- **Preliminary Denial of Accreditation:**
  Results when there is justification to deny accreditation to the organization as usually evidenced by a count of the number of non-
compliant standards at the time of survey. The threshold count is at least three standard deviations above the mean number of standards identified as not compliant for organizations in that accreditation program. The decision is subject to appeal prior to the determination to deny accreditation; the appeal process may result in a decision other than Denial of Accreditation

- **Denial of Accreditation:**
  Results when a health care organization has been denied accreditation. All review and appeal opportunities have been exhausted

- **Preliminary Accreditation:**
  Results when the health care organization demonstrates compliance with selected standards in the first of two surveys conducted under the Early Survey Policy Option One. This decision remains in effect until one of the other official accreditation decision categories is assigned, based on a complete survey against all applicable standards approximately six months later

- **Accreditation Watch:**
  Though not an official accreditation category, can be publicly disclosed by the Joint Commission. An organization is placed on Accreditation Watch when a reviewable sentinel event has occurred and has come to the Joint Commission's attention, and a thorough and credible root cause analysis of the sentinel event and an action plan have not been completed within a specified time frame. Following determination by the Joint Commission that the organization has conducted an acceptable root cause analysis and developed an acceptable action plan, the Accreditation Watch designation is removed from the organization's accreditation status. During the period of Accreditation Watch, the organization retains its accreditation status in one of the above categories.

Additional information regarding accreditation decisions, policies and procedures can be found in all of the Joint Commission's accreditation manuals. For more information, visit the Joint Commission website.

In New Zealand, the different conditions of the accreditation decisions are:

- **Accreditation**
- **Accreditation with priority recommendations**
- **Deferral of Accreditation**
- **Nil Accreditation.**

In Hospital Accreditation Program the levels of accreditation are as follows:
Accreditation for three years
Accreditation for two years
Accreditation for one year
Focus survey (pending award)
Non Accreditation.

Surveyor Skills & Ethics of Surveying

Surveyors are representatives of the accrediting body. Surveyors carry the responsibility to represent the accrediting body in a professional manner at all times by adopting good surveying practices and abiding by the Code of Ethics and Conduct, including the following:

- respecting the rights and dignity of all personnel
- ensuring confidentiality of information obtained through the survey and accreditation process
- identifying and communicating areas of potential conflict of interest
- refraining from using their position for financial or personal gain
- refraining from either giving or receiving gifts that may be perceived as influencing their decisions.

In fulfilling their mission, surveyors should adopt communication skills that will facilitate their task completion such as:

- speaking clearly and simply
- keeping eye contact
- repeating question if the surveyed does not seem to understand the question
- using verbal and non verbal communication skills
- avoiding interrupting the surveyed personnel while answering
- keeping a smile
- avoid showing negative impressions
- having a logical mind
- being a practical problem solver
- possessing good spoken and written communication skills
- having excellent negotiating skills
- being methodical and paying attention to detail
- having good management skills
- being good at working with people at all levels.
Conclusions

Despite diversity in survey processes, improving health systems and patient safety lies at the heart of accreditation mission. In order to succeed, accrediting bodies should adopt a reliable, valid and sustainable survey process. Surveyors, who are the ambassadors of the accrediting bodies, should always reflect a positive attitude about organizations they represent.

There are continuous changes coming in today, healthcare facilities should be “survey ready” in order to cope with these changes and to sustain prosperity, improvement, and quality of care. The best way to do so is to incorporate the standards requirements into daily activities. By continuously improving hospital's processes, it can improve existing methods and correct problems before they become serious.

REFERENCES


4. Useful Tips in Preparing for the Accreditation Survey Phase

A. Yassin, MPH

Planning and preparation for the accreditation’s survey phase are essential for a victorious outcome. The survey process will include interviews with hospital leaders, senior staff members, and other healthcare professionals. Surveyors visit a variety of inpatient and ambulatory patient care units during the survey. They also visit areas where high risk patients receive care or where high risk services are provided to patients, such as operation rooms where anesthesia is administered. They evaluate emergency services, imaging, and rehabilitation units to check the delivery of care. Acquiring the right knowledge, familiarizing ourselves with the concept, grabbing the accurate tools would increasingly help us in facilitating this apparently difficult endeavor. This section will comprise thorough and extremely helpful information that might be later reencountered in the next chapter discussing the actual accreditation survey process, but “practice makes perfect”. In fact, the reader will encounter details not mentioned in the next chapter discussing the survey phase itself, the intention is to thoroughly prepare health professionals to the so far thought challenge named accreditation.

How to apply for survey? How to conduct self assessment? How to implement action plan? How to facilitate the comprehensive on-site survey? These are just a few of the questions that will next be answered.

Self-assessment

Assessment is the process by which the characteristics and needs of clients, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action. Self-assessment against the published standards develops insight and commitment. It reduces the burden of external inspection because it helps organizations to identify, understand and resolve their own problems. Many programs consider this internalization a key to the rapidly increasing compliance with standards, which happens in healthcare organizations
(HCOs) in the months leading up to an external survey. The following steps are crucial in conducting self-assessment:

- examining the current processes and conducting self assessment
- reading and developing new policies and procedures
- knowing the hospital standards and the accreditation body standards
- never limiting compliance to specific departments or disciplines since surveyors look for multidisciplinary or organization wide approaches to the standards
- making sure to read the scoring guidelines. Some accreditation bodies offer Comprehensive Accreditation Manual for Hospitals (CAMH); using the scoring guidelines to conduct a mock survey and documenting any identified areas of partial compliance and non-compliance is very informative
- reading all the information in the Accreditation Manual for the healthcare facility. These manuals include all the healthcare facility standards as well as accreditation policies and procedures
- reading all the standards and determining their relevance to the healthcare facility remembering that the HCO is responsible for items in the intent statements as well as in the standards; again, make sure to read the scoring guidelines
- good preparation for a survey is achieved in incorporating the standards requirements into the daily activities; continuously improving the healthcare facility’s processes leads to improve existing methods and correct problems before they become serious.

Management Committee

It is named accreditation preparation committee and consists of the following members: the chief executive officer, the chief operating officer (when applicable), the chairman, governing body or similar representative, an elected or appointed leader of the medical staff, the medical director (when applicable), a nurse executive, a quality improvement coordinator, and other senior leaders, at the discretion of the hospital.

Survey application

The first thing to do is to contact or call the accreditation body and ask for information. After reviewing the information on accreditation, the HCO shall request an application package for the accreditation program at least 6 months in advance of target dates for survey, complete the application, and select a target month for the survey.
Most organizations need a minimum of six months to prepare for the initial survey. If the organization has not been surveyed within the six months period, it will forfeit their survey deposit, and it should reapply before it can be surveyed. Within those six months, an organization may change the month in which it wants to have the survey scheduled, with out financial penalty as long as it has not received written or verbal notice of the scheduled survey date.

Usually the application chart helps the accreditation staff to determine the length of the survey (number of days), determine the numbers of surveyors needed, prepare a draft survey agenda, and prepare a contract for a survey. Then, the accreditation body sends the supporting material and standards document to the applicant organization after it receives the fees.

**Survey fees**

The survey fees (cost) should be sent with the application. The cost of the survey differs from one organization to another according to the number of patients served, the number of offices and sites to be visited, their distances from the main site included in the survey, and the surveyors' expenses.

Some programs (e.g. UK and South Africa, COHSASA) consider and price “facilitation” as an integral part of the accreditation process, thus considering it inclusive. Others make a point of differentiating between consultancy (including general education and development) and training, which is specific to the accreditation standards and assessment process. Some programs also include all documentation and direct survey costs (e.g. surveyor travel and accommodation) into a single-price package per survey. Others aim to smooth the cyclical costs by running a subscription program. In 2000, the Australian ACHS charged $3400 for annual program membership. In Canada, a small organization with a budget of less than $3 million would pay an annual fee of $685 plus a survey fee, based on $1500 per surveyor day. In New Zealand there is no separate charge for surveys, but an annual subscription of $3200 is charged which includes education, guidance, standards, tools, survey and mid-term progress visits.

**Survey Agenda**

The survey team leader of the accreditation body will contact the organization staff in order to develop the agenda and to work out the details to ensure that staff is available and the schedule is comfortable for all the participants. An assistant should be provided during agenda development to ensure that unit visits in the same building or in close proximity are
scheduled within the same day when possible to prevent frequent moving from one building to another during the day in order to save time. Once the survey agenda is final, the HCO will list professional staff members who will participate in each activity of the survey process by name and title.

**Staff training and education**

The staff should be informed about the intent to become accredited. The accreditation should be made the organization’s priority. The following advices pertaining to the HCO’s staff would help a lot in making this delicate phase of the organization’s history a smooth one:

- providing them with clear expectations about their responsibilities in preparing for the survey
- giving them realistic time frames
- helping them prepare for survey and self assessment and assist them with quality improvement projects. The surveyors will interview staff members to see how well they understand the process
- meeting with the staff to review expectations and relive anxiety is essential immediately before the survey. Reviewing what will happen during the survey will help boost staff confidence and help people relax
- reading some of the many publications and other resources on hospital standards and related topics
- networking with colleagues from hospitals that have recently gone through the accreditation process
- attending professional associations meetings or call the counterpart in other organizations
- upon request, some accreditation organizations provide, on a cost – recovery basis, educational support to the organization on how to prepare for accreditation
- contacting the accreditation organization for any question related to standards
- ensuring that staff understands how to comply with the standards
- developing programs to educate staff about new systems
- conducting staff training to ensure that they understand how to comply with the standards
- developing information and educational programs to educate staff about new systems. These programs should take into consideration:
  1) Client requirements and course feedback
  2) Topical matters of direct relevance to quality and Accreditation or certification
3) Issues relating to the external evaluation standards and the external evaluation program and its processes

- setting a realistic time frame such as 18-24 months
- education for organizational leaders and managers (massive intensive awareness)
- introduction to accreditation philosophy and approach
- considering accreditation as quality improvement and risk reduction strategy
- reviewing the standards and measurable elements
- discussing the survey process and what to expect
- project planning and next steps
- conducting a detailed baseline assessment of the organization’s current adherence to the standards and each measurable element using knowledgeable and credible evaluators (either internal or external consultants) who will critically and objectively assess each area
- scoring as Met, Partially Met, or Not Met and citing specific findings and recommendations
- priority focus on the core standards in bold
- including all areas of the organization in the assessment
- collecting and analyzing baseline quality data as required by the quality monitoring standards
- establishing an ongoing monitoring system for data collection (e.g. monthly, with quarterly data analysis) to identify problem areas and track progress in improvement.

**Inspection tour**

Prior to the survey, facility managers and organization leaders need to do the following:

- Read the standards carefully
- Tour the facility
- Conduct an inspection according to the standards
- Address any deficiencies prior to survey
- Start the tour at the front door; looking everywhere, up, down, inside, outside, on top, and underneath
- Be ruthless in your observations
- Be aware of relevant laws, regulations and facility inspections and be able to share this information with the surveyors
- Representatives of the organization should be prepared to show the surveyors how their facility management plans are being implemented
- Prior to survey, the organization should check that all medical equipment has current inspections, testing and maintenance and that this is documented
Representatives of the organization should be prepared to explain or demonstrate how potable water and electrical are available 24 hours a day.

Sample outline of a facility inspection report

The building(s) included in the report:
- The patient care activities that take place in each building
- Any local codes, laws, or classifications for the buildings based on the activities
- The approximate age of each building

The building by building results of the inspection:
- Any general condition of the building that relate to local codes, and regulations
- Specific findings related to law, regulation, codes, and accreditation standards

The plan to correct the findings:
- Timetable
- Estimated budget (short range and longer range, if appropriate)
- The plan for monitoring the facility improvement process and for the continuing monitoring and improvement of the facility
- Safety concerns are prevented or eliminated through an ongoing planning and inspection process.

Worth noting is that the facility inspection report can be in any format that makes it an effective, practical management tool for the organization. The inspection can be conducted by knowledgeable HCO staff or by outside consultants. The report should be as complete as possible to demonstrate that the hospital is aware of all conditions in its buildings, and has plans to improve the safety of its buildings.

Mock surveys

It’s called some times consultative survey or advisory survey. A mock survey examines and scores compliance with the accreditation standards and results in a preliminary verbal report followed by a written report with recommendations. Depending on the number of locations and size of the organization, this usually requires 2-4 days on-site. On the last day areas that need work are identified and specific recommendations are made.
HCOs should conduct one or two mock surveys by using the actual standards as a baseline assessment of their survey readiness at least 4-6 months in advance of the target date of the actual accreditation survey.

Some organizations hire consultants (internal or external) who were not involved in the baseline assessment and preparation, who will look at the organization with a fresh and objective eye, to conduct mock surveys when the organization’s leaders don’t have time or expertise to do it themselves.

Regular mock surveys throughout the accreditation cycle help HCOs judge their effort at continuously improving performance and help fix problems before surveyors arrive. The scoring guidelines of the future accreditation process should be used in conducting a mock survey. Documentation of any area of partial compliance and non-compliance that is identified is important. Planning for drafting a final revision follows reviewing the results of the mock survey with the staff. This latter is drafted after the conduction of the final mock survey hoping to reach corrective actions and states based on the findings of the previous mock survey. After that, a preparation by the HCO members for an action plan comes into light.

**Action Plan**

Using the findings of the baseline assessment, HCOs must develop a detailed project plan, with assigned responsibilities, deliverables, and time frames. The following sequential steps can guide building the action plan:

- Start first with the priority areas of the core standards
- Develop an action plan to correct the problems found or to exploit areas of standards non-compliance
- Set priorities for improvement specially issues related to process rather than documentation
- Allocate resources that the organization can afford
- Assign responsibilities for implementation
- Take measures to improve areas that are not currently in compliance
- Establish a realistic schedule/time frame for improvements and implementation
- Implement the action plan
- Educate staff on new policies and procedures
- Do not forget to celebrate your accomplishment along the way.

Performance indicators

Clinical and organizational indicators are also collected as part of the assessment process, either during or between survey visits. They may be submitted directly by the facility being assessed, or alternatively, can be calculated independently by a third party. Their main purpose is to demonstrate that the organization has the capacity to generate and analyze performance data as part of an internal quality-improvement program.

The Canadian Council on Health Services Accreditation (CCHSA) has a threefold concern regarding indicators:

1. There is an increasing burden being placed on health care organizations to collect indicator data at a time when resources are extremely restricted.

2. Lack of clear definition of indicators makes it difficult to determine when and how indicators are to be used and this result in inconsistent and inappropriate use of indicator data.

3. The value of indicator data is often questioned especially as it relates to direct care delivery and management at the health care organization level. But if the data are complete, accurate and timely, and are standardized across facilities, they can also provide measures for comparing achievement between facilities in such areas as clinical process and outcome. Programs must decide how much weight, if any, such indicators should contribute to the assessment process, and to subsequent accreditation decisions.

Team approach

Preparation for the accreditation survey should involve all the health professionals. The latter should adopt the philosophy of delivering quality services; moreover, team interplay and a multidisciplinary approach are indispensable. Resources should be allocated, including facility enhancement, training, recruiting of new staff, and redesigning the system. The HCO shall assign the oversight of each chapter of standards to a respected champion /leader who will identify team members from throughout the hospital. It happens that the assigned champion/leader is someone who has been skeptical about the process. The champion leader should have good interpersonal skills, time management skills, and consensus building skills. It is good to know that as some champions emerge, old ones leaders drop out. It is a cyclical process.
Policies and Procedures

It is helpful to compile a list of all required policies and procedures that will need further development and revision. It will take sometime to get the before mentioned revised or developed, have them undergo an organizational review, and obtain the final approval for their implementation. It is certain that a policy reflects the facility’s actual practice, and this is what the surveyors will evaluate the organization against.

Midpoint strategies

It is very important to continue monitoring the progress in meeting the standards, such as a mini evaluation of each chapter at regular intervals (e.g. quarterly). Adjusting the project plan to make it more realistic is not an issue to be worried about; changes take always more time than expected. As many staff as possible should be involved in the process. It should be made as an organizational goal that everyone wishes to achieve.

External Facilitator

Many programs provide facilitators, such as program staff or trained surveyors; this support acknowledges that the early external assessments are as much a test of the standards, surveyors and procedures, as they are of the institution being visited. The facilitators should not be permitted to take part in, or influence the external survey. Training and educational support are provided by some, but not all, programs as an integral part of the preparatory process. This may include, for example, project manager training, standards interpretation, and internal assessment. The assistance of an independent facilitator to prepare for the external quality assessment can be extremely valuable:

- To help prepare institutions for their initial entry to the program
- To feed back the program with a notice of any systematic problems that arise
- Familiarize the organization with standards for accreditation
- To enable staff to appreciate how their organization functions
A facilitator cooperates with the organization to interpret the standards, explain the process providing advice and guidance on policies, protocols and procedures development. The organization receives feedback on the improvements needed to achieve accreditation.

In Zambia and South Africa, “educational surveys” and “facilitated accreditation” were adopted to encourage and support hospitals embarking on the long road to achieving accreditation. “After surveyors were trained, Zambia performed 20 educational surveys in 1998. Educational surveys are essentially accreditation surveys, except that no accreditation decision is made”. Also, in three different countries (in Australia, New Zealand and South Africa) more than 75% of the preparation for institutional accreditation is done by independent consultants whose exact costs are hard to identify, but are definitely considered a high burden by the acridities.

**Public Information Interview**

Some accreditation bodies require the healthcare facility to notify the public about the accreditation survey to provide an opportunity for the presentation of information by consumers and the public, as well as by personnel and staff of the organization undergoing survey. Anyone who has information about an organization's compliance or non-compliance with the accreditation standards may request a Public Information Interview.

Thus, the organization is required to post in public places on their premises the official announcement of the date of the survey and of the opportunity for a public information interview. Public notices must be posted 30 days before the survey date. Notices must indicate that requests for a public information interview are to be made in writing and that the accreditation organization must receive them at least five working days before an organization’s accreditation survey begins (an illustrative example is included in the next chapter). Notices must remain posted until the completion of the survey and include the dates of the scheduled survey. Furthermore, if anyone asks about the survey, the accreditation body expects the organization to inform the inquirer of the survey dates and of the possibility for scheduling a public information interview. The organization should promptly send any request it receives for a public information interview to its Account Representative and retain a copy for itself.

Notices usually should be posted in public eating areas, on bulletin boards near entrances, in care areas, treatment areas, or service areas. When such postings are not likely to bring the survey and public information interview to the attention of all staff, the organization must provide each staff person a written announcement via electronic mails for example.
Survey process (on-site visit)

The On-Site visit comes next. The healthcare organization must be in compliance with the standards for at least four months prior to the initial survey. In case of resurveys, most accreditation organizations require a 12-month "track record" of standards implementation. However, they expect the facility to be in compliance with applicable standards during the entire period of accreditation, so surveyors will look for a full three years of standards’ implementation and performance improvement activities.

In case of an initial survey, a healthcare organization should allow a 9-12 months period of preparation before deciding on the survey date. Sufficient time ought to be given to review the standards carefully, conduct an organizational self-assessment, and take corrective measures to improve where needed, develop new policies or procedures, and conduct staff training.

Every effort should be made targeting an efficient use of the facility and professional staff’s time. The organization’s management should not cease seeking the effort to provide necessary information to the surveyors enabling them to understand its unique characteristics. The survey team will be on site for a varying number of days depending on the organization size in terms of total bed numbers and services provided.

Opening conference

The survey begins with an opening conference in the morning of the first day. During this conference, the surveyors and key staff members introduce themselves, review and make any last minute changes to confirm the tentative survey agenda. The chief executive officer will determine the staff members that shall attend the opening conference, which is generally limited to 30 minutes. HCO participants include but are not limited to the chief executive officer, an individual responsible for coordinating the HCO’s survey agenda, other health professionals at the discretion of the organization, the needed documents/materials, and the final survey agenda.

The organization needs to set up a meeting or conference room large enough for the surveyors to meet with the key hospital leaders and survey coordinators, notify hospital receptionist so they can direct the surveyors to the room when they arrive, have copies of the survey agenda available for all participants in the opening conference, arrange for the surveyors to be served or purchase lunch, and notify hospital staff of the survey agenda. Prior to the survey, decide which leader or staff member will accompany each surveyor throughout the survey day. Each surveyor will wear a badge that will identify him or her as a surveyor, so prepare and make the needed amount of badges available in the opening conference.
Document review

The document review prepares the surveyor for the interactive part of the survey. During the review, the surveyors will evaluate standards that require written evidence of compliance such as the patient rights sheet. The importance of these documents is to orient the survey team to the organizational and management structure of the healthcare facility. The surveyor does not score compliance until he/she has examined the critical access facility's performance during later survey activities.

The facility’s participants should include staff members that are familiar with documents, can translate them, and respond to questions that the surveyors may have during the session. At the judgment of the team, surveyors may designate a limited number of staff members to attend and participate in the document review session. The session may be conducted as an interview between surveyors and staff about the documents. This approach has been very effective when language barriers exist and the survey activities necessitate the use of professional interpreters.

The documents/materials needed are those that surveyors will use to orient themselves to the way the critical access HCO functions. These documents focus on the critical access facility's performance and include committee minutes, reports of performance measurements and assessment activities, reports on medical staff’s appraisals, listing of the various HCO committees, the governing body, bylaws, planning documents, and other evidences of performance.

In order to prepare for the document review, the documents should be available to the survey team in the meeting room that has been designated for their use throughout the duration of the survey. At the beginning of the session, one staff person should briefly orient the survey team to the organization of the documents. During the remainder of the session, there should be a staff member readily available, in person or by telephone that can respond to any question the surveyors may have during this session. The material should remain available for the survey team throughout the survey for reference purposes. However, if documents are requested for use by organization staff, they can, of course, be removed. Surveyors may schedule a second document review session during the course of the survey. The review generally is scheduled for HCOs that have a survey of longer than three days, and may be scheduled on surveys of a shorter duration, based on need. The survey team may also request additional documents throughout the survey to become better informed about the organization’s policies and procedures or its performance. Hospital staff should be as proactive as possible in complying with the surveyors’ requests for documents.
If the HCO is using computer-based information, each member of the survey team should be provided with a monitor. A printer should be available in case a member of the survey team wishes to print a paper copy of a given document. Printed copies of bylaws and longer documents that may require extensive reading or scanning by surveyors should be available.

**Leadership interview**

The leadership interview session with all of the surveyors is meant to assess communication among senior leaders of the organization and how they address organizational performance issues. The surveyor will want to see how the senior leaders work together to plan, design, implement, and improve patient care services. The organization participants are the chief executive officer, the chief operating officer (when applicable), the chairman, governing body or similar representatives, an elected or appointed leader of the medical staff, the medical director (when applicable), a nurse executive, a quality improvement coordinator, and other senior leaders, as convened by the hospital.

No documents are needed in the leadership interview, however, during the document review session; the surveyors may have reviewed the following documents in preparation for the leadership interview:

- the organizational chart
- the mission statement
- budget and resource allocation documents
- strategic planning documents
- the information management plan
- the quality management plan
- a worksheet of applicable laws and regulations.

Preparing for the leadership interview consists of identifying the right participants in the interview; the leaders should be familiar with all of the standards. Conducting mock interviews with the participants would make them more comfortable with questions that might be raised.

**Facility tours**

Facility tours are usually conducted to address issues related to the physical facility, medical and other equipment, patient and visitor safety, and infection control.

Surveyors will visit patient care areas, such as, inpatient and ambulatory units, and treatment areas. Other non-patient areas include kitchen, heating and air conditioning rooms, central storage, laundry and power plant (if applicable). The facility’s participants are a chief engineer, a
safety officer and/or facility manager, and directors from the admission office, pharmacy, and dietary units.

During this tour, the facility management and safety (FMS) standards, the prevention and control of infections (PCI) standards, and the staff qualifications and education (SQE) standards are addressed. A facility inspection report and documents that describe the plans for ensuring an environment of safety and security, hazardous waste treatment, fire safety, medical equipment maintenance and utility systems should be prepared.

The organization shall prepare for this facility tour by equipping itself with the following items that must be available for the surveyors: a flashlight, a master key, and a ladder (to look above ceiling tiles). One person shall serve as a guide during the survey process. Gather all the policies, procedures, plans into a workroom for the surveyors. The organization inspection report should be available for the surveyors.

**Anesthesia visit**

The safe and efficient delivery of anesthesia to patients undergoing operative procedure is a vital component of the successful running of the operating room. Elsewhere in the organization, staff from this department may be called upon to provide services such as cardiopulmonary resuscitation or insertion of difficult intravenous lines. Internationally, anesthetists play a major role in special care units. The management of anesthetic services requires a nominated departmental head that is responsible for day to day running of the service.

The purpose of this visit is to observe the areas where anesthesia and sedation are provided and/or operative and other invasive procedures performed and to assess the process of care in those areas. This visit is located at the operating room, endoscopy, bronchoscopy, interventional radiology, and dental units. Participants in this visit include physicians and nurse managers of the anesthetizing and sedation locations. Care of Patients (COP), Assessment of Patients (AOP), and Facility Management and Safety (FMS) standards will be addressed. Clinical records of patients in the anesthesia and sedation locations at the time of the visit will be used.

Make sure the staff in the anesthesia and sedation location is knowledgeable about applicable standards. Prepare the staff by conducting mock interviews based on the standards. Carefully observe the area to look for other standards compliance issues that the surveyor is likely to notice on the tour. These include patient rights, fire safety, infection control, and patient education standards related issues.
Inpatient unit survey visit

The purpose of this visit is to evaluate the process of care for patients in different facility units. The HCO participants include clinical managers and others engaged in providing patient care in a specific unit/setting. The medical records of inpatients will be requested by surveyors. Managers and directors of each unit should be familiar with all applicable standards. Managers should evaluate the facility and equipment as well as the patient care practices applied by staff before the surveyors’ visits to the respective premises. Any necessary change should be made before the survey. Staff should be educated about care practices dictated by the standards. It is always helpful to conduct mock interviews to prepare the staff what to expect pertaining to the surveyors’ visit to the units. Since surveyors will review patient’s medical records, current documentation practices should be reviewed and compared with their respective policies and procedures. All the staff should be educated to abide by these standards and approved policies and procedures.

Infection control interview

The purpose of the infection control interview is to assess the processes used to develop the infection control and surveillance program, reduce nosocomial infections, ensure that infection control personnel are qualified, and improve performance in this area. Personnel working in the infection control program, and staff involved in implementing the infection control program will participate in this interview.

Minutes of any infection control committee, surveillance reports, quality improvement reports, and records of biological testing should be available. Preparation to this interview consists by familiarizing the involved staff with the applicable standards, and gearing up the staff to explain the components of the infection control program in the organization. Conducting mock interviews with staff members is once more very helpful.

Ambulatory patient clinic visit

The purpose of this visit is to evaluate the processes for patients care in ambulatory or outpatient settings. Clinical managers and others engaged in providing care in the outpatient settings will participate in this visit. Again, a good preparation consists of getting familiar with all the applicable standards. Managers should closely evaluate the facility and equipment as well as patient care practices used by the staff. Again, all necessary changes should be made before the survey. Staff should be educated in care practices
required by the standards. Staff ought to be informed about the date and time of the surveyors’ visit. It is helpful to conduct mock interviews with the staff to make them feel more comfortable with different types of questions surveyors may ask. Since surveyors will review patient medical records, current documentation should be closely reviewed and compared to the standards. All staff should be educated to carefully follow these standards and approved hospital policies and procedures.

**Pharmacy visit**

The hospital pharmacy fulfills multiple roles including the ordering, storage and dispensing of drugs. It should also monitor drug utilization and be extensively involved in the education of clinical staff regarding the appropriate use of pharmaceuticals. The pharmacy must fulfill legal requirements such as the monitoring and accounting of drugs which cause dependence or addiction. The purpose of the pharmacy visit is to assess the function of the pharmacy and the relationship of the pharmacy to any medication storage, and preparation areas within the organization, the preparation process for medications, including chemotherapeutic agents and intravenous and enteral nutrition, if applicable, and the access to formulary/drug list information.

The director/chief of the pharmacy and any other staff directly involved in the management of the pharmacy or in the functions taking place within the pharmacy participate in the visit. Surveyors will use pharmacy records and logs. The preparation consists of the same principles mentioned before, that is, getting familiar with the applicable standards, educating staff about the standards and the survey process, observing the facility for fire and hazardous material safety, reviewing records for compliance with standards and organization policy, reviewing and observing medication preparation and dispensing processes.

**Emergency service visit**

The purpose of this visit is to assess the activities of the emergency unit/department. The director of the emergency room and a nurse manager of the emergency department take part during the visit. Quality reports for emergency department unit will be made available. It is essential for the staff to familiarize with applicable standards, educate them about the standards and the survey process, and observe the department for fire and patient safety, review patient clinical records for compliance with standards and organizational policy, review the organizational policy on the referral and transfer of patients, and review and observe medication use and availability.
Pathology and clinical laboratory services visit

The purpose of this visit is to assess the activities of the pathology and clinical laboratory departments. Participating in this visit are the medical director and the pathology and laboratory services director. Needed documents are quality reports related to equipment, reports related to usage of blood products, policies and procedures related to blood usage, anatomical pathology and laboratory services, and in case of outsourcing services, the agreements related to contract services. The same rule applies for the preparation: be familiar with applicable standards, educate the staff about the standards and survey process, and review facility for fire safety.

Patient care interview

The purpose of the patient care interview is to address selected issues related to the provision of patient care in the organization and to address any unresolved issues identified during other survey activities such as the patient unit/setting visits. Staff from each of the specialties/disciplines within the organization who provide direct patient care, including, as appropriate: anesthesiology and surgery representatives, nutrition care services representatives, discharge planning representatives, and representatives of ethics function might also participate. All involved personnel must be prepared to answer questions about patient care, familiarized with all applicable standards, specifically Access and Continuity of Care (ACC), Patients and Family Rights, Care of Patients (COP), and Patient and Family Education (PFE) standards.

Rehabilitation services visit

The purpose of this visit is to assess those standards in rehabilitation patients’ care. In organizations not having rehabilitation units, another unit visit will be substituted. The participants are the leaders and managers of rehabilitation services in the organization, the leaders of closely related services such as social work services, recreational/occupational therapy, members of the nursing staff that work in rehabilitation services or other related services, plus staff selected by the organization. Quality reports for rehabilitation services will be used during this visit. Be familiar with the applicable standards, educate staff about the standards and the survey process, observe facility for fire and patient safety, review patient clinical records for compliance with standards and organizational policy, review
organizational policy on referral and transfer of patients, plus review and observe medication use and availability when relevant.

**Management of information/patient records interview**

The purpose of this interview is to evaluate the hospital’s ability to meet the information needs of clinicians and managers in the organization. HCO participants are staff involved in the information management department, staff in the medical records department, physicians’ and nurses’ representatives involved medical records’ review, the director of information technology (when applicable).

For this visit, information management plans, policies and procedures in relation to medical records’ equipment and storage, and patients’ records review will be used. The surveyors will request a sample of medical records. This sample will be based on the span of services offered by the hospital. The interview may be conducted in one large group or may, at the discretion of the surveyors, be separated into two interviews; one related to the patient record, and one related to the management of information in the organization.

**Imaging/radiology services visit**

The purpose of this visit is to assess the activities of the imaging services/department. Hospital participants are the director of radiology department, the chief radiologist/technologist, the administrative director of radiology services (when applicable), a physicist (if applicable), and nuclear medicine representatives (if applicable). Needed documents are quality control reports related to the department’s equipment; and agreements for contract services, if applicable. As known by now, the preparation consists of becoming familiar with the applicable standards, educating staff on the standards and survey process, observing the facility for fire and patients safety, and reviewing patient clinical records for compliance with standards and organization policy.

**Staff qualification and education**

The purpose of this interview is to address the organization’s processes to recruit, orient, educate and evaluate its entire staff. In addition, the interview addresses the facility’s methods applied in evaluating the credentials (credentialing) of medical staff, nursing staff, and other health professionals and measuring their ability to provide clinical services in a
way that is consistent with their qualifications. Organization participants are divided into three categories:

**Medical staff:**
- Elected or appointed senior leader of the medical staff and/or medical director (if applicable)
- Representatives of the medical staff involved in credentialing

**Nursing staff:**
- Chief nurse
- Other representatives of the nursing staff involved in the orientation, education and training of nursing staff

**Other health professionals and hospital staff:**
- Manager of the human resources department
- Representative(s) of group(s) involved in the orientation, education and training of health professional staff.

The organization should enlist all current administrative and medical staff in the document review session of the first day. The list should identify the specific employee’s discipline, hire date, and department or service assigned (for example: registered nurse; hired July 12, 2003; intensive care unit). These documents should be in English, when possible. The organization can use the Competence Assessment Process Review Form to review all personnel and credentialing files. The needed materials consist of all the policies and procedures related to human resources management, and staff credentialing.

**Quality improvement and patient safety interview**

The purpose of the quality improvement and patient safety interview is to review the organization’s quality management plans and current quality improvement activities, provide feedback on those quality management and improvement activities observed during the unit visit and interviews, plus provide education and technical assistance on the establishment of a coordinated program for managing quality and patient safety in the facility. The HCO participants consist of the chief executive officer, the chief operating officer, if applicable, the medical staff leadership, the nursing leadership, staff responsible for quality management and patient safety program, if applicable, and others at the discretion of the hospital’s leaders. A review of documents related to the quality activities of the HCO is needed. In the preparation phase become familiar with the applicable standards, educate staff on the organization’s approach to quality
improvement and patient safety, practice answering mock questions related to quality improvement and patient safety.

**Leadership exit conference**

The purpose of this conference is to report the findings of the survey to HCO leadership and to resolve any red flagged issues. The participants are the chief executive officer; the chief operating officer; the chairman, governing body, or similar representative; the medical staff leadership; the nursing leadership, and others at the discretion of the organization’s leaders. Participants should carefully listen to the feedback provided by the surveyors and learn from this.

**Objectivity and confidentiality**

In order to protect the objectivity of the process, all accrediting programs have to ensure that the written observations of individual surveyors remain confidential until the final assessment and report are completed and verified internally by the accrediting body. Many accreditation programs provide a draft report to the HCO, for confirmation, before the accreditation committee for a decision on the status to be awarded reviews it. Surveyors are expected to save their original notes until the process is completed, in case a dispute occurs or need for further clarification is requested by the surveyed.

**During the survey**

In surveys lasting more than one day, surveyors will present a summary for the organization leadership about the activities and relative findings on a daily basis. Surveyors might give their comments on some positive findings or on issues found problematic as long as compliance with the agreed upon standards is concerned. The organization will also have the opportunity to provide any relevant information that it missed giving the previous day but could be helpful for the final outcome. There will be no daily briefing on the last scheduled day of survey.

**Post survey process**

The healthcare organization will receive a report from the surveyor(s) at the completion of the on-site survey. In this report, any standards that are Not Compliant are identified in the Requirements for Improvement section
and sorted by Priority Focus Area. All the organizations have the right to appeal on the accreditation decision. Organizations should submit grounds and Evidence of Standards Compliance (ESC) to the accreditation organization after the completion of the survey within specified number of days depending on the accreditation organization. Elements of Performance are the specific measurable requirements of a standard that are surveyed and scored to determine overall compliance with the standard. These are the performance expectations that must be met in order to qualify an organization for accreditation. All “Not Compliant” standards and Accreditation Participation Requirements require follow-up from the organization. The accreditation organization will evaluate the ability of the accredited organization to appropriately anticipate and respond to the changing needs and health status of the population it serves. After the ESC and Measures of Success (MOS) are approved by the health organization to the accreditation organization, the organization will move into the accredited decision status. The organization submits MOS data at the end of four months to show that it has maintained compliance over time with the standards. Always keep in mind to celebrate the success, work on areas for improvement and submit a follow up progress report to the accreditation organization, grab the opportunity to maintain a momentum from the survey – establish an ongoing system of standards compliance and survey readiness.

**Challenges to get accreditation**

The following issues are considered to be challenges (obstacles) in the road to accreditation. Listing the circumstances that prohibit its occurrence follows each issue. In other words, the organization should eliminate these circumstances to make its happening possible.

**Clarity of purpose:** It is the failure to find a balance between the objectives of improvement (internal organizational development) and regulation (external control) within an overall policy for quality in the health care system. To resolve this problem the organization must define the values and objectives which initially prompted consideration of a new program, describe how these relate to plans for health reform in general, and to the national quality strategy in particular, and if there is no national quality strategy, start with the experience of others.

**Appropriate technology:** It is the failure to differentiate the methods of accreditation, licensing and regulation, and to match them to the defined objectives. Solve this issue by mapping the scope of existing mechanisms for external quality assessment, to identify gaps and overlaps, considering a
range of options for integrating, extending or supplementing these mechanisms (e.g. licensing, certification, accreditation) and assessing their suitability in the national context.

**Quality culture:** It is the failure to identify stakeholders, and involve them in the design and direction of the accreditation program, the unwillingness to share information, authority and responsibility. Treat the problem by defining the principal stakeholders who would use, or help to provide, an accreditation program e.g. patients, professions, insurers. Involve them in early discussion, demonstrating transparency; make policies and proposals freely accessible, assessing the capacity of prevailing attitudes among the public, professions, providers and politicians, to adapt to independent assessment of the performance of health care organizations, defining and encouraging voluntary self-regulation and public accountability. Do not underestimate the importance of a willing environment, or the time needed to develop it.

**Motivation:** Reliance on directives and sanctions, rather than internal organizational commitment to self-improvement, preferential funding and recognition of professional development, perverse incentives for superficial compliance with standards, unwillingness of employers to release staff to become accreditation surveyors, and unwillingness of these surveyors to work without additional pay are all indicators for lack of motivation. To settle these issues create rewards for organizations which gain voluntary accreditation, e.g. eligibility for training status, preferential reimbursement by health insurance, public recognition, and exemption from statutory inspection, design the program to be an external catalyst for internal change, encourage employers to second staff for training and work as voluntary peer group surveyors, promoting it as part of their personal professional development, and keep coercion and sanctions as a last resort.

**Independence:** Any government domination of program direction, leading to conflict of interest in assessment of public services, de-motivation of other stakeholders, and vulnerability to short-term political change, failure to authorize and support, by legislation if necessary, an independent governing body. The organization should keep the accreditation agency far enough from government to be credibly independent, establish a governing body which is representative of the principal stakeholders, but is dominated by none of them, provide enabling legislation, if necessary, to authorize the functions of the agency.

**Scope of responsibility:** Do not expect that the accreditation program will resolve issues for which it was not designed or resourced, e.g. facilities
licensing, professional registration, health care financing. Try not to fail in identifying priority concerns, e.g. patient safety, clinical performance, and priority sectors e.g. primary care, hospitals, and the continuity between them. Always define and prioritize the agency’s terms of reference in relation to the overall strategy for quality. Aim for a single national agency for all institutions, both public and private, and start with core standards and accreditation for single institutions, e.g. acute hospitals, polyclinics, health centers. Then aim for more specialized services, e.g. long-term care, mental health, followed by the linkages between them, e.g. preventive health, health networks.

**Clear relationships:** Avoid not having mechanisms to cooperate and communicate with related professional, academic, independent and governmental bodies, e.g. professional and teaching institutions, health insurers, ISO certification bodies and local government inspectorates. Rather than that, define the related organizations with which the agency should work, on what issues it should work, and how. Moreover, define the procedures for exchange of information between organizations (public and private), consistent with rules for data protection and for public information.

**Objectivity and probity:** Avoid any failure to comply with defined and transparent procedures for the assessment of facilities and decisions on accreditation awards, and any failure to separate independent functions of facilitation, assessment, awards and payments - leading to bias, lack of credibility and possible corruption. On the contrary, design and publish procedures for the contracting, facilitation, assessment, reporting and accreditation decisions. These procedures should promote confidence and avoid improper influence by any individuals or factions.

**Sustainable resource:** Avoid the pitfall of underestimating or under-funding of the time, personnel and skills needed to establish a new program. Do not set unrealistic expectations of the rate of uptake by health facilities and the capacity of the program to generate income from them. Avoid the lack of long-term government commitment to the program. Try to make projections of human and financial resources, based on realistic assumptions of the volume and scope of activities during the development phase, and on the rate of uptake and cost-sharing in the operational phase. Expect full core funding to be needed for 3-5 years before tapering towards funding from income generation (if any).

**External technical assistance:** Do not fail to learn from accreditation experience in other countries, which is available from publications, from technical consultancy and from the ALPHA program of the International
Society for Quality in Healthcare (ISQua). It is recommended to download the ALPHA principles and standards from www.isqua.org as a template for program policy, design and operation. Also try to identify agencies in other countries which are prepared to share their experience of accreditation in situations similar to yours.

How to reduce tension arising from time pressure in a survey?

Frequently, both surveyors and surveyed reported feeling that survey’s allocated time was too short to allow visits to every unit, and the chance to talk to all the staff and clients, to read all the relevant documents, and to gain an appreciation of every facet of operations. The tension arising from time pressure in surveys can be reduced by:

- thorough internal preparation
- complete and accurate self-assessments
- timely submission of pre-survey documents
- explicit sampling procedures
- efficient survey programming and time-management
- making available of specified documents for review on site.

N.B. Increasing the number of surveyor-days may not help, and will certainly increase the complexity and cost of the survey.

Strategies that have worked

Physicians’ commitment to the accreditation process is very important. Physicians must see accreditation standards as a framework by which organizational processes will be improved, and care will ultimately be of higher quality and safer for their patients. Always reassure physicians that accreditation is not intended to tell them how to practice medicine.

Learn from what others have done well and adapt the experience to the needs of the organization and ask the accreditation organization for assistance and clarification with standards interpretation—don’t waste time going down the wrong path. Do not forget to take advantage of resources that are available on the web, and download it to benefit the organization.

Pitfalls to avoid

Top leaders give “lip service” to the process, but can be totally unrealistic in what it will take to achieve it in terms of time and resources. As a result, the staff end up feeling that accreditation is extra work for which they are not rewarded or recognized.
Over-eager managers use standards as a stick rather as a carrot, can make the entire accreditation process feel punitive and inspecting rather than motivating.

**Future recommendations**

The Canadian Council on Healthcare Services Accreditation (CCHSA) offers recommendations for future trends to adopt in preparing for accreditation. The recommendations are based on direct survey finding from previous accreditation survey data and from general observations derived from their direct involvement with health care organizations:

- It is recommended that quality improvement efforts must be strengthened and endorsed. It is believed that quality improvement must continue to be developed since it is a major contributor to being able to sustain quality in the health care system.
- It is recommended that the development and use of indicators, both for clinical and non-clinical activities related to health care, be emphasized in order for quality improvement efforts to be of maximum benefit. To better facilitate development of indicators, it is further recommended that a process be put in place to:
  a. identify a core set of indicators and ensure the quality and integrity of the data
  b. acknowledge that different indicators are needed for different situations
  c. streamline indicators
- It is recommended that human resource planning be strengthened and coordinated on a national basis and at the health care organization level.
- It is recommended that clinical practice guidelines be better used. It has been observed that multiple clinical practice guidelines of the various professionals are not being brought together to form unified care plans for individual patients/clients/residents. It is recommended to encourage governing authorities and management of health care organizations to focus more attention on the integration of clinical practice guidelines within their organizations. Also encourage professional and licensing bodies to promote the value of integrating individual clinical practice guidelines into useful care plans for patients/clients/residents.
- It is recommended that ways to involve patients/clients/residents in their care be pursued and that the area of informed consent be targeted specifically.
It is recommended that there be improved documentation in the health care record.

It is recommended that a comprehensive plan for health information systems be developed and implemented to support clinical care and health services administration.

It is recommended that processes for dealing with ethical issues and their resolution be urgently developed.

It is recommended that immediate attention be given to the need for strong leadership within health care organizations, both at governance and management levels.

It is recommended that a national quality agenda for health care be developed.

Conclusions

This section has presented an overview of the most important part in the accreditation program, which is the accreditation preparation. All the common areas of the organization that will be visited by the surveyors were listed. Preparing for survey can be a challenging time. The organization will need to become acquainted with the standards and applicable elements of performance. The current processes should be examined, and then improve areas that are not currently in compliance. It is important to remember that on the initial survey, the surveyor will expect that the organization has been in compliance with the standards and applicable elements of performance for at least four months. On re-surveys, the “track record” requirement is usually twelve months. However, accredited organizations are expected to be in compliance with applicable standards during the entire period of accreditation. It is encouraged that a healthcare facility preparing for getting accredited refer to the accreditation program that it will join and check their standards and conduct the self assessment according to their standards.
REFERENCES


5. Measuring Quality and Quality Improvement: Methodologies and Tools towards Accreditation

S. Akgun, MD, PhD, A. F. Al-Assaf, MD, MPH, P. Pierce, RN, BSN, CPHQ

A key element of effectively managing healthcare is the ability to measure; measure where we are now; where we would like to be; and measure key aspects of service delivery. In this chapter measurements’ characteristics, which are strongly associated with the early stages of implementing accreditation in healthcare, will be discussed. A healthcare organization’s preparedness for accreditation, continuous quality improvement activities, general measurement framework for elemental areas in healthcare and measurement of quality will be discussed. At the initiation of an accreditation program, health organizations need to perform a “diagnosis” of the current “climate” and the situation where the accreditation program will eventually sit. For this purpose, several tools/forms that are extremely helpful in getting prepared and doing an initial assessment of the organization’s readiness for accreditation are presented.

General attitudes

Simple checklists, questionnaires are useful tools to start:

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<tr>
<th>Question</th>
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<td>How serious is management about quality?</td>
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<td>How serious is staff about accreditation?</td>
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<td>How serious are you about accreditation?</td>
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<td>How good is staff morale?</td>
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<td>How do you rate the trust on management development/education?</td>
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<td>How do you rate the trust on staff communication?</td>
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Current activity and initiatives

A substantial approach in assessing the readiness of a provider for a comprehensive accreditation program is to carry out an internal assessment. This invites staff participation via an open ended structured questionnaire to let the head of Performance Improvement department know what current initiatives and ongoing activity are in place to improve quality.

<table>
<thead>
<tr>
<th>QUALITY IMPROVEMENT INITIATIVES</th>
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<td>Clinical practice</td>
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<td>Standard setting and monitoring</td>
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<td>Clinical and management audit</td>
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<td>Training</td>
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Checklist of quality issues and the physical environment

1.0 Appointment information
   a) Are the directions and information to attend the appointment clearly defined?
   b) Is the information concerning the locations of car parks or bus stops clear?
   c) Does the information regarding car parks include parking charges and directions to the patient / visitors as to what to do if the hospital car park is full?
   d) Does the information include a plan or a pictorial perspectives view of the hospital?
   e) Does the information give details of catering facilities?

2.0 Planning the visit

2.1 Pedestrian.
   a) Are there sufficient buses / trains to take you to the hospital?
   b) Does the bus enter the hospital site or set down the patient outside the site? (If the latter what would be the problems of extending the bus service nearer to the main entrance?)
   c) Where buses enter the site have shelters been provided?

2.2 Car
   a) Is the local authority signposting to the hospital satisfactory?
b) Is the signposted name of the hospital commonly recognized by most people (local/outsiders)?

3.0 Arrival at Hospital

3.1 Pedestrian
   a) How close to the hospital does the bus/train bring you?
   b) Is the directional signposting from that spot satisfactory?
   c) Are the pedestrian footpaths/walks:
      - In good condition?
      - Clearly marked?
      - Adequately illuminated?
      - The shortest practicable route to the destination?
      - (If not, could they be or is there a reason for them not to be?)
   d) Is there any obstruction to the route? (e.g., major building contracts). If so, are they clearly marked and any alternative route adequately signposted?
   e) Are adequately drop curbs provided at road junctions for perambulators or wheelchairs?
      - Are the drop curbs in safe locations?
   f) Does the layout of the footpaths take into account the security of the users? Unlit or unsupervised long hallways are possible places for personal assault.

3.2 by Car
   a) What provisions have been made to restrict the speed of on site vehicles? Are they signposted and illuminated?
   b) Is the main parking lot clearly signposted? If designated a letter or number is this shown on the information leaflet ‘1’ above?

3.3 by Ambulance/Car/Taxi
   a) Can ambulances discharge patients under cover within close proximity of the entrance?
   b) Is the surface adequate?
   c) Is the area under cover from the elements?
   d) Is it close to the required entrance?
   e) Is there provision to allow taxis to wait close to the entrance?

4.0 Parking: The first impression of the hospital is often from the parking lot
   a) How easy is it to park?
   b) Is the surface of the car park satisfactory: free of pot-holes, solid and secure-feeling under foot?
   c) Is the location of the car park reasonably close to your destination?
   d) Is the layout of the car park adequate?
e) Is parking space wide enough to allow car door to open fully to allow unobstructed transfer into a wheelchair, either unassisted or assisted?

f) Are there parking spaces adjacent to the buildings for disabled users to minimize the distance to be travelled?

g) Is the location of the disabled parking spaces such that the approach route to the building/facility is not obstructed by other parked cars and away from moving traffic?

h) Are there parking spaces adjacent to the buildings for disabled users to minimize the distance to be travelled?

i) Are there covered bays for motorcycle and bicycles?

j) Are there non-parking areas clearly marked?

k) If the parking is ‘Pay and Display’ is there a change machine conveniently sited to the ticket machine?

l) Is the fact that a car park is ‘pay and Display’ shown on the information leaflet ‘1’ above?

m) Is there a litter bin adjacent to the ticket machine and at other locations on the site?

n) Does the car park portray a feeling of safety to both persons and vehicles?

o) Is the landscaping and lighting designed/maintained to mitigate risk of theft, vandalism and personal attack?

p) Does the landscaping obstruct a clear view of the cars/directional signs?

q) Are the sights and lines good on exit?

r) Are there low-level walls, rails, bollards or signs to point you to ‘overflow’ parking areas? (see also 1c above)

s) Is the directional signposting from the car park to the hospital satisfactory?

5.0 Signposting: Signposting is often a major cause of confusion on the Hospital site. It may be expedient to appoint a signposting coordinator to reduce the confusion.

a) Is the information given clear?

b) Is the location satisfactory?

c) Is the signposting confusing or over provided? (The main signs are main entrance, emergency, and maternity).

d) Are the signs adequately illuminated?

e) Are the symbols or directional lines used? If so, do they work?

6.0 Approach to building

a) Is the approach route smooth, slip resistant (whether wet or dry), free from incidental obstructions or hazards?
b) Are all public approach routes at least 1200 mm wide? (Approved Document M) – Wheel chairs cannot pass on this width.

   c) Are road level and roadside curbs blended at intersections? If slightly raised section unavoidable, this must be clearly defined with color contrast and good illumination, be feathered in detailed and not exceed 25mm in height.

   d) Are footpaths, ramps and crossing adequately lit to ensure security of footing?

   e) Is the pavement surface textured at the crossing location to assist blind and partially sighted users?

   f) Are handrails provided on all slopes and resting places provided at intervals where a ramp or approach is long?

   g) Are drop curbs contracted so that the gradient of the ramps is within 1:10 at maximum?

   h) Does ramp have a raised curb at least 100mm on any open side?

7.0 Arrival at the main entrance

   a) What was the walking time from the car park / bus stop?

   b) Are all public entrances to the building/facility accessible? (Ramps max1 in 12 preferred 1 in 20).

   c) Are access doors wide enough to facilitate wheelchair movement?

   d) Are thresholds eliminated or kept to a minimum?

   e) Are there handrails to ramps or steps? If so does handrail design obstruct wheelchair manoeuvring and is handrail high enough to facilitate free and safe arm movements?

   f) Do door characteristics and dimensions of related spaces allow it to be opened (and closed) easily by independent wheelchair users, moving in either direction?

   g) What doors can be eliminated?

   h) Is the entrance in the right place?

   i) Would re-location or provision of a secondary entrance improve the overall functioning of the department?

8.0 First impressions upon entry

   a) Is the reception desk easy to find?

   b) Is the information sign apparent?

   c) Is the design/color satisfactory?

   d) Are you aware of any deficiencies in the decor, lighting, temperature or general ambience?

   e) How much information is on view in the shape of signs, notice boards, notices or leaflets? Is it too much or confusing? (The Signposting Coordinator referred to above could also maintain the notice boards.)

   f) Is the reception area staffed?
g) If not, is it easy to locate someone?
h) Has the ‘corporate image’ of the uniform and design been used?

9.0 The reception: The reception area should have a feeling of openness while maintaining an aspect of security. (Sometimes this is achieved by the provision of a second reception area, for security purposes, in Emergency department.)

a) Is the reception desk in the right place?
b) Is the counter enclosed?
c) How? Glazed screen/solid/louvers?
d) Is there privacy at the counter?
e) Is the attitude and personality of the staff satisfactory?
f) If queuing is necessary is it ordered?
g) What system is used to control appointment times for patients? Is it satisfactory?

h) Is the Waiting Area visible from the reception?
i) Can patients in chairs use the reception desk conveniently and privately?

10.0 The waiting area: The standard of interior design should be followed in this area, including the lighting.

a) Are waiting areas protected from high winds as patients move in and out through the entrance doors?
b) Is the ambience satisfactory? (see 6d above)
c) Are there adequate facilities – drinks dispenser, magazines, litter bins, public telephones, free taxi phones and WCs? Are they all clearly marked?
d) Is there a WC for disabled people?
e) Are there magazine supplies?
f) Is the area comfortable?
g) Is there a prayer (meditation) area?
h) Are there plants around the area?
i) Is the seating varied in size, design, material – and comfort?
j) Is the seating arranged in away to provide visual interest to the patient?
k) Can patients using wheelchairs (their own or hospital chairs whilst waiting for treatment), sit with other patients without obstructing the corridors or circulation areas?
l) Are the floors carpeted?
m) Is there a view from the waiting area? (i.e., into a landscaped courtyard). If so, has consideration been given to providing features or plants to attract birds or butterflies?
n) Are telephones and other public mechanisms accessible to wheelchair users? Are knobs, dials, switches, handles and other controls operable and within convenient reach?
    o) Is there artwork on the walls?
    p) Could the area be used to show artwork as an exhibition (local artists, schools, college) or For Sale, either for the Artist or as a source of revenue for the hospital?
    q) Are the waiting areas, or adjacent courtyards, suitable for sculpture or craft demonstrations?
    r) Are there external areas, which, by the introduction of planning or screening to provide wind shelter, will allow patients to all outside in comfort?
    s) Has consideration been given to turning a courtyard into an outdoor room or atrium by the partially or fully glazing the roof to maximize the use of space?
    t) Does the staff provide an updating of information services?

11.0 Internal circulation

11.1 Corridors
    a) Are the lobby sizes adequate and safe both for independent and assisted wheelchair use?
    b) Are corridor and approach routes satisfactory? Do they allow passing and turning of wheelchairs and take adequate of corridor traffic conditions?
    c) Have all obstructions and projections from walls for similar hazards at floor level – such as changes of level been avoided? If unavoidable are they clearly discernible?
    d) Are internal doors widths adequate to allow wheelchairs turning through 90° from the corridor or lobby? Should either or both be increased?
    e) Have safety handrails been provided on corridors, ramps, and steps or at other points where they are required by persons with mobility? Have they been produced where they can be used as location aids by visually impaired people?
    f) Are any large areas of glass close to circulation area at framed so as to be clearly discernible to partially sighted people?
    g) Are seats available at intervals to permit an ambulant and elderly person to take a short rest when faced with corridors to negotiate?
    h) Are there clear, well lit signs posted to ensure easy within the building?
    i) What is the impression of the lighting and decor?
    j) Are there artworks, murals or photographs on the walls?
    k) Would the doors be difficult for the disabled to operate?
    l) Is the flooring materials on-slip?
m) Is there wall protection on one side/both sides of the corridor?

n) Is it in the right location for the various procedures?

o) Are refreshment areas accessible to disabled people?

11.2 Staircases

a) Are staircases safe and optimally comfortable for elderly and disabled people? Are handrails and landing satisfactory?

b) Are staircases clearly signposted?

c) Are lifts available, conveniently placed, accessible and signposted?

d) Are there location plans in the lift lobbies?

e) Are list controls accessible to the independent? Are the visual and audible signals, alarms and flora satisfactory? Are digits embossing appropriate and satisfactory for partially sighted persons? Is there a tip up seat or suitable pillows available?

12.0 Toilets

a) Are there correctly designed Unisex toilets (i.e. where a husband and wife may enter the cubicle together) available in the public areas of the premises?

b) Are there suitable cubicles for wheelchair users in other male and female toilets in the building?

c) Do cubicles for wheelchair users provide adequate manoeuvring space within, or are turning space provided outside? Is the level of privacy afforded satisfactory?

d) Are there cubicles available with appropriate grab rails for the use of ambulant disabled people?

e) Are WC and wash basin arrangements accessible to independent wheelchair users? Are the grab rails, mirrors, towels, door closing bars and other aids placed satisfactorily?

13.0 Treatment areas

a) Are all consulting and treatment areas fully accessible to disabled patients?

b) Are there changing cubicles suitable for wheelchair users, with room for assistance to be given if required?

14.0 Ward facilities

a) What are the impressions of the ambience, decor, lighting and floor material?

b) Is wallpaper used?

c) Are the ward floors noisy or slippery?

d) Could consideration be given to carpeting selected areas around beds?
e) Is the night lightening in apposition to annoy or prevent a patient from sleeping?

f) Do sanitary facilities offer maximum independence and privacy to disabled patients, both those who will be using wheelchairs and those who have walking difficulties?

g) Is the day room easily located and accessible, with a variety of seating heights to help ambulant disabled people? Are all noises clear to see and understand?

h) Are window controls, radio and television and call bells easily reached by disabled people and do they all function?

i) Can disabled visitors conduct private conversations with their friends in bed or in the ward?

15.0 Other features

a) Are emergency evacuation routes and emergency exits satisfactory?

b) Are fire alarms readily accessible to the semi-ambulant and wheelchair disabled? Are emergency call facilities stalled to call upon assistance in remote locations?

c) Are audio/visual alarms signals provided?

Environmental Audit:

An environmental audit shall be conducted on different organization locations and several of its issues. The locations, issues, and methods that could be used to do the environmental audit will subsequently be listed:

Locations:
- External entrances & approach
- Reception
- Outpatient areas
- Wards
- Departments
- Theatres
- Corridors.

Issues:
- Signposting
- Telephones/bleeps
- Cleanliness/bins
- Toilets
- Pictures
- Offices
- Plants/gardens/landscaping
- Availability of goods/shops/etc
- Colours
- Lighting
- Welcoming impression
- Notice boards
- Decorating/painting
- Photograph boards
- Reading material
- Seating and furniture
- Information
- Eating areas
- Individualized appearance
- Smoking areas
- Curtaining
- Relatives’ rooms
- Reception desk appearance
- Car parking
- External fabric
- Ventilation
- Privacy.

**Methods:**
- “First Impression” group or quest team
- External Customer Information (surveys, visitors’ complaints…)
- M.B.W.A.(management by walking around) and management audit
- Comparison between hospitals
- Prioritizing of effort
- Ownership by upper management & staff
- Local monitors
- Involvement of estates function
- Quality Improvement Annual Program
- Costing of improvements
- Allocation of funds
- Corporate strategy
- Relevance of environment on clinical outcome
- Need to attract patients & marketing
- Maintenance of standards
- Open meeting with staff to gain ideas and commitment.
Maternity: checklist (answer with yes or no when applicable)

Policies and procedures:
1. Admission, transfer and discharge policies have been clearly defined and communicated between staff and district level.
   a) Written clinical policies covering indication for procedures such as enemas, pubic shaving, artificial rupture of membranes etc are available on site and have been agreed upon between the professional groups concerned
   b) The most recent amendment was in place.
2. A mechanism exists to ensure that all staff gives consistent information and advice to patient.

Records:
3. The standard format of the obstetric notes used is the same in the consultant obstetric unit.
4. a) Separate clinical records are begun for each baby
    b) Babies’ notes are always cross-referenced with the mother’s notes.
5. The following records are retained after discharge:
   a) Obstetric notes
   b) Nurses’ cardex
   c) Booking and birth registration.
6. Obstetric and babies records are retained for 21 years
7. The following statistics are recorded:
   a) Number of women initially booked for GP unit or GP care
   b) Number of women transferred to consultant care during pregnancy
   c) Number of deliveries in GP unit or under GP care
   d) Number of live and still births
   e) Prenatal mortality figures
   f) Number of transfers to consultant care during labor
   g) Postpartum transfers to consultant care for maternal reasons
   h) Number of babies transferred to consultant care
   i) Number of neonatal deaths up to 7 days after discharge from unit.

The statistics recorded were last formally reviewed by clinical staff and efforts have been made to create a hospitable and comfortable atmosphere in the delivery suite.
Facilities and equipment:

The areas for first stage of labor meet the following standards:

a) There is space and an easy chair for the pregnant woman and a companion to move around
b) Toilets and washing facilities of a suitable size for pregnant woman are nearby
c) Call system is available
d) Doors are wide enough for moving beds or trolleys through
e) Privacy is assured for the pregnant woman and her companion.

8. The following equipment is available within the delivery suite:

a) A delivery table which can be quickly turned to the trandelenburg position
b) Equipment for inhalation analgesia
c) An anesthetic machine with emergency oxygen supplies
d) Drugs and intravenous equipment
e) Otolaryngeal airways, laryngoscopes, cuffed endotracheal tubes, suction catheters
f) An incubator, with temperature adjustable for normal infants or for sick or premature infants
g) Infant suction equipment
h) A separate oxygen supply to the incubator and infant resuscitation equipment
i) Cardiac resuscitation equipment (or readily available to delivery suite).

9. Lighting is flexible enough to provide a restful environment and allow clinical procedure to be performed.

10. Hot and cold running water, heating, and emergency power supply are provided for the delivery area.

11. The post-natal ward provides sufficient room for babies to room in with mothers.

12. Privacy for mothers is possible, e.g. when breast feeding.

13. Nursery facilities are comfortable and are adequate for teaching mothers about caring for their babies.

Staffing:

14. The hospital receives 24 hour coverage from registered midwives.

15. All GPs’ attending privileges at hospital are on the obstetric list and hold an individual contract with the health authority for admitting patients to the hospital.

16. A mechanism exists among medical staff to ensure that all doctors attending privileges have had sufficient practice recently to maintain professional competence.
17. Active encouragement is given to doctors to attend refresher courses and participate in other educational activities.
18. A consultant obstetrician last visited the hospital to review policies with local staff in the department.
19. Clearly defined arrangements/policies exist for sharing anti-natal care with consultant obstetricians.

**General medicine, care of elderly: checklist (answer with yes or no when applicable)**

1. Referring doctors have clear guidelines about the types of conditions appropriate for referral to the hospital.
2. Senior nursing staff is involved in arranging the admission of patients to the hospital.
3. A regular review of admissions is held by clinical staff.

**Personal Identity**
4. The way in which a patient would prefer to be addressed is noted and used.
5. Patients wear clothing at all times.
6. The staff demonstrates knowledge of the past history of the patient.
7. Patients are encouraged to choose:
   • The time they get up
   • Their clothing
   • Their bed time
   • Their meals from a menu.
8. Chairs in the dayroom are arranged in compatible groups, rather than around the walls.
9. Patients have:
   • Space for their own possession
   • Their own toiletries, flameless, etc.
   • Regular access to professional hairdressing.

**Privacy**
10. Catheter tubes and bags are concealed from sight.
11. Personal mirror are available.
12. Patients can bathe, wash and use the toilet in privacy.
13. Visitors can talk privately to patients.

**Dependence**
14. Most of the independent patients are given time and equipment to feed themselves.
15. Patients control their own money and can spend it anyway they like.
16. There is an area where patients who wish to are allowed to smoke.
17. Non – smokers do not have to suffer from a smoky environment.

**Contact:**
18. Patients who wish to regularly attend religious services in the hospital or outside.
19. Visiting hours are flexible and visitors are welcomed at all times.
20. The majority of patients do have visitors.
21. Up-to-date newspapers and magazines are available.
22. There is an accurate clock and calendar which is kept up to date in each of the sitting areas.
23. Call bells are answered promptly.

**Activities:**
24. Playing cards or board games are available.
25. If there is a piano it is playable and in tune.
26. Patients choose the program they want to watch or listen to.
27. Patients have easy access to library service. Large print books are available.
28. Transport is provided for outings. Patients are encouraged to plan and go on outings.

**Environment:**
29. The ward is free of unpleasant smells.
30. Decor is clean and bright and the ward is well lit.
31. Patients can easily see the garden or street.
32. If patient wish, pets are kept in the hospital, and patients’ own pets can be brought in to visit them.

**Health Care:**
33. A program of continence training is undertaken for all patients who require it.
34. Few patients require regular laxatives or sedation (including night sedation).
35. Deaf patients have functional hearing aids.
36. No patient should have dental problems which affect their availability to eat or speak.
37. Patients have had vision check (and spectacles provided if necessary) in the past year.
38. Treatable foot problems, which cause discomfort or limited mobility, are promptly managed.

**Organizational Quality**

**Organizational culture**

This is not a comprehensive checklist; it is more of a preliminary discussion tool aimed at raising awareness about the initial experienced
culture upon entering a hospital. A practical guide to discovering organizational culture when going into a hospital/medical center would include the following questions:

1.0 As you approach the facility, what does it look like: an office block, a factory, a school etc…? What?
2.0 What does the outside environment look like: industrial, crowded, green?
3.0 Has there been an attempt to improve the appearance, if so how?
4.0 What signs do you see on the outside?
5.0 What signs tell you the way to the entrance?
6.0 What does the main entrance look like?
7.0 What do you experience immediately upon entering the hospital/center?
8.0 How is the nature of your reception?
9.0 How does the hospital’s surrounding environment (indoor and outdoor), where you will spend most of your time look like?

*The visual messages of the inside of the hospital / center*

There are many ways to deal with the facility’s interior design. In a row of identical semi detached homes or on a vast anonymous housing estate, each one will be very different from the inside. Equally, institutions have enormous choices as to what they do with the inside of their facility. So have a good look around your hospital / centre as an interior designer would.

1.0 Are the walls and ceilings decorated? What messages does that give?
2.0 What textiles and fabrics are used (curtains, carpets etc?)
3.0 What kind of furniture is provided? What stage is it in?
4.0 What pictures, or other works of art are displayed?
5.0 Management team (MT) effectiveness
6.0 Organizational communication

*Organizational communication climate Survey*

The following questionnaire refers to the nature of interpersonal communication in a provider unit and is simple to use.

Directions: this brief questionnaire refers to the nature of interpersonal communication in your work unit or organization: employees, peers, and higher-level managers- typically display the behaviours described. You are not trying to evaluate any particular person; the aim is to get a picture of the overall climate of interaction in the work unit or organization
Answer key: VG: to a very great extent  
C: to a considerable extent  
M: to a moderate extent  
S: to a slight extent  
LN: to a little or no extent  

Circle the letters that best represent the extent to which you think the behaviour described is common in your work unit or organization

To what extent do people in this work unit / organization …?

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<thead>
<tr>
<th></th>
<th>1. Show that they listen to one another; try to understand others’ viewpoints?</th>
<th>VG</th>
<th>C</th>
<th>M</th>
<th>S</th>
<th>LN</th>
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<td>2. ‘Pick up on’ and verbally describe the feelings another member has and tries to express?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td>3. Ask others to repeat or clarify what they have said in order to better understand?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td></td>
<td>4. Restate for clarification what another person has said before making his or her own points?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td></td>
<td>5. Share their own feelings in clear non-threatening ways?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td>6. Provide support and encouragement in a discussion in order to explore an issue in depth?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td>7. Give others a chance to talk; opening the door for others to contribute a discussion?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td></td>
<td>8. Help explore an issue in depth without trying to push their own ideas?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td></td>
<td>9. Say clearly, up front, what their expectations of one another really are?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td></td>
<td>10. Face disagreements directly; try to understand the reason underlying differences?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td>11. Give one another feedback that is concrete and specific without being evaluated?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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<td></td>
<td>12. When talking, care about another as a person and colleague?</td>
<td>VG</td>
<td>C</td>
<td>M</td>
<td>S</td>
<td>LN</td>
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Standards setting and monitoring (answer with yes, working towards, or no if applicable)

1.0 Has the department written standards? Which are:
   a) Descriptive (i.e. usually not measurable)
   b) Measurable (i.e. specific, often numerical, can be measured)

2.0 Are the measurable standards:
   a) Comprehensive (i.e. covering all aspects of service)
   b) Covering between 1-10 major areas/topics

3.0 Does the department have clear idea/plan of area topics which should eventually be covered by standard setting?

4.0 Do all staff in the Department:
   a) Know a little about this process?
   b) Know and agree all these standards?

5.0 Is there clear monitoring process for accessing current performance against these standards?

6.0 a) Does a quarterly report get prepared?
   b) Is this discussed with staff?
   c) Does the senior manager receive a copy?
   d) Does “Non-conformance” which gets identified get acted upon?

Standards setting and monitoring checklist:

<table>
<thead>
<tr>
<th>Has the department written standards</th>
<th>Dept A</th>
<th>Dept B</th>
<th>Dept C</th>
<th>Dept D</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Descriptive</td>
<td>.</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>B) Measurable specific, (often numerical, can be measured)</td>
<td>Some</td>
<td>Some</td>
<td>Some</td>
<td>Some</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are measurable standards</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Compressive (i.e. covering all aspects of service)</td>
<td>90%</td>
<td>99%</td>
<td>Clinical 80% Administrative 75%</td>
<td>clinical 75% Admin 95% per service</td>
</tr>
<tr>
<td>B) Covering between 1-10 major areas/topics</td>
<td>No</td>
<td>.</td>
<td>.</td>
<td>.</td>
</tr>
<tr>
<td>C) 6 monthly review</td>
<td>?</td>
<td>To be</td>
<td>No</td>
<td>.</td>
</tr>
<tr>
<td>Does the department have a clear idea/plan of areas/topics, which should eventually be covered by standards setting?</td>
<td>Yes</td>
<td>Under review</td>
<td>Under review</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

| Do all staff in the department: |
|---|---|---|---|---|
| A) Know a little about this process? | । | । | । | । |
| B) Know and agree about these Standards? | । | । | । | । |
| C) Is this linked to audit? | । | In two areas | Being developed | । |
| D) Is this linked to customer feedback? | । | In outpatients | । | Annual report goes to referrers |

| Is there a clear monitoring process for assessing current performance against these standards? |
|---|---|---|---|---|
| 1. Cards audited | । | । | । | । |
| 2. Needs Development | । | । | । | । |
| 1. Waiting times audited | । | । | । | । |
| 2. Needs development | । | । | । | । |
| 1. Needs development | । | । | । | । |
| 2. Possible External Audit | । | । | । | । |
| 1. Annual out-put report | । | । | । | । |
| 2. Fortnightly peer review to link to standards | । | । | । | । |
| 3. Individual patient discharge checklist audit | । | । | । | । |
| 4. Link to Staff | । | । | । | । |

| 6 A) Does a quarterly report get prepared? | No | No | No | Annual report |
| 6 B) Is this discussed with staff? | No | No | No | Yes |
| 6 C) Does the senior manager receive a copy? | No | No | No | Yes |
| 6 D) Does identified “Non-Conformance” get acted upon? | Informally | Not informally | Not informally | Yes |
Background on continuous quality improvement activities

1-Assignment of responsibility for quality improvement:

   a. Who is responsible at the administrative/hospital level?
   b. Who is responsible at the departmental/clinical service level?
   c. Where is the responsibility detailed?
      Ex: Medical Staff Bylaws
          Job Description
          Quality Improvement
   d. To whom or to which committee(s) does the assigned responsible party report?

2-Delineate scope of care:

Healthcare professionals in the department/service must identify the patient/client services, which they provide, and the clinical activities they perform. In a department or service that provides direct patient care services, this step involves identifying the diagnostic and therapeutic modalities it uses (e.g. procedures performed, medication frequently used, services provided) as well as ascertaining the types of patient served (e.g. major, age or disability groups, disease entities treated), the processes of care (assessment, counselling, patient education, etc.), who provides care, and where care is provided (inpatient, outpatient, home care, etc.). (See Attachment A)

3-Identify important aspects of care:

Healthcare professionals in the department/service must identify the processes of care provided, aspects of care which are high risk, aspects of care provided in high volumes and aspects of care which are problem-prone. (See Attachment B)

Note: Collectively, any monitoring activities should include all the major services and care provided by all practitioners in department/services.

4-Indicators are identified and selected by performance improvement teams.

5-Means to identify and trigger evaluations are identified.

6 Data collection methods and data collection methodology are designed and implemented.

7-Data is organized, assessed, and priorities are set for evaluation.

8 Action is taken to improve care and service.

9-Effectiveness of actions is assessed and action is taken to ensure that improvement is maintained.

10-Results are communicated to relevant individuals and/or group.
**Attachment A**

Worksheet for defining scope of care

Department/service: ________________________________

Form completed by: ________________________________

1- Who are the critical internal and external customers?
2- What types of patient are treated (e.g. total number, demographic groups, inpatient-to-outpatient ratio, functional capability status (consider activities of daily living, range of motion, ambulatory status, etc.), conditions and diagnosis represented?)
3- What/where are the sites of care/service (centralized, decentralized, satellite)?
4- When are services provided (daily, weekly, monthly; shifts, weekends, etc.?)
5- Who provides/perform the care/service (position, title)?
6- What are the significant activities and processes performed exclusively by the department/service and what is the annual volume of each?
7- What are the diagnostic and therapeutic modalities used?
8- How does the department co-operate, consult and depend upon other departments, organizations, and professionals?

**Attachment B**

Worksheet for determining important aspects of care

Department/service: ________________________________

Form completed by: ________________________________

List five most frequently procedures/service:
1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

List five most frequent diagnoses: Average number per month
1. ______________________  ______________________
2. ______________________  ______________________
3. ______________________  ______________________
4. ______________________  ______________________
5. ______________________  ______________________

List services involving high risk to patients:
1. ______________________
2. ______________________
List the four surgical procedures with the highest rates of intraoperative and postoperative complications the average monthly complication rate of each.
1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________

List of two types of incidents that your department reported most often to the risk management department in the last six months:
1. ______________________________________________________________
2. ______________________________________________________________

Worksheet for determining important aspects of care

List new drugs and procedures performed, and/or any major new equipment obtained in the last nine months:
1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________

List infection control problems reported or identified in the last 12 months:
1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________

List examples of the following:

Unexplained variations in clinical practice:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Unexplained variation is utilization of limited or costly resources:
___________________________________________________________________________

___________________________________________________________________________

126
Unexplained variations in internal or external referral patterns:

___________________________________________________________________________

___________________________________________________________________________

General clinical uncertainties or controversies:

___________________________________________________________________________

___________________________________________________________________________

Uncertain indications for risky or costly interventions

___________________________________________________________________________

List of quality-of-care problems perceived by patients, clinicians, and/or managers:

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________
5. ___________________________

Now identify and cross off those listed important aspects of care which are more management oriented as opposed to clinically oriented (i.e., aspects of care more closely linked to direct patient/client care). Even though management oriented concerns do relate to the delivery of quality care, the thrust of monitoring and evaluation is clinical.

From the remaining items of the list, choose the six (6) most important aspects of care (most important by reason of high risk, high volume, and/or problem prone) and prioritize them from one (1) most (important) to six (6) (least important).

1.____________________________________________________________
2.____________________________________________________________
3.____________________________________________________________
4.____________________________________________________________
5.____________________________________________________________
6.____________________________________________________________
1- Patient Satisfaction Questionnaire- Inpatient Services

These questionnaires that you will fulfill, will light the way of further services of our hospital, which the target is to provide services that are more qualified. We would like to thank you for paying attention and for your help. We wish you healthy days.

Medical Chief Officer:
Date: ……………/…/……..

1- Sex: 1- Female 2- Male
2- Your age: ………………………………………………………………..
3- Your educational level: …………………………………………………
4- Your profession: …………………………………………………………
5- The department(s) that you receive service from:

…………………………/…………………………/……………………………

PATIENT ADMISSION

6- The official who managed the hospitalization procedures was concerned with me and polite to me.
   1- Yes, totally (3)
   2- Yes, partially (2)
   3- No (0)

7- Have you been informed sufficiently about the procedures?
   1- Yes, totally (3)
   2- Yes, partially (2)
   3- No (0)

8- Before the hospitalization, have you been informed sufficiently about the hospital rules (visiting times, smoking prohibition etc)?
   1- Yes, totally (3)
   2- Yes, partially (2)
   3- No (0)

INPATIENT UNITS

9- Have you been exposed to noise in your room?
   1- Yes (0)
   2- No (2)

10- In your opinion, how was the cleanliness of your room and the unit?
    1- Very clean (3)
    2- Clean (2)
    3- Not clean a lot (1)
    4- Not clean (0)

11- Did you find enough the warm and ventilation systems of your room?
    1- Yes (3)
    2- No (0)
12- Were they clean, the bath and toilets that you were using?
   1- Very clean (3)
   2- Clean (2)
   3- Not clean a lot (1)
   4- Not clean (0)

**PHYSICIANS**
13- Did you take comprehensive answers to the questions important for you, which you asked to the physicians?
   1- Yes, always (3)
   2- Yes, some times (2)
   3- No (0)

14- Did you have confidence to the physicians who treated you?
   1- Yes, always (3)
   2- Yes, some times (2)
   3- No (0)

**NURSES**
15- Did you take comprehensive answers to the questions important which you asked to the nurses?
   1- Yes, always (3)
   2- Yes, some times (2)
   3- No (0)

16- Did you have confidence to the nurses who took part in your treatment?
   1- Yes, always (3)
   2- Yes, some times (2)
   3- No (0)

**TREATMENT AND CARE**
17- Has it been making different comments about your status (the prognosis of your disease) leading to worry you?
   1- Yes, very often (0)
   2- Yes, some times (1)
   3- No (2)

18- During your treatment, have you been involved into the decisions about your treatment and care?
   1- Yes, always (4)
   2- Yes, some times (3)
   3- No (0)

19- How much information about your status and treatment was given to you?
   1- No sufficient information was given (0)
   2- Enough information was given (4)
   3- A lot of information was given (3)
20- When your relatives or friends wanted to talk to your physician, have they been given the opportunity?
   1- Yes, always (4)
   2- Yes, in some situations (3)
   3- No (0)

21- When it has been discussed about your status or your treatment, has it been respected the secrecy and your intimacy?
   1- Yes, always (3)
   2- Yes, some times (2)
   3- No (0)

22- Has it been provided enough intimacy when you were been examined?
   1- Yes, always (4)
   2- Yes, some times (3)
   3- No (0)

23- Has your call been answered when you have needed and called the nurse or the physician?
   1- Yes, immediately (in 5-10 minutes) (4)
   2- Yes, after a while (in 15-20 minutes) (3)
   3- Yes, it has been answered lately (in 25-30 minutes) (2)
   4- More than 30 minutes (1)
   5- No (0)

**DISCHARGING FROM THE HOSPITAL**

24- Did the physicians or the nurses, informed you about the problems that you might be confronted with, at home?
   1- Yes, for some situations (2)
   2- No (0)

25- Did the unit where you were threatened give a phone number to call when you need?
   1- Yes (3)
   2- No (0)

**GENERAL EVALUATION**

26- During the days you stayed in the hospital, did you think that you were been threatened with respect?
   1- Yes, always (3)
   2- Yes, some times (2)
   3- No (0)

27- How do you assess the “team work” of the nurses and physicians of the unit where you stayed?
   1- Perfect (4)
   2- Very good (3)
   3- Good (2)
   4- Average (1)
5-  Bad (0)

28- How do you assess the treatment and care provided to you?
   1- Perfect (4)
   2- Very good (3)
   3- Good (2)
   4- Average (1)
   5- Bad (0)

29- Do you think that the physicians and nurses did all that they could do?
   1- Yes, totally (3)
   2- Yes, partially (2)
   3- No (0)

30- How do you assess the general cleanliness and orderliness of the hospital?
   1- Perfect (4)
   2- Very good (3)
   3- Good (2)
   4- Average (1)
   5- Bad (0)

31- What do you think about the general quality of the hospital?
   1- Perfect (4)
   2- Very good (3)
   3- Good (2)
   4- Average (1)
   5- Bad (0)

32- If you need, would you prefer again this hospital?
   1- Yes (2)
   2- No (0)

COMMENTS - SUGGESTIONS
.................................................................
.................................................................
.................................................................
.................................................................
.................................................................
.................................................................
2- Patient Satisfaction Questionnaire- Out patient Services

These questionnaires that you will fulfill, will light the way of further services of our hospital, which the target is to provide services that are more qualified. We would like to thank you for paying attention and for your help. We wish you healthy days.

Medical Chief Officer .................................................................
Date: ........./...../.....

1- Gender: 1- Female 2- Male
2- Your age: ..........................................................
3- Your educational level: ...........................................
4- Your profession: ......................................................
5- The department(s) that you used service from:
   a. ............................................................../...........

6- PHYSICAL ENVIRONMENT/ INFRASTRUCTURE
7- Is it easy to reach the hospital entrance and the outpatient units?
   a. Yes, it is (2)
   b. No, it is difficult (0)

8- How was the cleanliness of the outpatient units?
   a. Very clean (4)
   b. Clean (3)
   c. Not bad (2)
   d. Dirty (0)

9- How was the cleanliness of the toilets in the outpatient units?
   a. Very clean (4)
   b. Clean (3)
   c. Not bad (2)
   d. Dirty (0)

PHYSICIAN’S EXAMINATION
10- Was the time enough to discuss your health problems with your physician?
   a. Yes, absolutely (4)
   b. Yes, partially (3)
   c. No (0)

11- How much time did it take the examination of your physician?
   a. 5 minutes around
   b. 6-10 minutes
   c. 11-20 minutes
   d. more than 20 minutes

12- Did your physician explained you the given treatment or exercises in a comprehensive way?
a. Yes, totally (4)
b. Yes, partially (3)
c. No (0)

13- Did the physician listen to your complaints?
   a. Yes, surely (4)
   b. Yes, partially (3)
   c. No (0)

14- Did the physician answer in a comprehensive way the question that you thought to be important?
   a. Yes, absolutely (4)
   b. Yes, partially (3)
   c. No (0)

15- Did you have confidence to the physician who did your examination?
   a. Yes, surely (4)
   b. Yes, partially (3)
   c. No (0)

16- OTHER PROFESSIONALS

17- Which one of the personnel did take care of you?
   a. Nurse
   b. Physiotherapist
   c. X-Ray technician
   d. Psychologist
   e. Other, please write…….

18- Did the health care personnel answer in a comprehensive way, question that you thought to be important?
   a. Yes, absolutely (4)
   b. Yes, partially (3)
   c. No (0)

19- Did you have confidence to the health worker who took care of you?
   a. Yes, surely (4)
   b. Yes, partially (3)
   c. No (0)

20- GENERAL EVALUATION

21- Did the personnel give you sufficient information about your status and treatment to in the outpatient unit?
   a. Not enough information was given (2)
   b. Enough information was given (4)
c. A lot of information was given (3)
d. No information was given (0)

22- Did the personnel pay attention to your intimacy during the interviews about your disease?
   a. Yes, totally (3)
   b. Yes, partially (2)
   c. No (0)

23- Did the personnel pay attention to your intimacy during the examinations?
   a. Yes, totally (3)
   b. Yes, partially (2)
   c. No (0)

24- Did the personnel ask your opinion about the recommended treatment and applications?
   a. Yes, totally (4)
   b. Yes, partially (3)
   c. No (0)

25- Did the personnel introduce themselves during your examination?
   a. Yes, all of them (3)
   b. Yes, some of them (2)
   c. No, neither of them (0)

26- DISCHARGING FROM THE HOSPITAL

27- Did the physician explain in a comprehensive way, how to use the drugs and why were they prescribed?
   a. Yes, totally (3)
   b. Yes, partially (2)
   c. No (0)

28- At the end of the examination, did your physician give an information note about your status and which is usable in case of need?
   a. Yes (3)
   b. No (0)

29- Did your physician explain dangerous signs of your disease that could occur while you go to your home and the situations that could occur during your treatment?
   a. Yes, totally (4)
   b. Yes, partially (3)
   c. No (0)

30- Did your physician give a phone number-communication address to call when you get bad or anxious?
   a. Yes (3)
b. No (0)

31- OVERALL SATISFACTION

32- Are you satisfied with the service given to you about the problem that you admitted the hospital?
   a. Yes, totally (4)
   b. Yes, partially (3)
   c. No (0)

33- Were the outpatient services in order?
   a. They were not in order (0)
   b. They were quite in order (3)
   c. They were very good managed in order (4)

34- If you express in a general point of view, were the personnel respectful during the outpatient services that you took?
   a. Yes, always (4)
   b. Yes, some times (3)
   c. No (0)

35- How do you assess the outpatient services that you used?
   a. Perfect (5)
   b. Very good (4)
   c. Good (3)
   d. Average (2)
   e. Bad (0)

f. COMMENTS AND SUGGESTIONS

..........................................................................................................................
## Patient satisfaction of the pain management programme

<table>
<thead>
<tr>
<th>Questions</th>
<th>Coding Categories</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many nights have you spent as a patient in this hospital?</td>
<td>Enter the total number of nights. Enter whole numbers only. If patient has spent less than one night in hospital, enter the number 555</td>
<td></td>
</tr>
<tr>
<td>What is your nationality?</td>
<td>(permanent resident)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Saudi</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(not permanent resident)</td>
<td>4</td>
</tr>
<tr>
<td>er of respondent</td>
<td>Male 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female 2</td>
<td></td>
</tr>
<tr>
<td>In what month and year were you born?</td>
<td>Month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Year</td>
<td></td>
</tr>
<tr>
<td>How old were you on your last birthday?</td>
<td>Record age (in completed years)</td>
<td></td>
</tr>
<tr>
<td>What is your martial status?</td>
<td>Single 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Married 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separated 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Divorced 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Widow/Widower 5</td>
<td></td>
</tr>
<tr>
<td>What is the highest level of education that you have</td>
<td>Illiterate...</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Less than...</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Diploma</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(2-year post-…)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baccalaureate</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Masters Degree</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Doctorate or equivalent</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Other (specify)</td>
<td>8</td>
</tr>
<tr>
<td>What is your current work status?</td>
<td>Unemployed 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employed (part-time)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Self-employed (full-time)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Self-employed (part-time)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Volunteer worker</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Trainee</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>I housewife/husband</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Never worked 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retired 11</td>
<td>11</td>
</tr>
<tr>
<td>What is the permanency of your work?</td>
<td>Permanent 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seasonal</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Occasional</td>
<td>3</td>
</tr>
<tr>
<td>What is your main</td>
<td>Specify</td>
<td></td>
</tr>
</tbody>
</table>
I would now like to ask you a few questions concerning the management of your pain, during your stay in the hospital.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the doctor prescribe any pain medication to you during your stay in the hospital?</td>
<td>Yes 1 No 2 Don't know</td>
<td>Go to</td>
</tr>
<tr>
<td>Were you able to self-regulate the amount of pain medication you received?</td>
<td>Yes 1 No 2 Don't know</td>
<td></td>
</tr>
<tr>
<td>Have you experienced any pain during your stay in the hospital?</td>
<td>Yes 1</td>
<td>Go</td>
</tr>
<tr>
<td>How often have you experienced pain during your stay in the hospital?</td>
<td>Frequently Occasionaly Rarely 3 Never 4</td>
<td></td>
</tr>
<tr>
<td>Were doctors and nurses aware of your pain?</td>
<td>Yes 1 No 2 Don't know</td>
<td></td>
</tr>
<tr>
<td>How would you rank the overall management of your pain, by the hospital staff?</td>
<td>Excellent Very Good Good 3 Fair 4 Poor 5 Very Poor Don't know</td>
<td></td>
</tr>
<tr>
<td>in summary, how would you rate your level of satisfaction with the overall services provided by the doctors in this hospital?</td>
<td>Extremely 1 Satisfied Dissatisfied Very tied 4</td>
<td></td>
</tr>
<tr>
<td>in summary, how would you rate your level of satisfaction with the overall services provided by the nursing staff of this hospital?</td>
<td>Satisfied Dissatisfied Very tied 4 Don't know</td>
<td></td>
</tr>
<tr>
<td>in summary, how would you rate your level of satisfaction with the overall services provided by the ancillary personnel of this hospital (e.g., physical therapist, radiology technicians, ward clerks)?</td>
<td>Extremely 1 Satisfied Dissatisfied Very tied 4</td>
<td></td>
</tr>
</tbody>
</table>
3-Measuring patient satisfaction and improvement of patient education

**PATIENT & FAMILY EDUCATION ASSESSMENT FORM**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>AGE:</th>
<th>GENDER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTACT NUMBER (HOME):</td>
<td>MOBILE:</td>
<td></td>
</tr>
<tr>
<td>CASH/COMPANY:</td>
<td>MEDICAL RECORD #:</td>
<td></td>
</tr>
</tbody>
</table>

**SOCIAL HISTORY**

<table>
<thead>
<tr>
<th>MARITAL STATUS:</th>
<th>SINGLE</th>
<th>MARRIED</th>
<th>WIDOW</th>
<th>DIVORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCCUPATION:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMOKING:</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY**

<table>
<thead>
<tr>
<th>ALLERGIES:</th>
<th>MEDICATIONS:</th>
<th></th>
</tr>
</thead>
</table>

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>OB/GYNE HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER OF PREGNANCY:</td>
</tr>
<tr>
<td>BIRTH CONTROL METHODS:</td>
</tr>
</tbody>
</table>

**SYSTEM REVIEW**

<table>
<thead>
<tr>
<th>NEUROLOGICAL</th>
<th>CARDIOVASCULAR</th>
<th>GIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>STROKE</td>
<td>HEART DISEASE</td>
<td>GIT ULCERS</td>
</tr>
<tr>
<td>SEIZURES</td>
<td>HYPERTENSION</td>
<td>LIVER DISEASE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GALL BLADDER</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DISEASE</td>
</tr>
</tbody>
</table>

**RESPIRATORY**

<table>
<thead>
<tr>
<th>BRONCHIAL</th>
<th>ASTHMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>SICKLE CELL ANEMIA</td>
<td>G6PD</td>
</tr>
<tr>
<td>THALASSEMIA</td>
<td>HEPATITIS, A, B, C</td>
</tr>
<tr>
<td>(CIRCLE WHICH TYPE)</td>
<td></td>
</tr>
</tbody>
</table>

**ENDOCRINE**

<table>
<thead>
<tr>
<th>DM</th>
<th>THYROID</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTI</td>
<td>ERDS</td>
</tr>
<tr>
<td>STONES</td>
<td></td>
</tr>
</tbody>
</table>

**UROLOGY**

<table>
<thead>
<tr>
<th>NEPHROSIS</th>
<th>ENDOCRINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSTEOARTHRITIS</td>
<td>OSTEOSKELTAL</td>
</tr>
<tr>
<td>OSTEOARTHRITIS</td>
<td>OSTEOPOROSIS</td>
</tr>
</tbody>
</table>

**EDUCATION PLAN:**

**NEEDED CONSULTATION:**
Patient teaching center:

REFERRAL FORM

Name of Patient: _______________________________

Medical Records File #: _______________________________

Diagnosis: _______________________________

Referred to: _______________________________

Brief of Education provided: _______________________________

Date: _____________________

Recommendations:
________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

Name of Educator      Signature

Feedback to Hospital Patient Teaching Center

Name: _______________________________

Date: _______________________________
4-Patients’ experiences of surgery:

First, we would like to ask about what happened before you went into hospital.

1. Did you receive any written or printed information about your treatment before you went into hospital?
   Please tick one 1. Yes 2. No

2. Did anyone explain your treatment to you before you went into hospital?
   Please tick one 1. Yes 2. No

Now we would like to ask you about the time you spent in hospital.

3. What operation did you have? You may tick more than one.

1. Hernia repair 11. Cystoscopy
2. Arthroscopy 12. Laparoscopy
3. Myringotomy or grommets 13. Sterilization (women)
5. Anal fissure dilatation /excision 15. Cataract extraction
7. Circumcision 17. Carpal tunnel release
8. Removal of ganglion 18. Termination of pregnancy
9. Orchidopexy for undescended testicles 19. Dilation and curettage (D&C)
21. Other (please specify)

4. How long did you stay in hospital?
   Please tick one 1. For the day or less 2. For one night or more
Patient-Visitor complaint follow-up sheet

NAME: ____________________________
GENDER: _____________________________
AGE: _________________________________
FILE: __________________________________
ADDRESS: _____________________________
DATE: _________________________________
TIME: _________________________________

TYPE OF COMPLAINT:
□ Medical □ Clinic □ Reception
□ Housekeeping □ Radiology □ Laboratory
□ Admission Office □ Discharge Office □ Maintenance
□ Communication □ Nursing □ Patient Relation
□ Medical Records □ Dietary □ Others:_________________

Brief Description for Complaint:

Action Taken about the Issue:

Recommendation (for Future):

Name___________________________
Signature: ________________________

Refer to: □ Department □ Management □ PI Committee
Signature: ______________________________Date:________________

Performance Improvement Manager
Staff satisfaction survey

Your Job Description (Tick one)  Date: ____________________

Medical □ Physician □ Nurse □ Technician
Non-Medical □ Administrative □ Secretarial □ Support Service

Instructions: This survey will be used to improve our workforce practices. Please answer each question as accurately as possible. If you do not understand a question, answer it as well as you can and note your question(s) in the margin. Your answers will be kept confidential and will not affect your status as an employee at our organization. When you have completed this survey please return it in envelope provided. If you have questions, you can contact PI Department. Thank you.

• Opinion Questionnaire. Please rate your work at our organization in the following areas. Circle the number under the word that most closely describes your overall opinion of each item

<table>
<thead>
<tr>
<th>Orientation and Training</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Availability of a clear job description for your position.</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Communication of expectations about your job performance.</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Completeness and timeliness of orientation about our organization in general and your workplace in particular.</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sufficient training materials and training opportunities to allow you to perform your job well.</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Availability of follow-up training.</td>
<td>0 1 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Availability of a supervisor to answer your questions and to assist you to carry out your duties.</td>
</tr>
<tr>
<td>7. Feedback and evaluation regarding your performance.</td>
</tr>
<tr>
<td>8. Recognition by your Supervisor for your accomplishments.</td>
</tr>
<tr>
<td>9. Fairness in supervision and employment opportunities.</td>
</tr>
<tr>
<td>10. Relationship with your Supervisor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compensation and Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Do you get your salary in time?</td>
</tr>
</tbody>
</table>
12. Your rate of pay for your work. | 0 | 1 | 2
13. You receive money for overtime work. | 0 | 1 | 2
14. Hospital Policy regarding medical insurance for staff is fair. | 0 | 1 | 2
15. The hospital policy regarding vacations is fair and satisfying. | 0 | 1 | 2
16. Are you satisfied with your present accommodation? | 0 | 1 | 2

**Other Aspects of Your Experience**

17. The organization accurately, depicts mission and vision statement. | 0 | 1 | 2
18. Opportunities to share your ideas about improving the services provided: “My opinion counts...” | 0 | 1 | 2
19. Your schedule’s flexibility. | 0 | 1 | 2
20. Opportunities for ongoing professional development. | 0 | 1 | 2
21. Degree to which your skills are used. | 0 | 1 | 2
22. Morale in your office or program. | 0 | 1 | 2
23. Relationship with your co-employees | 0 | 1 | 2
24. Attitude of patient and families towards our organization. | 0 | 1 | 2
25. Do you enjoy working in the department you presently are working in. | 0 | 1 | 2
26. Someone at work encourages my development and I have the opportunities to learn and grow. | 0 | 1 | 2
27. I find my work rewarding. | 0 | 1 | 2

**Departmental Interaction**

28. Did you receive accurate information about your job or the hospital from the recruitment agency? | 0 | 1 | 2
29. Do you get assistance from the computer department in the time you require? | 0 | 1 | 2
30. Do you get the service you require from the employee centre in time? | 0 | 1 | 2
31. Do you get the service you require from governmental public relations office in time? | 0 | 1 | 2
32. Do you find supportive services department (Accommodation, transportation, laundry, catering, house keeping), giving you the support you expect when you need? | 0 | 1 | 2
# General Measurement framework for key areas of healthcare

## Well-being baby assessment form

**USE ONE SIDE OF THIS SHEET ONLY**

**FILE NO**

**NAME:**

**SEX:**

**AGE:**

**WEIGHT:**

**NATIONALITY:**

**CASH/COMPANY:**

**DOCTOR’S ORDER SHEET**

UNLESS CHECKED HERE, I AUTHORIZED THE USE OF FORMULARY EQUIVALENTS AS PROVIDED FOR BY THE PHARMACY AND THERAPEUTICS COMMITTEE OF THIS HOSPITAL

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Checked</th>
<th>Well Baby Standing Order</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number 1.</strong></td>
<td>Keep baby warm under overhead warmer, monitor temperature.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 2.</strong></td>
<td>Check baby coming from L&amp;D, confirm Konakion injection 1 mg IM (Vit. K) was given &amp; antibiotic eye drops was instilled.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 3.</strong></td>
<td>Check HGT on admission for low birth weight or large for date (&lt;2.5 kg. and &gt; 4 kg.) or IDM then follow instructions of PPG for hypoglycemia.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 4.</strong></td>
<td>Check HGT after 2 hours, and then give distilled water or D/W 5% 5-10 ml orally. If tolerated well, ask mother to breast feed her baby and complete with milk formula (ready to feed) as tolerated every 3 hrs.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 5.</strong></td>
<td>Check V/S every 2 hr. For 6 hr. then 4 hr.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 6.</strong></td>
<td>Observe for abnormal signs: lethargy, poor feeding, apnea, cyanosis, twitching, abdominal distension, vomiting, sweating, pallor, voiding urine, and passing meconium.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 7.</strong></td>
<td>Do Hb, Hct, blood group and Rh (G6PD, sickle cell test if positive family history) from cord blood or heel prick.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 8.</strong></td>
<td>Do T4 - TSH before discharge.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 9.</strong></td>
<td>Give BCG 0.1 ml ID, Hepatitis B vaccine 0.5 ml IM, 1st dose in the NICU/ MATERNITY after initial examination.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 10.</strong></td>
<td>Transfer to Maternity nursery 4 hours after birth</td>
<td></td>
</tr>
<tr>
<td><strong>Number 11.</strong></td>
<td>Remove umbilical cord clamp after 48 hours if completely dry according to age.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 12.</strong></td>
<td>If clinically jaundiced obtain bilimeter reading and if reading is clinically significant on the first day or second day or therefore, do total bilirubin as per PPG (bilimeter should be calibrated monthly).</td>
<td></td>
</tr>
<tr>
<td><strong>Number 13.</strong></td>
<td>For male infant, do bleeding and clotting time &amp; inform surgeon on call in OR once the consent has signed by the father and witnessed.</td>
<td></td>
</tr>
<tr>
<td><strong>Number 14.</strong></td>
<td>Mother with HBsAG positive test, give specific HEPA B immunoglobulin 0.2 ml /kg IM/IV (according to brand), in the 1st 24 hours after birth with HEP. B vaccination 0.5 ml. LM.</td>
<td></td>
</tr>
</tbody>
</table>

**Nurse’s signature:**

**Doctor’s signature:**

---

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Surgical case review data collection sheet

MR# _______________   Primary diagnosis ______________

Admission Date: _________________ Discharge Date: ________________

Date of Surgery:___________________

Procedure:_______________________

Type of Surgery: ________________ Surgeons: ________________

Criteria:                              Yes  No  N/A

1. Preoperative and postoperative diagnoses are the same: ______  ______

Selecting Appropriate Procedure:

2. There is a note present indicating the reason for surgery. ______

3. Patient’s physical status assessed prior to procedure ______

4. Diagnostic data is documented in medical record prior to procedure. ______

5. Written operative note contains description of findings, preoperative diagnosis, procedure(s), specimen(s) removed, post op diagnosis, name of primary surgeon and assistants. ______

Preparing the Patient:

6. An informed consent is completed prior to the procedure. Which includes documentation of risks/benefits discussed with patient/parent and the need and risk of blood transfusion. ______

7. Plan for level of post procedural care is documented in the medical record. ______

8. Preoperative nursing record completed prior to procedure. ______
Providing Post Procedure Care/Monitoring the Patient:

9. a. Estimated blood loss > 10cc/kg within 24 hours of surgery. 
   b. For resections, EBL > 15cc/kg within 24 hours of surgery 
   c. Estimated blood loss > 20cc/kg within 24 hours of surgery.

Performing the Procedure/Monitoring the Patient:

10. For Bone Marrow Harvests: 
    a. The patient's (6 hour) post-operative Hgb was: 
       < 8.5 g/dl for an autologous transplant patient 
       < 10 g/dl for a normal donor. 
    b. An adequate amount of bone marrow is obtained. 

11. Delayed insertion of chest tube (thoracoscopy) 
    determined by x-ray illustration of increase in pneumothorax. 

12. Necessity for conversion to open procedure. 

13. Failure to obtain adequate material for biopsy. 

Providing Post Procedure Care:

14. Return to surgery within 14 days, related to initial surgery. 

15. Post operative nursing care is in accordance with the nursing standards. 

16. Wound infection within 30 days of surgery. 

17. Neurological deficit or organ failure not present prior to surgery (within the same admission). 

18. Death, within the same admission. 

Comments:

QI reviewer: ___________________ Date of review: ____________
**Preoperative cardiology evaluation form**

Dear Colleague, (Consultant Cardiologist On Call), please evaluate this cardiac patient scheduled for ___________________________ to determine the following.

I. Primary Diagnosis:

II. Secondary Diagnosis:

III. Hemodynamic Stability: □ stable □ unstable

IV. Cardiac risk: □ Low □ Moderate □ High

V. Current Medication:  
- β
- β

VI. Investigations:  
- β ECG:  
- β Stress ECG:  
- β Echo:  
- β Cardiac Catheterization:

VII. Required additional medication prior to surgery:

VIII. Required additional investigation prior to surgery:

IX. Co-Morbid Disease:  
- □ DM  
- □ HTN  
- □ Renal Disease  
- □ Hepatic Disease  
- □ Others

Cardiologist: ________________ Signature: ________________

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# PAIN ASSESSMENT

Doctors as well as nurses should do pain assessment. Assessment differs from adults and pediatrics.

1.0 Clinical assessment includes the location, severity, (use of pain score) radiation, duration, frequency, characteristics, precipitating factors, alleviating and allergy status.

2.0 Score Assessment

   2.1 Pediatrics: Pain rating scale

   2.2 Adults: Visual analog pain score that states pain score form 0-10 according to pain severity experienced by the patient

      2.2.1 0 – no pain; 10 – most severe pain

      2.2.2 Verbal Rating Scale

      2.2.3 use of word descriptors (none, mild, discomforting, distressing, horrible, excruciating)

      2.2.4 limited by choice of words

      2.2.5 sensitive to gender and ethnic differences

      2.2.6 may be superior to Visual Analog Scale in assessing effects of analgesics on acute pain

Assessment should be done upon admission of the patient and after analgesic injection after 30 minutes and according to clinical demand.
Visual Analog Scale

2.1 single dimension scale
2.2 in adults, horizontal = vertical
2.3 valid in ages > 7 years
2.4 failure rate = 7%
2.2.1 Verbal Rating Scale and Visual Analog Scale

---

**Simple Descriptive Pain Intensity Scale**

No pain | Mild pain | Moderate pain | Severe pain | Very severe pain | Worst possible pain

---

**0–10 Numeric Pain Intensity Scale**

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10

No pain | Moderate pain | Worst possible pain

---

**Visual Analog Scale (VAS)**

No pain | Pain as bad as it could possibly be

---

1 If used as a graphic rating scale, a 10 cm baseline is recommended.
2 A 10-cm baseline is recommended for VAS scales.
## OBJECTIVE PAIN SCALE OPERATIONAL DEFINITIONS

### Pediatric Patients

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Score</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood Pressure</strong> (Systolic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;= 10% preop</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>&lt; 10-20% preop</td>
<td>.5</td>
<td></td>
</tr>
<tr>
<td>&gt;20% preop</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Crying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not crying</td>
<td>0</td>
<td>Awake and not crying or asleep</td>
</tr>
<tr>
<td>Crying but responds to TLC</td>
<td>.5</td>
<td>Crying is controlled by being touched, reassurance or being held by nurse/parent</td>
</tr>
<tr>
<td>Crying; does not respond to LC</td>
<td>1</td>
<td>Crying uncontrollably. Measures to comfort child are unsuccessful.</td>
</tr>
<tr>
<td><strong>Movement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>Asleep or if patient is awake, lying or playing quietly.</td>
</tr>
<tr>
<td>Restless</td>
<td>.5</td>
<td>Child unable to sit or lie still. Frequent position changes. No threat of self-harm.</td>
</tr>
<tr>
<td>Thrashing</td>
<td>1</td>
<td>Child kicking and /or squirming. Potential for self-harm. Has to be protected or restrained for safety.</td>
</tr>
<tr>
<td><strong>Agitation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asleep or calm</td>
<td>0</td>
<td>Asleep or awake and calm</td>
</tr>
<tr>
<td>Mild</td>
<td>.5</td>
<td>Tense, voice quivering. Responds rationally to questions and/or responds to attempts to console.</td>
</tr>
<tr>
<td>Hysterical</td>
<td>1</td>
<td>Does not appear rational; eyes wide. May be clinging to nurse/parent. Does not respond to attempts to console.</td>
</tr>
<tr>
<td><strong>Verbal Evaluation or Body Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep or states no pain (preverbal child – no special posture)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mild pain or cannot localize preverbal child – (flexing extremities)</td>
<td>.5</td>
<td>Complains of general feeling of discomfort, but unable to describe location of pain, or states pain is mild in nature. Legs drawn up. Arms may be folded across body.</td>
</tr>
<tr>
<td>Moderate pain and can localize Preverbal child – (holding location of pain)</td>
<td>1</td>
<td>Complains of pain that is bothersome and is able to point to or describe location of pain. Holding, guarding, or touching location of pain. Infants with legs drawn up, fists clenched.</td>
</tr>
</tbody>
</table>

**PEDIATRICS OBJECTIVE PAIN SCALE**
## Operational Definitions For Neonatal Pain Assessment Scale

<table>
<thead>
<tr>
<th></th>
<th>Score</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sleep</strong></td>
<td></td>
<td><strong>Score</strong></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>Awake continuously.</td>
</tr>
<tr>
<td>Short naps</td>
<td>0.5</td>
<td>Sleeps quietly and rests peacefully only 5-10 minutes out of an hour.</td>
</tr>
<tr>
<td>Longer naps</td>
<td>0</td>
<td>Sleeps quietly and peacefully more than 10 minutes out of an hour.</td>
</tr>
<tr>
<td><strong>Facial Statement of Pain</strong></td>
<td></td>
<td><strong>Score</strong></td>
</tr>
<tr>
<td>Marked, constant</td>
<td>1</td>
<td>A continuous facial grimace.</td>
</tr>
<tr>
<td>Less marked, intermittent</td>
<td>0.5</td>
<td>An occasional frown or grimace.</td>
</tr>
<tr>
<td>Calm, relaxed</td>
<td>0</td>
<td>Restful, neutral facial statement.</td>
</tr>
<tr>
<td><strong>Spontaneous motor activity</strong></td>
<td></td>
<td><strong>Score</strong></td>
</tr>
<tr>
<td>Thrashing, incessant agitation or no activity</td>
<td>1</td>
<td>Frequent gross motor movements of arms, legs, and/or torso. Does not readily respond to comfort measures OR no spontaneous movement.</td>
</tr>
<tr>
<td>Moderate agitation or decreased activity</td>
<td>0.5</td>
<td>Occasional gross motor movements of arms, legs, and/or torso. Responds to comfort measures OR diminished activity for this patient.</td>
</tr>
<tr>
<td>Normal</td>
<td>0</td>
<td>Usual activity pattern for this patient.</td>
</tr>
<tr>
<td><strong>Overall tone</strong></td>
<td></td>
<td><strong>Score</strong></td>
</tr>
<tr>
<td>Rigid or flaccid</td>
<td>1</td>
<td>Rigid extension or flexions of arms, legs, and/or torso; fingers are lightly clenched in fists, toes curled in tight flexion. OR lack of tone with flaccid extension of extremities.</td>
</tr>
<tr>
<td>Moderately tensed or decreased tone</td>
<td>0.5</td>
<td>Tense extension of flexion of arms, legs, and/or torso. Fingers may be splayed or flexed, toes flexed, OR diminished tone for this patient.</td>
</tr>
<tr>
<td>Normal/relaxed</td>
<td>0</td>
<td>Unusual tone for this patient.</td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
<td></td>
<td><strong>Score</strong></td>
</tr>
<tr>
<td>None after 2 minutes</td>
<td>1</td>
<td>After 2 minutes of comfort measures, the patient remains fussy, agitated, and awake.</td>
</tr>
<tr>
<td>None after 1 minute</td>
<td>0.5</td>
<td>Quiets after 1 minute of comfort measure and remains quiet until pain assessment if left undisturbed.</td>
</tr>
<tr>
<td>Quiet within 1 minute</td>
<td>0</td>
<td>Immediately responds to comfort measures and remains calm and quiet until next pain assessment if lefty undisturbed.</td>
</tr>
<tr>
<td><strong>Cry</strong></td>
<td></td>
<td><strong>Score</strong></td>
</tr>
<tr>
<td>Vigorous cry/silent cry</td>
<td>1</td>
<td>Crying loudly and continuously (does not respond to comforting) OR intubated infants with obvious facial and oral movements associated with crying.</td>
</tr>
<tr>
<td>Whimper</td>
<td>0.5</td>
<td>Intermittent moaning, sobbing, OR intubated infants with evidence of crying.</td>
</tr>
<tr>
<td>No cry</td>
<td>0</td>
<td>Quiet, but responsive to care giving activities.</td>
</tr>
<tr>
<td><strong>Heart Rate</strong></td>
<td></td>
<td><strong>Score</strong></td>
</tr>
<tr>
<td>&gt;20% increase</td>
<td>1</td>
<td>&gt;20% increases in heart rate over baseline assessment.</td>
</tr>
<tr>
<td>10-20% increase</td>
<td>0.5</td>
<td>10-20% increase in heart rate over baseline assessment.</td>
</tr>
<tr>
<td>Within baseline</td>
<td>0</td>
<td>Heart rate is consistent with normal baseline range for this patient.</td>
</tr>
<tr>
<td><strong>Systolic Blood Pressure</strong></td>
<td>1</td>
<td>&gt;10mmHg increase in systolic blood pressure over baseline assessment.</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>&gt;10mmHg increase</td>
<td>0.5</td>
<td>10mmHg increase in systolic blood pressure over baseline assessment.</td>
</tr>
<tr>
<td>10mmHg increase</td>
<td>0</td>
<td>Systolic blood pressure is consistent with normal baseline range for this patient.</td>
</tr>
<tr>
<td>Within baseline</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Respiratory Rate &amp; Frequency</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tachypnea /splinting</td>
<td>1</td>
<td>&gt;40% increase in respiratory rate over baseline OR splinting may result in apnea.</td>
</tr>
<tr>
<td></td>
<td>0.5</td>
<td>&gt;20% increase in respiratory rate over baseline.</td>
</tr>
<tr>
<td>Tachypnea</td>
<td>0</td>
<td>Respiratory rate and pattern normal for this patent.</td>
</tr>
<tr>
<td>Within Baseline</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Oxygen Saturation</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 10% increase in F1O₂</td>
<td>1</td>
<td>Requires &gt; 10% increase in F1O₂ to maintain oxygen saturation within prescribed limits.</td>
</tr>
<tr>
<td>≤10% increase in F1O₂</td>
<td>0.5</td>
<td>Requires up to a 10% increase in F1O₂ to maintain oxygen within prescribed limits.</td>
</tr>
<tr>
<td>No increase in F1O₂</td>
<td>0</td>
<td>Requires no increase in F1O₂</td>
</tr>
</tbody>
</table>

**NEONATAL PAIN ASSESSMENT SCALE**
Medical Record Review Form

Medical Record Number: ______________ Type of Chart: __________
Discharge Date: ________________ Physician: _______________

<table>
<thead>
<tr>
<th>Medical Record Review Form</th>
<th>Documentation Is Present</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Indicators</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Upper GI Endoscopy:</strong></td>
<td></td>
</tr>
<tr>
<td>History and Physical with pertinent medical history</td>
<td></td>
</tr>
<tr>
<td>√ Physician documentation of current meds</td>
<td></td>
</tr>
<tr>
<td>√ Physician documentation of allergies</td>
<td></td>
</tr>
<tr>
<td>√ Physician documentation of informed consent</td>
<td></td>
</tr>
<tr>
<td>Procedure report dictated within 24 hours</td>
<td></td>
</tr>
<tr>
<td>Patient monitoring/care</td>
<td></td>
</tr>
<tr>
<td>Post-procedure patient education</td>
<td></td>
</tr>
<tr>
<td>No adverse or unusual event post-procedure</td>
<td></td>
</tr>
<tr>
<td>Paul Gann Blood Act Compliance</td>
<td></td>
</tr>
<tr>
<td><strong>Bronchoscopy</strong></td>
<td></td>
</tr>
<tr>
<td>History and physical dictated prior to procedure</td>
<td></td>
</tr>
<tr>
<td>Physical documentation of current meds</td>
<td></td>
</tr>
<tr>
<td>√ Physician documentation of current allergies</td>
<td></td>
</tr>
<tr>
<td>√ Physician documentation of informed consent</td>
<td></td>
</tr>
<tr>
<td>√ Op report dictated within 24 hours</td>
<td></td>
</tr>
<tr>
<td>Patient monitoring/care</td>
<td></td>
</tr>
<tr>
<td>√ Post-procedure patient education</td>
<td></td>
</tr>
<tr>
<td>√ No adverse or unusual event post-procedure</td>
<td></td>
</tr>
<tr>
<td><strong>C-Sections:</strong></td>
<td></td>
</tr>
<tr>
<td>√ Surgical history and physical dictated prior to surgery</td>
<td></td>
</tr>
<tr>
<td>√ Physical documentation of informed consent</td>
<td></td>
</tr>
<tr>
<td>√ Op report dictated within 24 hours</td>
<td></td>
</tr>
</tbody>
</table>

**Nursing inspection guide: monthly inspection**
Hospital: ______________
Nursing Unit: __________
Department: ____________
Time: _________

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled drugs are secured and documented.</td>
<td></td>
</tr>
<tr>
<td>Emergency drugs in proper supply and location.</td>
<td></td>
</tr>
<tr>
<td>No expired items are present.</td>
<td></td>
</tr>
<tr>
<td>A first-in, first-out system are used.</td>
<td></td>
</tr>
<tr>
<td>All medications, including oral liquids ophthalmic medications, multidose injectable, nasal preparation and inhalation solution are dated when opened and discarded after 30 days in ophthalmic 7 days in inhalation or sooner if directed.</td>
<td></td>
</tr>
<tr>
<td>Antiseptics. Disinfectants and drugs for external use are stored separately from oral and injectable medicines.</td>
<td></td>
</tr>
<tr>
<td>Thermometers are used and temperature results are monitored and recorded twice daily.</td>
<td></td>
</tr>
<tr>
<td>Refrigerated drugs are stored at 2-8 C and frozen drugs are stored at 20 to 10C.</td>
<td></td>
</tr>
<tr>
<td>All drugs are returned to pharmacy after discontinuation or patient’s discharge.</td>
<td></td>
</tr>
<tr>
<td>All medicines are properly labelled.</td>
<td></td>
</tr>
<tr>
<td>Food is not stored in medication refrigerators.</td>
<td></td>
</tr>
</tbody>
</table>

Notes and comments as a result of discussion of inspection with nurse in charge.

_____________________________________________________________
_____________________________________________________________

Nurse (Signature)                                                        Pharmacist (Signature)
ID#:                                                                             ID#: 
Indicators

What is an indicator?

An indicator is a quantitative measure that can be used as a guide to monitor and evaluate the quality of important patient care and support services activities. Quality indicators are not direct measures of quality but they are pointers that indicate potential problems areas for further management.

Why to develop indicators?

Indicators answer following questions
• Are we doing the right things?
• Are we doing them in the right way?
• Are we staying within cost?

Functions of indicators:

Indicators:
• Help to understand the variation that exist in process
• Monitor a process over a time frame
• Show the effect of a change in process
• Provide a common reference point

Developing indicators:

Consider:
• They must be related to patient care activities directly or indirectly.
• What key quality characteristics (process/outcome) do they measure?
• What is the rationale of this indicator?
• What is the specific name?
• List the department to which this indicator applies

Operationalizing indicators and data collection:

Consider:
• Writing down operational definitions
• Describing data collection plans
• Setting control baseline data figures
• Defining a target/goal
• Describing the analysis plan
• Describing data reporting plan

The United States uses various indicator programs to monitor quality of care, and to ensure external accountability and reporting. Some dimensions in selecting indicators are the followings:

1-Access to care: This reflects the ease of being examined and evaluated for a health problem in a timely manner. Most organizations decide to measure emergency unit waiting times, waiting times in outpatient departments, and access to critical care beds to assess the access of care.

2-Clinical care: This refers to technical proficiency or, in other words, treatment complications. Different programs recommend that categories and indicators for clinical care be approached in a variety of ways. They advocate a focus on the key dimensions of existing clinical practice in the hospital, and state that all indicators should be selected with careful consideration, after consultation with expert clinicians. Following these guidelines, and choosing a set of indicators based on discussions with groups of experts from each hospital department is highly recommended. Different critical care indicators can be monitored in a computerized system and experts from each unit/department identify additional indicators that they feel should be included based on department-specific demands and needs.

3- Appropriateness of care: This pertains to the potential benefit compared to the potential harm of a given treatment. Standardized utilization rates for some specific procedures are selected as indicators in most acute hospitals.

4-Safety of care: To assess safety, health professionals focus on the numbers of hospital-acquired infections and on other findings in hospital-wide incident reports.

5-Effectiveness of care: In this area, usually investigated are the overall mortality in a health care facility, selected mortality rates and the numbers of re-admissions and/or unscheduled returns associated with certain diseases, among with some other indicators.

6-Continuity of care: Essential indicators identified for this purpose are discharge protocols and the discharge process.
7-Satisfaction with care: To assess this area, certain parameters derived from surveys are used as indicators and the rates of patient complaints are also taken into consideration.

8-Organizational management: A number of efficiency measures are used here along with parameters derived from internal customer satisfaction surveys and staff turnover rates.

Illustrations

Performance Improvement Report:

Part 1: performance measurement plan and findings

<table>
<thead>
<tr>
<th>Department</th>
<th>Team Name:</th>
<th>Other departments/ or teams involved:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Year: Submitted by:  
Date Initiated: Date Discontinued:

Measurement Plan

<table>
<thead>
<tr>
<th>Performance Improvement Measure #:</th>
<th>Submit to Hospital Administration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

*Note: Complete one form for each performance measure

Function:  
Dimensions of performance: □ Efficacy □ Appropriateness □ Availability  
□ Timeliness □ Effectiveness □ Continuity □ Respect and Caring  
□ Safety □ Efficiency

Method of data collection: Sample size:  
□ Retrospective □ Concurrent

Age specific:  
□ Yes □ No

Frequency of Data Assessment: □ Monthly □ Quarterly □ Every other quarter □ Other:

Rationale for choice of performance measure:  
Goal or Anticipated outcome:

Data Aggregation Findings:

<table>
<thead>
<tr>
<th>Performance Measure:</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total/Average</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance measure source:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

159
<table>
<thead>
<tr>
<th>Numerator</th>
<th></th>
<th></th>
<th>Denominator</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benchmark or Threshold:</strong></td>
<td>Benchmark/ Rate: Threshold Source:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Part II: Analysis and Plan for improvement for Performance Measure #:**

<table>
<thead>
<tr>
<th>DATE</th>
<th>Summary of Problem/s Identified Or Opportunity For Improvement</th>
<th>Plan of Action (Plan-Determine What Needs To be done. And Create A Plan for Achieving That goal.) (Act-Modify Or revise the Plan to Improve Performance</th>
<th>Individual Responsible For Actions</th>
<th>Date And Description Of Implementation Of plan (Do- Put The plan into Action)</th>
<th>Evaluation Of Implemented Plan (Check-Evaluate/ Re-evaluate The Effectiveness Of The plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

160
Performance Improvement: Departmental Scope of Care:

Department: _____________________________________________
Revision/Revision Date: ________________________________

The scope of care for this department includes the following:

Types of patients served (consider major age or disability group):
________________________________________________________________________
________________________________________________________________________

Range of conditions and diagnoses treated:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Range of treatments or activities performed (e.g., procedures performed, frequently used medications, as well as activities other than direct patient care)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Types of staff carrying out these activities (e.g., physicians, nurses, technicians, etc…)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Sites where care and service are provided (e.g., inpatient vs. outpatient settings, department, nursing unit, etc…)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Times when care and service are provided (e.g., shifts, weekdays, 24 hour service).
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Assignment of Responsibility:
Responsibility for identifying indicators is assigned to: _____________
Responsibility of collecting data is assigned to: _____________
Responsibility for evaluating care (analyzing data) is assigned to: ___________
Responsibility for taking actions to improve care is assigned to: ____________

Department Manager: ________________________
Implementing and Sustaining an Effective Quality Program

An effective quality improvement (QI) program is one in which QI is viewed as an organization-wide philosophy, rather than as an independent function. Developing staff so that they view QI as an ongoing part of the way they perform their job duties everyday is key to the success of the program. This buy-in to the QI philosophy can yield significant improvements in the efficiency and efficacy of the care delivery system.

Dr. Donald Berwick, world renowned for his expertise in healthcare quality, uses the comparison of two differing management approaches to describe how to lead an effective healthcare QI program. The first method is known as the *Theory of Bad Apples*, which subscribes to the “quality by inspection” mindset, relying on the discovery and removal of “bad apples” in an attempt to achieve quality results. The focus is on identifying outliers and assigning blame rather than on objectively analyzing the service delivery processes in order to improve performance. In contrast, the *Theory of Continuous Improvement* seeks to identify process defects which result in suboptimal performance. These defects are viewed as “treasures” that pinpoint critical junctures in the service delivery process which can be improved. A philosophy of continuous quality improvement (CQI) is anchored by a consistent and objective process for collection, aggregation and analysis of data. Teamwork is the hallmark of the CQI framework.

Leadership is unarguably critical to the success of a QI program. Dr. Stephen Covey describes principle-centred leaders as those who possess the following characteristics:

1. Seek continuous learning, both experiential and academic
2. Are service oriented, viewing life as a mission, rather than a career or job
3. Radiate positive energy, optimistic and enthusiastic
4. Believe in other people and their unseen potential, which promotes a climate for growth and opportunity
5. Lead balanced lives, remaining active physically, intellectually, socially and able to set appropriate priorities
6. View life as an adventure, an attribute that is a natural fit for the CQI philosophy
7. Are synergistic, acting as change catalysts who optimize the strengths and minimize the weaknesses of other members of the team
8. Exercise for self-renewal by taking time to meet mental, emotional, and spiritual needs

The Leadership team must establish a strategic plan with clearly defined and cohesive goals which support the Organization’s mission and
vision. Communication is pivotal to the success of this process. However, simply having a strong group of individuals possessing the core attributes of effective leaders cannot sustain an effective QI program unless a solid infrastructure is in place.

First on the list of things to consider is the composition of the healthcare organization’s quality oversight committee. Clearly, senior management must be represented. The multidisciplinary team should represent a cross-section of the key players in the care delivery system. This would include nursing leadership, clinical support departments (e.g. pharmacy, laboratory, rehabilitative services, medical records), as well as, members of the medical staff. If the Organization’s Chief Executive Officer chairs the committee, or if this individual co-chairs with the Chief of Staff, the tone is set for the entire organization regarding the priority placed upon quality-related activities. This committee must have action-taking authority if the program is to achieve the goals established by the Organization.

Once membership has been determined, the frequency of the committee meetings should be established. Meeting at least once per month should provide ample time for review of reports, analysis of findings, and decision-making. Adoption of a standardized template for taking meeting minutes to document the committee’s findings, conclusions, recommendations, actions, and follow-up will prompt the recorder to document all aspects of the committee’s quality analysis process (Attachment 1). It is important to keep an attendance record, as well, so that Administration can monitor accountability of the committee members.

All quality activities throughout the Organization must be driven by a well developed organization-wide quality plan. This document should:

- State the purpose of the plan.
- List guiding statements, such as the mission and/or vision statement(s) of the Organization.
- Delineate the scope of the program, to include both the customers being served and all components of the care delivery system included in the plan.
- Delegate oversight responsibility.
- Define goals and objectives of the QI program.
- Assign roles and responsibilities of the various levels and departments of the Organization.
- List dimensions of performance being measured.
- Discuss the process for prioritization of QI activities.
- Describe the program’s structure.
• List the pre-established quality activities, based upon identification of high volume/high risk/problem prone procedures, in addition to those measures which are required by governing, regulatory, or accrediting bodies.

• Describe the Organization’s performance improvement methodologies and the statistical tools to be used in the data analysis processes.

• Address the process for annual evaluation of the program’s effectiveness.

The plan should be reviewed and approved by Administration, medical staff leadership and the governing body. The effectiveness of the plan should be evaluated at least annually. Once the plan has been evaluated, an updated plan should be developed for the upcoming year. Processes still in need of improvement should be carried over into the next year. New initiatives should be added based upon consideration of problem-prone or high risk processes, new regulatory or accrediting agency requirements, or the need to monitor issues such as the addition of new services being offered by the Organization (e.g. the addition of a high-risk specialty such as neurosurgery).

Establishing a reporting calendar is another essential piece of the framework (Attachment 2). This will serve as a means to clearly define each department’s accountability, as well as, facilitate timely reporting. Publishing the reporting calendar each year and sending reminders to departments the month prior to the reports being due will help to promote a positive relationship with the quality department. Reminders the month prior to data/reports being due will allow time for assistance, if needed, with analysis of data and report development. This can also serve as a team-building activity. Encouraging participation in the QI program by providing adequate support and time for reporting sets a positive tone for the program. If staff members feel harassed or are embarrassed by having missed a deadline for reporting, they are not likely to buy into the quality program. It is important that the quality department be viewed as a support to the service delivery areas, rather than as having a police-like function.

The quality committee meetings must be conducted in a consistent and efficient manner in order to maximize the productivity of the team. The discussion should be agenda-driven, with attention first being given to review of the previous meeting’s minutes and discussion of old business items which required follow-up. New business should include regular reports which are due per the reporting calendar, as well as, any other issues identified which are in need of the committee’s attention. An example of this could be that there has been an increase noted in patient complaints or, perhaps, a department is having trouble gaining cooperation from another department which has had a negative impact on the department’s efficiency.
There will, also, need to be some time left for members to discuss other business items that may have arisen after the agenda was developed (Attachment 3). In the interest of time, it is helpful if the previous meeting’s minutes can be sent out prior to the actual meeting for review by committee members. The old business, new business, other business layout is representative of the organization’s continuous improvement culture.

The quality committee may soon find that there are more things in need of improvement than are feasible to address at one time. Use of a prioritization matrix allows the committee to evaluate the impact of the issues at hand and determine which ones are most critical to the organization’s service delivery. This process involves establishment of criteria which are used to rank the issues in an objective manner. A well-defined process for prioritization will help gain consensus of the group (Attachment 4). Criteria utilized in this ranking process may include such factors as:

- Patient safety
- Quality of care
- Patient outcomes
- High volume/high risk processes
- Patient, staff or physician satisfaction
- Finances
- Accrediting or regulatory requirements
- Risk management
- Mission/vision of the Organization
- House-wide versus department-specific impact

Development of a uniform reporting format is important to the efficiency of the committee. If departments are using standard formulas for calculations and consistent tracking and reporting, benchmarking and comparative data analysis will be possible. Setting up a spreadsheet that lists the indicators, goals, and a grid for monthly data entries allows for a relatively easy-to-read view (Attachment 5).

The quality committee has the responsibility to monitor the performance of departments and teams and make recommendations, as appropriate, if the activities related to the monitoring and evaluation are not effective. The committee is ultimately responsible for ensuring that improvements are sustained. It is extremely important for the committee to be viewed as a resource for individuals or departments in need of assistance in achieving goals, allocation of resources to do the same, or help with leveraging participation from pertinent areas.
For those organizations interested in meeting Joint Commission International accreditation standards, it is a good practice to include the dimensions of performance and chapters being addressed by the indicators on the spreadsheet, as well. It is a nice way to package the report so that it is easy for a surveyor to see that attention was given to the standards when selecting performance indicators. Dimensions of performance provide a description of what specific aspect of the process is being monitored and include:

1. Efficiency – relationship between the resources used to provide care and the outcomes of the care delivery
2. Efficacy – degree to which the services accomplished the desired outcomes
3. Appropriateness – degree to which services are relevant to the patient’s needs
4. Safety – degree to which the services are delivered such that the risks to the patient and staff are reduced
5. Timeliness – degree to which services are provided within an appropriate timeframe
6. Continuity – degree to which patient care is coordinated among disciplines, levels of care, or other facilities
7. Effectiveness – degree to which services delivered meet desired outcomes
8. Respect and caring – degree to which providers of services do so with respect for the patient’s individual needs and expectations, as well as, the degree to which the patient is involved in decisions pertaining to their care

Overall a separate quality department typically accomplishes day-to-day coordination of the quality committee and QI activities. The quality specialist positions are often filled by registered nurses with several years of clinical experience, although this function can be performed by other clinical disciplines, as well. Whomever the Organization assigns the duty of pulling together the house-wide quality activities must have good organizational skills, attention to detail, and a hardy demeanor, as this can often be a daunting task.

Communication of information pertaining to the Organization’s quality improvement activities is key to an effective program. It is very beneficial for reports of department-specific quality activities and house-wide initiatives to be discussed at departmental staff meetings. Hospital and medical staff leadership should receive regular reports. Provision of education pertaining to the overall quality program and quality improvement methodologies is essential in maintaining a viable, ongoing program. This
includes the need to educate the governing body, leadership, management, and front-line staff members.

Many organizations have found it helpful to organize an annual educational fair for staff that covers information on quality, plus updates on patient safety issues and any new accrediting or regulatory requirements. If the fair is designed to be both educational and enjoyable to the staff, the participation level and positive impact of the education will increase. Staff members often enjoy such activities as drawings for prizes and games. Having small items to give away at the various education booths makes for an enjoyable time. Setting up attractive booths to cover each topic tends to encourage staff members to interact with one another, reviewing the content of the material, with shared problem-solving and discussions. These opportunities to collaborate and interact in a quality setting will help to sustain a culture of quality.
## ATTACHMENT 1

FCRAF Meeting Minute Template

**ORGANIZATION NAME**

Committee Name  
**MEETING MINUTES**  
Meeting Date  
Meeting Time  
Meeting Location

<table>
<thead>
<tr>
<th>MEMBERS PRESENT:</th>
<th>Name-Title (include name of “Recorder”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBERS ABSENT:</td>
<td></td>
</tr>
<tr>
<td>GUESTS PRESENT:</td>
<td>(Identify guests here or state “None”)</td>
</tr>
</tbody>
</table>

**Packet Content Attachments:** Agenda, Minutes (state date here), list any other packet contents  
**Handout Attachments:** state any handouts here or state “None”

<table>
<thead>
<tr>
<th>TOPIC or AGENDA ITEM (mirrors the agenda)</th>
<th>FINDINGS/CONCLUSIONS</th>
<th>RECOMMENDATIONS /ACTIONS</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 CALL TO ORDER</td>
<td>The meeting was called to order at ______.</td>
<td>______________________</td>
<td>______</td>
</tr>
<tr>
<td>2.0 INTRODUCTION OF NEW MEMBERS OR GUESTS</td>
<td>If this applies, list new members or guests. If not, delete this section and move “Approval of Minutes” to this section. Do not re-introduce members each time. It clutters agenda and minutes unnecessarily.</td>
<td>Informational Item Only. No Action Required.</td>
<td>None Required</td>
</tr>
<tr>
<td>3.0 APPROVAL OF MINUTES</td>
<td>Meeting minutes for (date) were reviewed and approved as written OR “with the following corrections”:</td>
<td>Minutes were approved as written. OR “Quality Management Department will make the requested changes to the minutes. No further action required of this committee today.”</td>
<td>None Required</td>
</tr>
<tr>
<td>4.0 Old Business</td>
<td>If none, state “None” and delete 4.1, 4.2 etc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOPIC or AGENDA ITEM (mirrors the agenda)</td>
<td>FINDINGS/CONCLUSIONS</td>
<td>RECOMMENDATIONS/ACTIONS</td>
<td>FOLLOW-UP</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------</td>
<td>-------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>5.0 NEW BUSINESS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Topic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Topic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If none, state “None” here and delete 5.1, 5.2, etc.</td>
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________________________________________  ___________________  
Signature of Committee Chairperson                               Date
# ATTACHMENT 2 - Quality Reporting Calendar

Quality Council
2005 Reporting Calendar
( Page 1 of 2)

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**Other Reports**

*FMEA
*Root Cause Analysis
*Sentinel Event Alerts
**Annual PI Evaluation

*As indicated (at least one FMEA to be completed annually)
** Annual Quality Plan Evaluation reports include: Utilization Review, Risk Mgt, Operative and Invasive, Medical Staff Quality, Autopsies, Quality Controls, Environment of Care, Continuing Medical Education
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ATTACHMENT 3 - Agenda Template

ORGANIZATION NAME

State Meeting Date Here
State Meeting Time Here
State Meeting Location Here

AGENDA

1.0 CALL TO ORDER

2.0 INTRODUCTION OF NEW MEMBERS OR GUESTS

3.0 REVIEW OF PREVIOUS MEETING MINUTES - Date: / /20_

   3.1 Examples (for topics, refer to “Follow-up” column from previous meeting minutes and always identify person who will be speaking)  

4.0 OLD BUSINESS

   4.1 Examples (scheduled updates on previous reports or new issues to be discussed; time period for updated report – i.e. “2nd quarter, 2005”; identify person who will be reporting or speaking to the issue)

5.0 NEW BUSINESS

6.0 OTHER BUSINESS (topics that need to be discussed which were not known at the time the agenda was finalized)

7.0 ANNOUNCEMENTS

8.0 ADJOURNMENT
**ATTACHMENT 4 - Prioritization Matrix**

**Quality Improvement Prioritization Grid**

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<thead>
<tr>
<th>Satisfactory</th>
<th>Improve patient outcomes</th>
<th>Decrease risk</th>
<th>Patient Visitors</th>
<th>High volume/ high risk/ problem prone</th>
<th>Cost reduction</th>
<th>Meet regulatory/ accrediting requirement</th>
<th>Complex house-wide issue</th>
<th>Complex dept-specific issue</th>
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The project scoring the highest total points is considered for highest priority.
ATTACHMENT 5 – QI Spreadsheet Example

Quality Improvement Tracking Spreadsheet

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<th>Important Functions</th>
<th>Dimensions of Performance</th>
<th>V</th>
<th>R</th>
<th>P</th>
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Key:

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<th>Dimensions</th>
<th>Key</th>
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<td>AP = Appropriateness</td>
<td>V = High Volume</td>
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<tr>
<td>FMS = Facility Management and Safety</td>
<td>AV = Availability</td>
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<tr>
<td>SQE = Staff Qualifications and Education</td>
<td>CO = Continuity</td>
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</tr>
<tr>
<td>PCI = Prevention and Control of Infection</td>
<td>EC = Efficiency</td>
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<td>MOI = Management of Information</td>
<td>EF = Efficacy</td>
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<td>QPS = QI and Patient Safety</td>
<td>ET = Effectiveness</td>
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<tr>
<td>COP = Care of Patients</td>
<td>RC = Respect &amp; Caring</td>
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<td>AOP = Assessment of Patients</td>
<td>SA = Safety</td>
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<td>PFR = Patient and Family Rights</td>
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PFE = Patient and TM = Timeliness
Family Education
GLD = Governance,
Leadership and Direct.

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<th>Indicators</th>
<th>Goals</th>
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<td>JAN</td>
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</table>

N.B. The above two sections should be connected together to form one spreadsheet. They have been separated for lack of space availability.
REFERENCES


Mears Peter, Quality Tools and Techniques, McGraw-Hill, R.R.Donelly& Sons Company, United States of America,1995


6. Accreditation Standards

R. Seif, MS,
N. Maamari, MD, MPH

Accreditation is the formal evaluation of any organization (health related or not) according to accepted criteria or standards. A professional society, a non-governmental body, or a governmental agency may do it. Accreditation is the process by which a facility becomes officially certified as providing services of a reasonably good quality, increasing the public trust in the quality of its delivered services. This chapter discusses different aspects of accreditation standards: setting the standards; accreditation scoring system; quality improvement, infection control and other accreditation related plans; the NCQA guide for school based health centers and the URAC accreditation standards are also reported. The reader will be exposed to different accreditation standards setting scenarios, and will witness the tailoring of accreditation standards accordingly with the unique and different backgrounds in which they originated.

Accreditation Standards of Lebanese Acute Hospitals

The Lebanese Ministry of Public Health listed in December 2003 its second revised edition of accreditation standards and guidelines for acute hospitals in Lebanon. The initial standards were divided into two parts, basic standards and accreditation standards, both with corresponding guidelines. The revised standards are combined into one set of standards. Previously the guidelines were presented separately; in every instance now, they precede the set of standards for which they apply.

The guidelines, which were prescriptive in nature, are now written in a narrative form to allow for flexibility of interpretation. The paradigm of interpretative flexibility allows for the uniqueness of each hospital, their demographics, patient population and geographical positioning. However, as hospitals choose to demonstrate this flexibility, work activities, policies and procedures must be supported by current theories and practices as demonstrated by research. Policies and procedure must be hospital specific and commensurate with work practices.

The standards correspond to 38 hospital departments. It is not the intent of this chapter to describe all the standards. The following table...
illustrates the distribution of standards per department as they were listed by
the Lebanese ministry of public health:

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<tr>
<td>Nursing Administration</td>
<td>NA</td>
<td>16</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>OB</td>
<td>18</td>
</tr>
</tbody>
</table>
The 17 standards of the buildings department, retrieved from the following link: [http://www.public-health.gov.lb/BU.pdf](http://www.public-health.gov.lb/BU.pdf), will be used as an example for writing down, setting standards and making them a measurable entity:

This department refers to the physical structures of the hospital facility, its maintenance and its components. Architectural design and structure, plumbing, electrical supply, sewage systems, and all electro mechanical systems that are “built into” the physical structure of the hospital come under the auspices of buildings. The hospital administration should apply for and retain all the necessary governmental building permits and licenses and must meet all governmental guidelines and regulations. Acute hospital services are expected to be provided within a structure meant solely for hospital purposes. It is also expected that the hospital be free of asbestos. Consequently many small hospitals subsumed within other buildings have difficulty meeting many of the building standards required. It is prudent therefore for owners / managers to consider the above when renovating or building a new hospital. The day to day maintenance of the facility is invariable the responsibility of a maintenance manager (however named). Detailed maps / plans are needed to indicate exact locations of all utilities within the hospital. Each system must be clearly indicated with locations including valve placements. Maintenance staff must be proficient in their knowledge of policies and procedures related to the safe maintenance and repair of all areas under their jurisdiction as well as having a clear understanding of their responsibilities in the event of an emergency.

The day to day maintenance of the facility is invariable the responsibility of a maintenance manager (however named). Detailed maps /
plans are needed to indicate exact locations of all utilities within the hospital. Each system must be clearly indicated with locations including valve placements. Maintenance staff must be proficient in their knowledge of policies and procedures related to the safe maintenance and repair of all areas under their jurisdiction as well as having a clear understanding of their responsibilities in the event of an emergency.

Electricity outages continue to be common in some areas, and generator backup for electricity is therefore required. The entire hospital is expected to have at least one generator backup system with an automatic switch over. Critical care areas such as intensive care units, operating, emergency rooms and laboratories must be assured of an uninterrupted electricity supply for monitoring and life support equipment. Lag times for emergency electrical support on the critical branch generator ideally should be less than 10 seconds – an international standard. Short of that standard, UPS backup must be present in all critical areas of the hospital to provide safe patient care. These emergency systems should be regularly challenged with follow up reporting and correction. The latter needs to be clearly documented along with any preventive maintenance conducted. Any multi-storied hospital should provide for at least one elevator on UPS backup. The electrical backup systems should provide evidence of surge protection and overload monitoring.

The water supply to the hospital is to be filtered at point of entry. Adequate records of any chemical treatment and all bacteriologic testing of water should be readily available. Non-potable water must be clearly separated and labelled as such throughout the hospital. Water that is treated / filtered for specific purposes (such as dialysis) must also be clearly indicated.

Drinking water from whatever source needs to be periodically tested for chemical and bacteriologic content. In multi-level hospitals, water supplies should be pressurized through circulating pumps to ensure adequate water supply and pressure to upper floors.

Ideally, water supplies to fire suppression hoses and ceiling installed sprinkler systems should have a separate mains connection other than the domestic water supply. Failing this, separate water tanks servicing the fire hoses must have a reducing gauge system to increase and maintain the pressure during supply. Alternatively, a system should be installed whereby water levels and pressure is maintained for the fire hoses over and above general hospital water supplies.

Architecturally, the functional design of hospital facilities should provide compartmental segregation for fire containment throughout the building including the roof area. Fire rated automatic isolation doors should be present. Other safety mechanisms such as: functioning smoke detectors; heat sensing sprinkler systems; fire hoses; appropriate fire extinguishers,
and clearly marked fire evacuation pathways must be provided. It is suggested that in order to reduce the risk of fire the hospital promotes a no smoking policy.

For patient and employee safety, finishing should ensure that there is no exposed electric wiring, all areas are well lit and lighting fixtures are provided to shield bare bulbs. Staircases are to have hand safety railings. It is expected that multi-storied hospitals strive to provide at least two exits from each floor in the event of a fire (elevator not included).

Hospital signage and neighbourhood surroundings should be adequately lit, be clearly written and ideally include international symbols indicating services. Fire exit signage within the hospital should be illuminated at all times. Ideally, escape routing has path lighting during power outages.

Emergency service entrances while being clearly identified must be well lit and provide clear traffic signage disallowing parking, except for ambulances and emergency cases. Ideally, wheelchair access ramps should be installed in at least one entrance to the hospital besides the emergency services entrance. It is expected that the emergency services entrance, with adequate weather protection has a ramp to facilitate trolley transportation.

The overall effective functioning of the hospital requires adequate storage space for each department including general hospital stores, biomedical stores, clean and dirty utility rooms, janitor’s closets, kitchen stores etc. Separate entry for goods delivery should be provided with clear signage to indicate the goods entrance.

Ideally, each patient’s room will contain a bathroom and the door to the bathroom is expected to open outwards to prevent patient entrapment. An emergency nurse call system should be evident in both the bedroom and the bathroom. Adequate bathroom facilities are also expected to be provided for staff and visitors.

A quality improvement system needs to be in place to optimize the overall condition of the building/s and its component parts. Regular audits should be conducted and any errors/faults reported and corrected. It is expected that data from these audits is analyzed to determine trends with relating to faults or recurring repairs required. This may aid with future planning risk assessment with respect to safety and finance.

The above information is not intended to all inclusive. Thus, individual hospitals and each department have the responsibility to research and source information that allows them to comply with the accreditation standards below.

<table>
<thead>
<tr>
<th>Standards</th>
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<tbody>
<tr>
<td>BU 1</td>
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181
<p>| | |</p>
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<tr>
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</thead>
<tbody>
<tr>
<td><strong>1.1</strong></td>
<td>• The total building is used for hospital services only</td>
</tr>
<tr>
<td><strong>1.2</strong></td>
<td>• Appropriate heating and cooling facilities are provided for all staff and patient areas</td>
</tr>
<tr>
<td><strong>BU2</strong></td>
<td>Standards</td>
</tr>
<tr>
<td><strong>2.1</strong></td>
<td>• Generator backup for electricity supply available for the entire hospital</td>
</tr>
<tr>
<td><strong>2.2</strong></td>
<td>• Lag time less than 10 secs.</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
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<tr>
<td><strong>2.3</strong></td>
<td>• Lag time 30 secs or less</td>
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<tr>
<td><strong>OR</strong></td>
<td></td>
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<tr>
<td><strong>2.4</strong></td>
<td>• Lag time less than 1 minute</td>
</tr>
<tr>
<td><strong>BU3</strong></td>
<td>Standards</td>
</tr>
<tr>
<td><strong>3.1</strong></td>
<td>• List of all areas where Uninterrupted Power Supply (UPS) is supplied</td>
</tr>
<tr>
<td></td>
<td>Provide evidence of emergency generated power with automatic cut in and mechanical interlocks to protect each power source from the other this should include but not limited to the following:</td>
</tr>
<tr>
<td><strong>3.2</strong></td>
<td>• Isolating transformer</td>
</tr>
<tr>
<td><strong>3.3</strong></td>
<td>• Overload monitor</td>
</tr>
<tr>
<td><strong>3.4</strong></td>
<td>• Line isolation monitor</td>
</tr>
<tr>
<td><strong>3.5</strong></td>
<td>• Over-current circuit breaker</td>
</tr>
<tr>
<td><strong>BU4</strong></td>
<td>Standards</td>
</tr>
<tr>
<td><strong>4.1</strong></td>
<td>Traffic signage/instructions are provided for:</td>
</tr>
<tr>
<td><strong>4.2</strong></td>
<td>• Patients</td>
</tr>
<tr>
<td><strong>4.3</strong></td>
<td>• Staff</td>
</tr>
<tr>
<td><strong>4.4</strong></td>
<td>• Visitors</td>
</tr>
<tr>
<td><strong>4.5</strong></td>
<td>• In language(s) suitable for the hospital population</td>
</tr>
<tr>
<td><strong>4.6</strong></td>
<td>• Easily identifiable</td>
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<tr>
<td><strong>4.7</strong></td>
<td>• Includes basic symbols</td>
</tr>
<tr>
<td><strong>4.8</strong></td>
<td>• Clearly visible</td>
</tr>
<tr>
<td><strong>BU5</strong></td>
<td>Standards</td>
</tr>
<tr>
<td><strong>Lifts</strong></td>
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<tr>
<td>5.1</td>
<td>• Separate lift(s) are available for patients/visitors and maintenance personnel</td>
</tr>
<tr>
<td>5.2</td>
<td>• Evidence of maintenance contracts with schedule of service for all lifts</td>
</tr>
<tr>
<td>5.3</td>
<td>• Clearly identifiable alarm system in all lifts</td>
</tr>
<tr>
<td>5.4</td>
<td>• Alarm system identified by written instructions and graphic symbols</td>
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</table>

**Standards**

**BU6**

**Fire systems:**

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>6.1</td>
<td>• Smoke sensors in all physical plant areas</td>
</tr>
<tr>
<td>6.2</td>
<td>• Thermal fire alarm systems in all physical plant areas</td>
</tr>
</tbody>
</table>

**Fire hoses throughout the hospital**

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<tr>
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<tbody>
<tr>
<td>6.3</td>
<td>• Centrally located</td>
</tr>
<tr>
<td>6.4</td>
<td>• Separate water supply with adequate pressure</td>
</tr>
<tr>
<td>6.5</td>
<td>• Appropriate fire fighting equipment in the physical plant area</td>
</tr>
<tr>
<td>6.6</td>
<td>• Fire rated isolation doors in the main body of the building</td>
</tr>
<tr>
<td>6.7</td>
<td>• Hospital maintains a clearly documented and enforced no smoking policy</td>
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**Standards**

**BU7**

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>7.1</td>
<td>• Evidence of electricity earth monitoring and isolation system for general hospital areas</td>
</tr>
<tr>
<td>7.2</td>
<td>• Separate and specific electrical earth monitoring systems for special care units and operating rooms</td>
</tr>
<tr>
<td>7.3</td>
<td>• In situ, diagrammatic representation demonstrating areas that have an earth monitoring system</td>
</tr>
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</table>

**Standards**

**BU8**

**Evidence that the hospital water system:**

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<tbody>
<tr>
<td>8.1</td>
<td>• Is filtered</td>
</tr>
<tr>
<td>8.2</td>
<td>• Is appropriately treated</td>
</tr>
<tr>
<td>8.3</td>
<td>• Is tested for bacteriological content monthly</td>
</tr>
<tr>
<td>8.4</td>
<td>• Provides water supply for internal fire ring main hose reels and fire suppression systems (sprinklers) and has an independent main connection from the</td>
</tr>
<tr>
<td>Standards</td>
<td>8.5</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<td>8.6</td>
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<tr>
<td><strong>BU9</strong></td>
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<td>9.1</td>
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<td>9.2</td>
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<td>9.3</td>
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<td>9.7</td>
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<tr>
<td><strong>BU10</strong></td>
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<td><strong>BU11</strong></td>
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<td>11.1</td>
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<td>11.2</td>
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<td>11.3</td>
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<td></td>
<td>11.4</td>
</tr>
<tr>
<td><strong>BU12</strong></td>
<td></td>
</tr>
<tr>
<td>12.1</td>
<td>• The building layout and structure</td>
</tr>
<tr>
<td>12.2</td>
<td>• Electrical system</td>
</tr>
<tr>
<td>12.3</td>
<td>• Plumbing system</td>
</tr>
<tr>
<td>12.4</td>
<td>• Fire alarm system</td>
</tr>
</tbody>
</table>

**Standards**

**BU13**

**General Building status:**

| 13.1 | • Absence of exposed electrical wiring |
| 13.2 | • Absence of jagged surfaces (e.g. broken stairs) |
| 13.3 | • Presence of banisters on all stairways |
| 13.4 | • Building safety |
| 13.5 | • All lighting sources have covers (no bare bulbs) |

**Standards**

**BU14**

**Public Address System**

| 14.1 | • Available throughout the hospital |
| 14.2 | • Free of distortion |
| 14.3 | • Backup system available in the event of failure |

**Standards**

**BU15**

**Medical Gases**

| 15.1 | • Medical gases are reticulated |
| 15.2 | • Medical gas cylinders are stored externally in an enclosed secure area |

**Standards**

**BU16**

**Entrances**

| 16.1 | • A separate emergency entrance is available |
| 16.2 | • The emergency entrance is weather protected |
| 16.3 | • The emergency entrance is of an adequate size to facilitate weather proof transfer of patients to the emergency department |
| 16.4 | • Availability of ramp(s) |
| 16.5 | • No-parking signs to ensure unobstructed 24 hour access |
| 16.7 | • Entrance way to be free of obstruction |
16.8 • Goods entrance to be clearly marked
16.9 • Goods entrance to be separate from main entrance
16.10 • Main and emergency entrance to be clearly identifiable from a distance
16.11 • All entrances to be well illuminated

<table>
<thead>
<tr>
<th>Standards</th>
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<tbody>
<tr>
<td>BU17</td>
</tr>
<tr>
<td>Flammable Items</td>
</tr>
</tbody>
</table>
17.1 • A secure external storage is provided for all bulk flammable items
17.2 • The storage area for flammable items must be clearly identified with a graphic illustration

**Egyptian Hospital Accreditation Program: Standards**

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The Egyptian Ministry of Health and Population (MOHP) with the assistance of the USAID-funded Partnerships for Health Reform Project (1995–2001) successfully developed and implemented an accreditation program for their primary health centres. Building on this experience, the MOHP Quality Improvement Directorate drafted a set of standards for hospital accreditation. The standards then were refined with the collaboration of government/public sector hospitals, university hospitals, teaching hospitals, and private hospitals. The USAID-funded Partners for Health Reformplus Project provided technical assistance to this current version of the hospital accreditation standards. The standards are specific for Egypt, in that they comply with Egyptian laws, regulations, and culture, but they also meet the basic intent of international standards.

A total of 716 standards were developed and agreed on, and are categorized into three types: (69) critical standards, (322) core standards, and (325) non-core standards. To become accredited, a hospital must meet all the critical standards and reach a cumulative score of 85 percent on the
core standards. The noncore standards constitute a more ambitious target that hospitals are encouraged to work toward; current accreditation requires hospitals to reach a cumulative score of 40 percent on the non-core standards.

The standards are expected to serve as a catalyst for change and improvement in both the culture and practice of health care in Egypt.

This is the sixth edition of the accreditation standards for Egyptian hospitals. The development of these standards was a collaborative effort of representatives from all health sectors, including the Quality Improvement Directorate of the Ministry of Health and Population (MOHP), university hospitals, teaching hospitals, and private hospitals.

The standards are specific to Egypt, but they have been compared to international standards and found to meet the basic intent of all international standards that apply to Egyptian laws, regulations, and culture. It is expected that the standards will be a catalyst for change and improvement in both the culture and practice of health care in Egypt. The standards are divided into three categories: critical standards (written in bold italics), core standards (written in bold type), and non-core standards (written in plain type). To become accredited, a hospital must meet all the critical standards and reach a cumulative score of 85 percent on the core standards. The non-core standards are a future and even higher target. To become accredited, a hospital must reach a cumulative score of 40 percent on the non-core standards.

ACRONYMS:
CPR Cardiopulmonary resuscitation
CSSD Central sterilization supply department
CT Computerized Tomography
EDL Essential Drug List
H&P History and physical examination
HVAC Heating, ventilation, and air conditioning
IBCLCs International Board Certified Lactation Consultants
ICUs Intensive care unit
MOHP Ministry of Health and Population
PHRplus Partners for Health Reformplus
QI Quality improvement
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
WHO World Health Organization
1. Patient and Family Rights

Introduction

Each patient and his or her family are unique, and the hospital and its staff should strive to understand each individual’s needs, beliefs, and rights. Although patients and families may be very trusting of their doctors and the hospital, care outcomes and patient/family satisfaction are improved when patients receive sufficient information to participate in decisions regarding their care, to the extent they wish to participate. This chapter outlines processes to perform the following:

- Obtain the patient or family’s consent for certain types of procedures or treatments
- Ensure that the patient is informed and protected when enrolled in a research project
- Allow the patient or family to make complaints or offer suggestions
- Evaluate patient and family satisfaction
- Identify and protect the patient’s rights

PR.1 The hospital has a specified list of procedures or treatments for which informed consent is required from the patients or other authorized person. The list includes the following (when applicable to the hospital’s services):

PR.1.1 Surgery and invasive procedures
PR.1.2 Anesthesia/moderate or deep sedation
PR.1.3 Use of blood
PR.1.4 Research
PR.1.5 High-risk procedures or treatments (including but not limited to Electro Convulsive Treatment, radiation therapy, chemotherapy)

PR.2 The hospital complies with laws and regulations governing when someone other than the patient can give consent.

PR.2.1 If consent is given by someone other than the patient, this is documented in the patient’s medical record.

PR.3 Patient consent forms are available in all applicable locations at the hospital. The locations include at least the following:

PR.3.1 All nursing inpatient units
PR.3.2 All areas where surgery or invasive procedures are done
PR.3.3 All ambulatory clinics where procedures on the list requiring consent are done
PR.3.4 Radiation therapy
PR.3.5 Outpatient chemotherapy area
PR.3.6 Psychiatry units where electroconvulsive treatment is done

PR.4 Informed consent is obtained for all relevant processes of care, including research, before performing such procedures or starting the
research. Informed consent requires giving patients information about the risks, benefits, and alternatives to the proposed treatment plan. The patient's signature or other documentation of consent is in the patient's medical file. 
PR.5 The hospital ensures that the Ethics Committee has reviewed and approved all research protocols that involve human subjects as required by law.
PR.6 There is a process to allow patients to make oral or written complaints or suggestions and the process allows the complaint or suggestion to be anonymous if the patient so wishes.
PR.6.1 Relevant staff members understand this process and can advise patient and family.
PR.7 There is an assigned committee for reviewing and acting on these complaints and suggestions.
PR.7.1 This committee has terms of reference that include the following:
PR.7.2 Reviewing aggregate data relating to complaints to determine if there are any recurring problems
PR.7.3 Taking action to correct any recurring problems
PR.7.4 Reviewing the action taken on individual complaints to determine if it was appropriate and timely
PR.7.5 Committee minutes demonstrate that the terms of reference were met.
PR.8 The hospital provides training in patient satisfaction and interpersonal communication for staff.
PR.8.1 All medical and nursing staff have been trained.
PR.8.2 All other staff has been trained.
PR.9 The hospital has implemented a patient satisfaction questionnaire.
PR.9.1 An adequate sample size is obtained.
PR.9.2 Aggregate data from these questionnaires are analyzed at least twice every year.
PR.10 Written policies on patients’ rights are available, disseminated, or made visible to patients. Patients’ rights include at least the following:
PR.10.1 Right to reasonable access to care
PR.10.2 Right to care that respects the patient’s personal values and beliefs
PR.10.3 Right to be informed and participate in decisions relating to their care
PR.10.4 Right to security, personal privacy, and confidentiality
PR.10.5 Right to have pain adequately treated
PR.10.6 Right to make a complaint or suggestion without fear of retribution
PR.10.7 Right to know the price of services and procedures
PR.10.8 Rights as defined by laws and regulations
PR.10.9 Informed of their rights in a manner they can understand
PR.11 The hospital has a policy that defines its responsibilities for patient’s possessions. The policy defines at least the following:
PR.11.1 When the hospital assumes responsibility for these possessions and how it will protect them
PR.11.2 Information to be given to the patient or family about the hospital’s responsibility
PR.12 Signed patient consent form or documentation of the patient’s verbal consent for participation in research is available in the research files.
PR.12.1 A copy of the consent form or other documentation of the patient’s participation in the research project is in the patient’s medical file.
PR.13 The hospital informs patients and families about its services and how to access those services.
PR.14 The hospital informs patients and families about their rights and responsibilities related to refusing or discontinuing treatment.
PR.14.1 There is a written hospital policy.
PR.15 Social Services Department is directed and staffed by experienced and qualified individuals, as required by the job description.
PR.15.1 The hospital has defined in writing the scope of services to be provided by the Social Services Department and the timeframe in which these services are to be provided.
PR.16 Social services are integrated with services provided by different departments.
PR.17 The Social Services Department is involved in community needs assessment and health education activities.

2. Access and Continuity of Care
Introduction
Hospitals vary in the scope of services they provide and thus the types of patients they may effectively serve. Patients frequently receive care by more than one department and in more than one location. An episode of care must be understood as a continuum from admission to discharge and not a sequence of isolated actions. Therefore, the hospital and its staff must work collaboratively to make this continuum work smoothly. This chapter defines processes to perform the following:
• Egyptian Hospital Accreditation Program: Standards ensure that the hospital can effectively meet the patient’s needs
• Admit patients
• Determine the priorities for patients’ care
• Conduct transfers within the hospital
• Conduct transfers to another hospital
• Have available the medical record as a communication tool
• Discharge patients from care
AC.1 There are policies and procedures to ensure coordination and continuity of care that include at least the following:
AC.1.1 Process to screen patients to determine that the hospital can meet their health care needs
AC.1.2 Admission of patients, including those from emergency services
AC.1.3 Information to be given to the patient at the time of admission
AC.1.4 A triage process to determine priority of care in emergency services
AC.1.5 A screening process after admission to determine the priority of the patient’s medical and nursing care needs
AC.1.6 Criteria for admission to specialized units such as intensive care units (ICUs)
AC.1.7 Specific criteria for eligibility for enrolment in research projects or protocols
AC.1.8 Transfers from one hospital unit to another, including documentation of the process, in the patient’s medical file
AC.1.9 Transfers from the hospital to another hospital, including monitoring and mode of transportation and requirement to notify the receiving hospital.
AC.1.10 There is evidence that appropriate staff, including physicians, have been educated about these policies.
AC.1.11 The policies have been implemented and are being followed.
AC.2 Diagnostic services and surgical and non-surgical treatment services are available and there are defined timeframes for the availability of these services.
AC.2.1 The diagnostic and treatment services are appropriate to the types of patients served.
AC.3 The patient’s record must be available to care providers and contain up-to-date information and must be available within one hour.
AC.4 The hospital has a policy that identifies who may have access to the patient’s record to ensure confidentiality of patient information.
AC.4.1 The policy defines the circumstances under which access is granted.
AC.5 The complete patient record containing up to date essential information must be transferred with the patient when being transferred from one unit to another within the hospital.
AC.5.1 The medical file must document the reason for the transfer.
AC.6 Patient records must contain a copy of discharge summary. The discharge summary must include the following:
AC.6.1 The reason for admission
AC.6.2 Significant findings, including investigations
AC.6.3 Procedures performed
AC.6.4 Any diagnosis made  
AC.6.5 Medications and/or other treatments  
AC.6.6 Patient’s condition at discharge  
AC.6.7 Discharge instructions, including medications and follow-up instructions  
AC.6.8 The name of the physician who discharged the patient.  
AC.7 A referral sheet containing patient’s clinical information is completed and sent with the patient when referred to another facility. A copy is retained in the patient’s record. The referral sheet contains at least the following:  
AC.7.1 Reason for referral/transfer  
AC.7.2 Significant findings, including investigations  
AC.7.3 Procedures, medications, and/or other treatments  
AC.7.4 Patient’s condition at time of referral or transfer  
AC.7.5 Name of the facility the patient is being transferred to  
AC.7.6 Transportation means and required monitoring

3. Patient Assessment

Introduction
Evaluation of the patient to determine his or her needs and the priority of those needs is the basis on which subsequent care decisions are based. The evaluation may be done by multiple qualified disciplines and the content of the assessment may vary according to the patient’s condition or location of care. The evaluation may include relevant diagnostic investigations. The assessment and reassessment is a continuing process throughout the patient’s course of care. This chapter describes the evaluation process, including the following:

- By whom, when, and how evaluations and re-evaluations are done
- Diagnostic investigations

General Patient Assessment Standards
PA.1 All patients have their health care needs evaluated by defined assessment processes.
PA.2 The hospital has defined who may assess patients.
PA.3 Each discipline has defined the scope and content of assessments, including the timeframe for their completion.
PA.4 Each discipline has defined the frequency of reassessment.

Pain
PA.5 When relevant to their condition, each patient has his or her pain assessed, treated, and reassessed to determine the effectiveness of treatment.

Laboratory
LB.1 The hospital has written polices and procedures for laboratory services. The policies include at least the following:
LB.1.1 Procedure manuals or guidelines for all tests and equipment
LB.1.2 Report times for results
LB.1.3 Quality control processes
LB.1.4 Inspection, maintenance, calibration, and testing of all equipment
LB.1.5 Management or reagents, including availability, storage, and testing for accuracy
LB.1.6 Procedures for collecting, identifying, processing, and disposing of specimens
LB.1.7 Norms and ranges for all relevant tests
LB.1.8 Laboratory safety program, including infection control
LB.2 There is qualified supervision of laboratory functions during and after normal work hours.
LB.3 The head of the laboratory has at least a M.Sc. degree in clinical pathology.
LB.4 All laboratory staff including technicians are certified and licensed.
LB.4.1 All laboratory staff including technicians has training and experience as required by law and regulations and by their job description.
LB.5 Twenty-four hour laboratory coverage is provided to meet routine and emergency needs of patients, or coverage is provided as appropriate to the types of services offered by the hospital and its size.
LB.6 Referral laboratory services are available for tests not available in the hospital through formal or informal contracts.
LB.6.1 The referral laboratory is licensed and accredited by MOHP.
LB.7 The tests are appropriate to the size of the hospital and its scope of services.
LB.7.1 There is a written list of laboratory test that are currently available.
LB.8 Tests are reported in an acceptable timeframe and signed by the laboratory doctor when the test requires professional interpretation.
LB.9 All laboratory results are documented in the laboratory and reviewed by a lab supervisor every day.
LB.10 All laboratory test result/reports have reference (normal) ranges specific for age and sex.
LB.11 Reporting of significantly abnormal values is documented. The documentation includes the following:
LB.11.1 Name of patient
LB.11.2 Date and time of sample examination
LB.11.3 Date and time of notification of the abnormal result
LB.11.4 Name of the individual to whom the result was reported
LB.12 All surgically removed tissue is sent for pathologic examination. The examination may be done at the hospital or in a reference laboratory. The
hospital may have a list of approved exceptions of surgical specimens that do not have to undergo pathology examination.

LB.13 All completed pathology reports contain gross and microscopic description and diagnosis as relevant to the specimen.

LB.14 Cytology services are performed according to written procedure, and are supervised by a pathologist or other qualified physician.

LB.15 There is a written chemical hygiene plan that defines the safety procedures to be followed for all hazardous chemicals used in the laboratory. The plan defines at least the following:

- LB.15.1 The storage requirements
- LB.15.2 Handling procedures
- LB.15.3 Requirements for personal protective equipment
- LB.15.4 Procedures following accidental contact or overexposure
- LB.15.5 The plan is reviewed annually, and updated if needed, and is part of new employee orientation and the continuing education program.

LB.16 When chemicals and reagents are ordered, steps are taken to determine the hazards and to transmit that information to those who will receive, store, use, and dispose of these chemicals.

Radiology

RD.1 The hospital has written current radiology policy and procedures that cover at least the following:

- RD.1.1 A radiation safety program
- RD.1.2 Timeliness of the availability of diagnostic imaging procedures and the results
- RD.1.3 A quality control program covering the inspection, maintenance, and calibration of all equipment

RD.2 The radiology department follows all the guidelines developed by MOHP.

RD.3 Radiology services are authorized by MOHP and are operated according to applicable laws and regulations of the Executive Office of Radiation Protection.

RD.4 A qualified individual(s) is responsible for managing the radiology services.

RD.5 The radiology department is covered 24 hours a day by a radiologist and technician, according to MOH rules and regulations.

RD.6 The radiology department has adequate supplies and equipment for its function according to MOHP regulations and the scope of services provided.

RD.7 The radiology department has adequate space according to MOHP regulations and the scope of services provided.

RD.8 All diagnostic equipment is regularly inspected, maintained, and calibrated, and appropriate records are maintained.
RD.9 Individuals with adequate training, skills, orientation, and experience administer the tests and interpret the results.
RD.10 The department has defined special techniques or procedures that must be done under physician supervision.
RD.11 A radiation safety program is in place, followed, and documented.
RD.12 Reporting of radiation safety program findings is timely.
RD.13 Medications needed for emergency treatment for any reaction caused by injectable contrast media are readily available in the room.
RD.14 The radiology report of examination is kept in patient’s medical record.
RD.15 Duplicate copies of all reports are kept in the department.
RD.16 The department has defined the timeframe for reporting interpretation of radiology tests and procedures, and the timeframes include both emergency and routine reports.
RD.17 There is a register book in which all (simple and complicated) cases are written.
RD.17.1 Information includes the procedure done and the number of films taken.
RD.17.2 The department keeps data on the number of film “retakes” because of inadequate technical quality.

4. Patient Care

Introduction
The previous chapter is the basis for patient care. The processes of patient care include planning care, providing care, evaluating the patient’s response to care, and planning follow-up care. Care may be provided in multiple locations, by multiple disciplines, and it may involve different processes. This chapter outlines the care processes for the following:
- Care planning and coordination
- Surgical care
- Anesthesia care
- Medication use
- End of Life Care
- Blood use
- Emergency care
- Newborn care

General Care

GC.1 All care is planned and documented.
GC.1.1 The care plan includes all disciplines that are providing care to the patient.
GC.2 There are policies and procedures for the care of special patients, including the following:

GC.2.1 Patients who are comatose or on life support
GC.2.2 Patients on dialysis
GC.2.3 Patients who must be restrained
GC.2.4 Patients with communicable diseases.

Surgical Care

SC.1 All surgical procedures (except in life-threatening emergencies) are performed only after appropriate history, physical examination, and indicated diagnostic tests have been completed and documented in the patient's medical record.

SC.2 The preoperative diagnosis has been recorded in the medical record for all patients prior to surgery.

SC.3 Except in life-threatening emergencies, the surgeon must have obtained an informed consent and this must be documented in the patient's medical record.

SC.4 The nursing care of patients undergoing surgery must be planned and documented in the medical record, directed by a trained nurse, and include the following:

SC.4.1 Location of post-operative care
SC.4.2 Type of care and monitoring needed
SC.4.3 Pain management
SC.4.4 Patient's understanding of discharge instructions (if being discharged home).

SC.5 Operative reports are written in the patient's record immediately after surgery and include at least the following:

SC.5.1 The procedure performed
SC.5.2 Findings during surgery
SC.5.3 Post-operative diagnosis
SC.5.4 Surgical specimens removed
SC.5.5 Name of surgeon and anesthesiologist and any assistants
SC.5.6 Signature of the surgeon

SC.6 There is a process to positively identify the patient and ensure that the correct procedure and the correct side are confirmed prior to starting the surgery.

SC.7 There are processes and policies defining the appropriate safety before and during surgery, including at least the following:

SC.7.1 Aseptic technique
SC.7.2 Sterilization and disinfections
SC.7.3 Selection of draping and gowning
SC.7.4 Counting of sponges, instruments, and needles
SC.8 There are supplies, equipment, and instruments available for all surgeries performed according to the MOHP list.
Anesthesia and Sedation Care
AN.1 Anesthesia care, which includes moderate and deep sedation, is planned and documented in the patient’s record.
AN.2 A pre-anesthesia/sedation assessment has been done by a qualified physician or surgeon prior to the induction of anesthesia.
AN.2.1 The assessment determines that the patient is a safe candidate for anesthesia or moderate or deep sedation.
AN.2.2 The patient is reassessed immediately prior to induction of anesthesia by an anesthesiologist.
AN.3 The plan is consistent with the patient assessment and includes the anesthesia to be used and the method of administration.
AN.4 Prior to administration of any pre-anesthesia medication, an informed consent for the use of anesthesia must be obtained and documented in the medical record.
AN.5 Each patient’s physiologic status is continuously monitored during anesthesia or sedation administration and the results of the monitoring are documented in the patient’s medical record on an anesthesia form.
AN.5.1 The monitoring includes pulse rate and rhythm.
AN.5.2 The monitoring includes blood pressure.
AN.5.3 The monitoring includes oxygen saturation.
AN.5.4 The monitoring includes respiratory rate.
AN.6 The anesthesia record includes medications administered.
AN.6.1 The anesthesia record includes fluids administered.
AN.6.2 The anesthesia record includes blood or blood products administered.
AN.6.3 The anesthesia record includes the actual anesthesia used (if different from the plan).
AN.6.4 The anesthesia record includes any unusual events or complications of anesthesia.
AN.6.5 The anesthesia record includes the condition of the patient at the conclusion of anesthesia.
AN.6.6 The anesthesia record includes the time of start and finish of anesthesia.
AN.7 The patient is monitored during the post-anesthesia/surgery recovery period and the results of monitoring are documented in the patient’s medical record.
AN.7.1 The time of arrival and discharge from anesthesia recovery are recorded.
AN.8 Patients are recovered from anesthesia/sedation in an area that has at least the following:
AN.8.1 Qualified nurses
AN.8.2 Equipment as required by MOH regulations, but at least the following:
AN.8.3 Oxygen source
AN.8.4 Ability to monitor O2 saturation
AN.8.5 Suction
AN.8.6 Ability to monitor blood pressure, pulse, and heart rate and rhythm
AN.9 The anesthesiologist, or other qualified physician, must make the decision to discharge the patient from post-anesthesia care and this decision must be based on documented results of monitoring during anesthesia recovery.
AN.9.1 The anesthesiologist, or other qualified physician, must sign the discharge order.

Medication Use and Pharmacy Services
MU.1 The pharmacy and medication use practices comply with applicable laws and regulations.
MU.2 The hospital has written policies and procedures for at least the following:
MU.2.1 Acquisition of medications, including when the pharmacy is closed
MU.2.2 Safe prescribing, ordering, storage, administration, and monitoring of the effect of medications
MU.2.3 Who may order and who may administer medications
MU.2.4 Where medication orders are uniformly written in the medical record
MU.3 A licensed pharmacist is available at all times and is responsible for supervising all pharmaceutical services.
MU.4 There are sufficient certified pharmacists and support personnel to meet the needs of the hospital.
MU.5 Pharmacists actively participate in developing and monitoring implementation of the hospital policy on antibiotic and other medication usage.
MU.6 There is a system to ensure availability, safety, and security of required emergency and lifesaving drugs 24 hours a day.
MU.7 There are written policies for distribution and control of narcotics in compliance with laws and regulations.
MU.8 Pharmacists actively participate in the quality improvement program related to pharmacy services and related medication use activities.
MU.9 Medication dispensed from the pharmacy is labeled with at least the following before being administered to the patient:
MU.9.1 The patient’s name
MU.9.2 The name of the drug and its concentration/strength
MU.9.3 The expiration date
MU.9.4 Written instructions for use/administration
MU.10 Outpatients receive appropriate information about the prescribed drug from a pharmacist and information is given in a language and form that the patient can understand. The information includes at least the following:
MU.10.1 Direction on the use and administration of the drug
MU.10.2 Potential significant side effects
MU.10.3 The importance of following the directions
MU.11 For inpatients, the pharmacist ensures that the medication is appropriately labeled and provides information to nursing and medical staff on the medication’s use, administration, and side effects, including potential adverse reactions.
MU.12 The hospital has a medication recall system.
MU.13 There are defined written processes and procedures to dispense medications that ensure the medication is given according to the following:
MU.13.1 To the right patient
MU.13.2 The right drug
MU.13.3 In the right dose
MU.13.4 By the correct route of administration
MU.13.5 At the right time
MU.14 The hospital has a written definition of a medication error. The definition includes the following:
MU.14.1 Medication given to the wrong patient
MU.14.2 The wrong medication administered
MU.14.3 Medication given in the wrong dose
MU.14.4 Medication given by the wrong route of administration
MU.14.5 Medication given at the wrong time, including missed doses
MU.14.6 The definition has been provided to nursing, pharmacy staff, and to all physicians
MU.15 There is a system for reporting medication errors.
MU.15.1 The hospital leadership creates a “blame-free” process for reporting.
MU.15.2 Aggregate data about medication errors are analyzed to identify ways to reduce the most common type of errors.
MU.16 The Essential Drug List (EDL) is adopted and listed by generic name.
MU.16.1 The EDL includes all therapeutic groups of drugs.
MU.16.2 The EDL is distributed to all physicians.
MU.16.3 The EDL is updated at least annually.

End of Life Care
ELC.1 There are policies for managing end-of-life care and they include at least:
ELC.1.1 Management of symptoms, including pain.
ELC.1.2 Provision, if applicable, of support for psychosocial and spiritual needs and support to the family.

**Blood Bank and Transfusions Services**

BB.1 *The hospital has written polices and procedures for hospital blood bank services that cover all services offered.*

BB.2 All hospital blood bank staff including technicians are certified and/or licensed and have appropriate training and experience.

BB.3 Hospital blood bank supplies and equipment are adequate for its function.

BB.4 Blood and blood products are maintained to meet the amount specified by the hospital according to the size of the Hospital and its scope of services.

BB.5 A record is kept to ensure easy tracing of a unit of blood from drawing (or receipt) until final disposition.

BB.6 Testing of donors is performed as per routine acceptable standards for screening of communicable diseases and blood type and Rh.

BB.7 *There are specific written procedures that are followed for all blood bank tests done in the hospital.*

BB.8 Blood and blood components are collected, stored, and handled in such a manner that they retain their maximum potency and safety.

BB.9 There is a written policy on screening of blood donors that follows the national selection criteria.

BB.10 *All blood products are labelled with at least the identification number, name of the product, required storage condition, expiration date, production date, and name of the blood bank.*

BB.11 Blood warming systems are monitored so that blood is not warmed above 38°C.

BB.12 Donor blood not intended for preparation of platelets is refrigerated at a temperature of 2° to 6°C.

BB.13 Frozen plasma components are stored at a temperature of -18°C or below.

BB.14 Refrigerators or freezers in which blood, blood components, or derivatives are stored are used only for storage of donor samples, patient samples, or blood bank reagents.

BB.15 Refrigerators and freezers for storage have central electronic monitors or 24-hour chart recorders to ensure all blood and components are continuously stored at acceptable temperature.

BB.15.1 If there is no continuous automated recording, temperatures are manually recorded at least every four hours.

BB.15.2 The recorded temperature on all systems is checked at least once daily.
BB.16 Temperature recording charts and manual temperature logs show at least the following:
BB.16.1 Identity of the refrigerator or freezer
BB.16.2 Dates of temperature reading
BB.16.3 There is a policy on how blood is to be stored outside the blood bank prior to administration.
BB.16.4 Acceptable temperature range
BB.16.5 Identity of personnel inserting/removing charts or logging temperatures
BB.16.6 Any temperature fluctuations falling outside acceptable range
BB.16.7 Name and telephone number of person to be notified when malfunction occurs
BB.16.8 Action taken
BB.17 There are written procedures to follow if temperature limits are exceeded.
BB.17.1 These instructions are posted on or near the refrigerator or freezer.
BB.18 There is an alarm system, which is tested at least once per week.
BB.18.1 The tests are documented.
BB.19 There are defined procedures to ensure positive identification of the patient prior to obtaining a specimen for typing and cross-matching and before administration of blood.

Emergency Care
EM.1 The physical location of the emergency room must support at least the following:
EM.1.1 Ready access by ambulance, car, or walking
EM.1.2 Readily identified by signage both within the hospital and from the outside
EM.1.3 Ease of access to other services such as X-ray
EM.1.4 Entrance and exit without going through other areas of the hospital
EM.2 The facility ensures the presence of qualified staff 24 hours a day.
EM.2.1 The hospital has a plan of how to staff the emergency room.
EM.3 All emergency room staff is trained in CPR (cardiovascular resuscitation), emergency care, and the use of emergency equipment.
EM.4 The record of every patient receiving emergency care includes at least the following:
EM.4.1 Time of arrival
EM.4.2 Conclusions at termination of treatment
EM.4.3 Patient’s condition at discharge
EM.4.4 Follow-up care instructions
EM.5 The hospital must have and use clinical guidelines on emergency care. The guidelines must include at least the following:
EM.5.1 Emergency stabilization and treatment of chest pain
EM.5.2 Emergency stabilization and treatment of shock
EM.5.3 Emergency stabilization and treatment of polytrauma
EM.5.4 Two additional guidelines for the most common diagnoses or presenting complaints
EM.5.5 The clinical guidelines must be reviewed at least every two years and updated when indicated by current literature.
EM.6 Essential emergency equipment, as required by MOHP rules and regulations, is available and in good working order.
EM.7 EDL medications and lifesaving drugs for emergency care must be available and secure at all times in each emergency room area.
EM.8 Support diagnostic services are available 24 hours a day.
EM.9 All hospitals either have an ambulance or have an arrangement for ambulance services.
EM.10 The hospital ensures that the ambulance service meets the requirements of the MOHP rules and regulations.
EM.11 The hospital should have an emergency plan to deal with internal disasters such as the arrival of one or more seriously injured patients. The plan should include the following:
EM.11.1 A list of emergency response members, including physicians, nurses, and technicians for laboratory and radiology, and the list is posted in the emergency room
EM.11.2 The ability of the team to be able to reach the emergency room within half an hour.
EM.11.3 A list of referral centres
EM.11.4 A plan to mobilize hospital staff and distribute responsibilities among them
EM.12 The hospital has a plan and process for responding to resuscitation emergencies anywhere in the hospital, which includes personnel who will respond; required emergency lifesaving drugs, including their location, types, and security; and required equipment.

Baby-Friendly Care
BC.1 In hospitals with mother-baby units, care is provided according to clinical guidelines as noted in QI.6.3.1–QI.6.3.3.
BC.2 There is a clinical guideline for supporting and encouraging breastfeeding that follows the recommendations of UNICEF and the World Health Organization (WHO).

5. Clinical Safety
Introduction
Protecting patients, family members, visitors, and staff members from harm of infection or other injury is a fundamental responsibility of all hospitals. Prevention of hospital-acquired infections, including those that are a result
of inadequately sterilized equipment and supplies, is the cornerstone of this responsibility. This chapter describes the following processes:

- Prevention and control of infection
- Sterilization of equipment and supplies
- Evaluation of employee health

**Infection Control**

IC.1 *The hospital has an active program to reduce the risks of nosocomial infections.*

IC.1.1 The program covers patients, staff, and visitors.

IC.1.2 The program is based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.

IC.2 The hospital has established a functioning infection control committee.

IC.3 All relevant disciplines are represented on the committee.

IC.4 There are clear terms of reference for the infection control committee. The terms of reference include the following:

- Approving the qualifications of the infection control nurse and physician
- Approving the surveillance activities
- Reviewing, aggregating, and analyzing infection control data
- Taking or recommending action (including education) when infection control issues are identified
- Reviewing the effectiveness of these actions
- Periodically reviewing the infection control plan and program

IC.5 A qualified physician oversees the infection control activities.

IC.6 A qualified nurse (at least one) assists in infection control activities.

IC.7 The hospital has identified those procedures and processes associated with increased risk of infection. At a minimum, these include the following (when relevant to the hospital’s services):

- Respiratory tract infections associated with intubation, ventilator support, or tracheostomy
- Urinary tract infections associated with catheters;
- Blood stream infections associated with intravascular devices
- Surgical wound infections

IC.8 The hospital has written infection control policies and procedures. The policies and procedures are followed and include, but are not limited to, the following:

IC.8.1 Handwashing

IC.8.2 Isolation policy, including the management and reporting of patients with suspected communicable diseases

IC.8.3 Management of patients who are immunocompromised
IC.8.4 Prevention of blood-borne infections among hospital staff, including disposal of sharps

IC.8.5 Prevention of surgical sites infection

IC.8.6 Prevention of hospital-acquired respiratory tract infections

IC.8.7 Selection and uses of antiseptics and disinfectants

IC.8.8 Infection control surveillance and data collection

IC.8.9 Management of outbreaks of infections

IC.8.10 Policies for specific high-risk areas applicable to the hospital, including, but not limited to, the following:

- Operating theatre
- Neonatal units
- Burn units
- Laboratory
- Emergency department
- Dialysis units
- Intensive care units
- Organ transplantation units
- Kitchen
- Laundry
- Post-mortem areas
- Sterilization areas
- Patient-related procedures such as central line insertion and urinary catheters
- Policies for patient ventilator management
- Policies for staff health
- Disposal of infectious waste and body fluids
- Policies on management of hemorrhagic patients
- Hospital cleaning policy
- Cultures surveillance in high-risk areas (operating rooms, nurseries, ICU, and others)
- Training of staff

IC.9 Infection control policies and procedures are disseminated to all concerned departments after being approved by the infection control committee.

IC.10 Infection control policies and procedures are reviewed and updated regularly by the infection control committee at least every two years, and the review is based on current professional literature.

IC.11 All relevant staff have been oriented and trained in the applicable infection control policies and procedures as relevant to their position or job.
IC.12 When relevant to the hospital’s services, there are special isolation rooms in the hospital, including negative pressure rooms, for isolating infection cases.

IC.13 There are hand hygiene facilities in each isolation room.

IC.14 The surveillance data of hospital-acquired infections, and the effectiveness of the program, are regularly aggregated and analyzed by the infection control committee.

IC.14.1 The results are disseminated to senior management to concerned departments or units and, when relevant, are utilized by them for improving the quality of care.

IC.15 All communicable diseases are reported as required by MOHP regulations.

Sterilization

ST.1 The hospital has a central sterilization supply department (CSSD) or defined unit.

ST.1.1 The department is managed by an individual who is qualified by education and/or training.

ST.2 The functions of cleaning, processing, and sterile storage and distribution are physically separated.

ST.3 In all areas where instruments are cleaned there must be airflow that prevents cross contamination and prevents contaminated material from exiting the area.

ST.4 There are means of preventing cross-contamination in the cleaning area.

ST.5 Based on the services provided and the size of the hospital, the sterilization area has at least one functioning autoclave.

ST.6 Boiling water is not used as a sterilization technique.

ST.7 Whatever sterilization technique is used (including chemical cleaning/sterilization of scopes), there is documented evidence that complete sterilization has been accomplished.

ST.8 There are specific policies and procedures that are followed for each sterilization technique or device used, including manufacturer’s manuals.

ST.9 There is documented evidence in their human resources file that staff are trained in these procedures.

ST.10 Policies and procedures have been developed and used for all processes, including the following:

ST.10.1 Receiving, disinfection, and cleaning of used items

ST.10.2 Preparation and processing of sterile packs

ST.10.3 Appropriate inventory levels

ST.10.4 Emergency (“flash”) sterilization

ST.10.5 Expiration dates for sterilized items

ST.10.6 Storage of sterile supplies
ST.11 Quality control processes and all policies and procedures are uniformly applied in all areas where sterilization is done.

Employee Health
EH.1 The hospital has an employee health program that is described in policies and procedures and covers all new and all existing employees, and the program conforms to government laws and regulations.
EH.2 The hospital has policies and procedures that have been implemented to identify and deal with occupational hazards.
EH.2.1 The hospital has completed and documented an occupational hazard survey.
EH.2.2 The employee health program is based on this survey and on government laws, rules, and regulations.
EH.3 Each current employee who may have direct or indirect contact with patients has an evaluation as required by law or by the hospital (as relevant to the occupational hazards for each department and job position).
EH.3.1 The employees are reevaluated periodically as required by law and regulation or by the hospital.
EH.3.2 When screening results or investigations are positive, there is a policy that guides the action to be taken.
EH.4 Each new hire who might have direct or indirect contact with patients has a complete preemployment evaluation as required by law or by the hospital (as relevant to the occupational hazards for each department and job).
EH.4.1 When screening results or investigations are positive, there is a policy that guides the action to be taken.
EH.5 The hospital staff is trained in occupational health hazards and safety procedures, the training is included in initial orientation, and additional training is provided when new procedures or equipment presents new hazards.

6. Environmental Safety
Introduction
For patients to receive quality care in a safe environment, hospitals must devote their attention to managing the physical environment and assets such as equipment and utilities. The hospital must have plans for managing the safety of the environment, must implement these plans, must train all relevant staff in their responsibilities, and must collect and analyze data to determine the effectiveness of the plans. This chapter defines the hospital’s responsibility for the following:
• General safety
• Fire safety
• Emergency response
• Hazardous materials and waste
• Medical equipment
• Utility systems
• Training of relevant staff

ES.1 The hospital is aware of all laws, regulations, and facility inspection requirements that relate to management of the physical environment, and the leadership has ensured compliance.

ES.2 The hospital has an overall plan to manage the physical environment. The plan includes at least the following:

ES.2.1 General safety and security
ES.2.2 Fire and smoke safety
ES.2.3 Emergency response
ES.2.4 Hazardous materials and waste
ES.2.5 Medical equipment
ES.2.6 Utility systems
ES.2.7 Training of relevant staff

ES.3 The plan has been implemented.

ES.4 All seven components of the overall plan are monitored with collection, aggregation, and analysis of data to identify areas for correction.

ES.5 All programs are operated continuously.

ES.6 There is an overall plan and implemented program to manage general safety and security.

ES.6.1 The hospital has a documented, current, and accurate inspection of its physical facilities.

ES.6.2 There are measures to protect against infant abduction and to protect patients, visitors, and staff from harm, including assault.

ES.6.3 There is a plan for correction of identified deficiencies in safety and security. The plan includes priorities for correction.

ES.6.4 The plan for correction is being implemented.

ES.7 There is a fire and smoke safety plan and an implemented program that addresses prevention, early detection, response, and safe exit when required by fire or other emergencies. The plan addresses at least the following:

ES.7.1 Frequency of inspecting fire detection and suppression systems
ES.7.2 Maintenance and testing of fire protection and abatement systems
ES.7.3 At least annual testing of the facility evacuation plan
ES.7.4 Documentation of staff training in fire response and evacuation
ES.7.5 Enforcement of the law prohibiting smoking in the hospital
ES.7.6 Documentation of all inspections, maintenance, testing, and training

ES.8 There is an emergency preparedness plan to respond to likely community or internal emergencies.
ES.8.1 The plan for response to external emergencies plan is developed according to government guidelines relating to the responsibility of the hospital in the event of an external emergency.
ES.8.2 The plan for response to internal emergencies includes a personnel recall system; alternate care sites, if needed; and alternate sources of medical supplies, utilities, and communication.
ES.8.3 The hospital has tested its plan.

ES.9 There is a hazardous materials and waste management plan for the use, handling, storage, and disposal of hazardous materials and waste. The plan includes at least the following:
ES.9.1 An inventory of the types and locations of hazardous materials and waste
ES.9.2 Safety requirements for the handling, storage, and response to spills or exposures
ES.9.3 Disposal in accordance with applicable laws or regulations
ES.9.4 Labelling of hazardous materials and waste;
ES.9.5 Monitoring data on incidents to allow corrective action

ES.10 There is a plan and an implemented program for inspecting, maintaining, and testing medical equipment. The plan includes at least the following:
ES.10.1 Inventory of all medical equipment
ES.10.2 Schedule for inspection and preventive maintenance according to manufacturer’s recommendations
ES.10.3 Testing of all new equipment before use and repeat testing when required
ES.10.4 Data about frequency of repair or equipment failure.

ES.11 There is a plan and an implemented program for regular inspection, maintenance, and repair of essential utilities. The plan covers at least the following:
ES.11.1 Electricity, including stand-by generators
ES.11.2 Water
ES.11.3 Heating, ventilation, and air conditioning
ES.11.4 Medical gases
ES.11.5 Communications
ES.11.6 Waste disposal
ES.11.7 Regular inspections
ES.11.8 Regular testing
ES.11.9 Regularly scheduled maintenance
ES.11.10 Correction of deficiencies identified
ES.12 For each plan, there is documentation that appropriate staff members have been trained.
ES.12.1 The staff’s knowledge is periodically evaluated.

7. Support Services

Introduction
Although direct provision of care is the primary function of a hospital, its patients and staff are dependent on support services to ensure safe care that is satisfying to patients. One of the more critical requirements in maintaining a safe environment for patients and staff and reducing the risk of hospital-acquired infections is the cleanliness of the hospital and the cleanliness and proper management of linen. In addition, the hospital must ensure that patients receive adequate meals that are nutritious and safely stored and prepared. This chapter defines the requirements for the following support services:

- Housekeeping, including standardized cleaning procedures, infection control committee oversight, and adequate training
- Food service, including sources of food, storage, preparation, and distribution
- Laundry and linen services, including safe handling of contaminated linen and safe cleaning and distribution

Housekeeping
HK.1 The hospital has standardized procedures for cleaning, including instructions for the use of disinfectants.
HK.1.1 The procedures are described in policies that have been approved by the infection control committee.
HK.1.2 The policies include at least a cleaning schedule, cleaning and disinfection solutions to be used in various areas, high-risk area policies, and specific general cleaning procedures to be used, including specific areas where dry sweeping is permitted.
HK.2 All cleaning staff are aware of cleaning procedures and have been trained in proper techniques.
HK.3 There is an adequate supply (three months) of approved cleaning material and disinfectants.
HK.4 The housekeeping supervisor ensures there is an adequate number of cleaning staff per shift according to the size of the hospital and the scope of services it provides.

Food Service and Kitchen
FS.1 The kitchen and food services are managed according to applicable laws and regulations, and hospital leaders are knowledgeable of these laws and regulations and ensure compliance.

FS.2 There are policies and procedures that have been implemented and include at least the following:
FS.2.1 A current list of acceptable suppliers of foodstuff and supplies
FS.2.2 Appropriate storage of perishable food and non-perishable items, including expiration dates
FS.2.3 Standards of sanitation for all food handlers
FS.2.4 Procedures, which have been approved by the infection control committee, for cleaning and/or sterilization of all items used in food preparation
FS.2.5 A kitchen safety program, including fire prevention and suppression
FS.2.6 A list of all special diets available
FS.2.7 A schedule for meals and a process to ensure their timely distribution
FS.2.8 In conjunction with nursing and medical staff, a policy on how to deal with food brought in by family members

FS.3 The kitchen and food service manager maintains a work schedule that ensures that there is an adequate number of staff for each shift.

FS.4 All food service workers are trained.

Laundry and Linen Services

LL.1 Laundry and linen services are operated according to specific policies and procedures. These policies, all of which must have been approved by the infection control committee, include at least the following:
LL.1.1 Collection of soiled linen
LL.1.2 Specific procedures for handling, including labelling, of materials contaminated with hazardous materials or body fluids
LL.1.3 Policies and procedures for cleaning of contaminated materials
LL.1.4 Cleaning supplies approved by the infection control committee for use
LL.1.5 Quality control program, including measure of water temperatures
LL.1.6 Storage and distribution of clean linen
LL.2 There is at least one fully functioning automatic washing machine.
LL.3 Adequate supplies and washing detergents are available.
LL.4 Contaminated linen is separated from clean linen.
LL.5 The laundry supervisor ensures that sufficient staff is available for each shift.
LL.6 All laundry workers are trained.
LL.7 If laundry and linen services are performed through an outside contract, there must be documentation that the requirements of standards LL.1–LL.6 are met by the contractor (also see ML.4.7).
8. Quality Improvement and Patient Safety

Introduction

The quality improvement and patient safety standards found in this chapter may be the most important of all the standards. Continuous improvement and constant concern over reducing the risks to patients identify hospitals that are committed to the welfare of their patients. To improve quality and reduce risks, the hospital must constantly evaluate (measure) its performance and use that information to identify ways in which it can improve. This self-evaluation must be planned and ongoing and should focus on systems and processes, not solely on individual performance. To be successful, the hospital leadership must ensure that the climate does not allow focus on “who is to blame.” To be able to effectively improve quality of care, the hospital must collect, aggregate, and analyze data concerning its current performance. Quality is improved when the hospital ensures that care follows “best practices” that are based on professional literature and not on individual opinion or routine. The hospital must also be able to identify significant unexpected or adverse events and intensively analyze them to understand their underlying causes and, as a result, make the necessary effective changes. This chapter defines the requirements for the following areas to help improve quality and reduce risks:

- A planned and hospital wide approach
- The required structure (committee)
- The development and implementation of clinical guidelines
- Measurements (data collection) for both clinical and managerial indicators of quality
- Identification and analysis of significant events

QI.1 The hospital has a quality improvement and patient safety committee assigned to improving the quality of care at the hospital.

QI.1.1 The committee is chaired by the hospital director.

QI.1.2 The membership is multidisciplinary and includes senior members of the medical and nursing staff, other department representatives, and the QI coordinator.

QI.1.3 There are terms of reference for the committee, which include the following:

QI.1.3.1 Ensuring that all departments participate
QI.1.3.2 Establishing hospital wide priorities for improvement
QI.1.3.3 Ensuring that all required measurements are done
QI.1.3.4 Reviewing the analysis of aggregate data, including the frequency of data collection and analysis
QI.1.3.5 Using authority to direct action in response to identified quality improvement or patient safety issues
QI.1.3.6 Reporting information both upward to leaders and downward to staff members.

QI.2 There is an assigned quality improvement coordinator whose role is to coordinate QI activities.

QI.2.1 The QI coordinator is a member of all relevant hospital committees.

QI.2.2 There is a written job description for the QI coordinator.

QI.3 The hospital has a written quality improvement and patient safety plan. The plan includes at least the following:

QI.3.1 A description of the methodology to be used

QI.3.2 The membership of the quality improvement and patient safety committee

QI.3.3 Authority of the committee

QI.3.4 Criteria for establishing priorities

QI.3.5 Information flow

QI.3.6 Description of required measurements

QI.4 There is an incident-reporting policy describing a system with written procedures on the following:

QI.4.1 List of reportable incidents

QI.4.2 Persons responsible for initiating reports

QI.4.3 How, when, and by whom incidents are investigated

QI.4.4 Corrective action plan and assigned responsibilities

QI.5 As part of their orientation, all employees receive basic training in the principles and practice of quality improvement.

QI.6 The hospital has developed, disseminated, and adopted clinical practice guidelines for priority clinical services and procedures provided.

QI.6.1 Clinical practice guidelines are based on current professional literature.

QI.6.2 Relevant staff is educated about the guidelines.

QI.6.3 Clinical practice guidelines cover the three most common diagnoses in each medical department.

QI.6.4 Clinical practice guidelines cover the three most common procedures in each medical department.

QI.6.5 Clinical practice guidelines cover at least two high-risk diagnoses and two high-risk procedures (if applicable) in each medical department.

QI.6.6 Each medical department develops and implements at least one additional clinical practice guideline each year.

QI.6.7 Clinical practice guidelines are reviewed at least every two years and are revised when needed based on current professional literature.

QI.6.8 As part of the quality improvement program, the hospital collects, aggregates, and analyzes data about compliance with the clinical practice guidelines.

QI.7 The hospital provides QI training to its staff.
QI.8 The hospital monitors clinical care by collection, aggregation, and analysis of data related to at least the following:

QI.8.1 Patient assessment
QI.8.2 Laboratory and radiology safety and quality control programs
QI.8.3 Surgical and invasive procedures
QI.8.4 Use of antibiotics, other medications, and medication errors
QI.8.5 Use of anesthesia and moderate and deep sedation
QI.8.6 Use of blood and blood products
QI.8.7 Medical records, including availability and content
QI.8.8 Infection control
QI.8.9 Adherence to rules on clinical research

QI.9 Managerial monitoring includes at least the following:

QI.9.1 Procurement of routinely required supplies and medications essential to meet patient needs
QI.9.2 Reports as required by law and regulation
QI.9.3 Risk management
QI.9.4 Utilization management
QI.9.5 Staff expectations and satisfaction
QI.9.6 Patient and family expectations and satisfaction
QI.9.7 Patient demographics and diagnoses and procedures
QI.9.8 Finance
QI.9.9 Identified patient safety issues

QI.10 Individuals with appropriate experience, knowledge, and skills systematically aggregate and analyze data in the hospital.

QI.11 Intensive assessment is done when significant unexpected events and undesirable trends and variation occur. Significant events that will be analyzed in detail include at least the following:

QI.11.1 Unexpected deaths
QI.11.2 Confirmed transfusion reactions
QI.11.3 Significant adverse drug reactions that cause harm to a patient
QI.11.4 Significant medication errors that cause harm to a patient
QI.11.5 Significant anesthesia events that caused harm to a patient
QI.11.6 Significant differences between pre- and post-operative diagnoses, including surgical pathology findings

QI.12 The hospital data are analyzed and used by hospital management for decision-making.

QI.13 The governing body, hospital director, and heads of departments actively participate in the planning and monitoring of the quality improvement and patient safety program.

9. Medical Records

Introduction
The medical record is the source document that allows evaluation of the quality of care, effective communication among all health care professionals, the appropriate transfer of information between units within the hospital and to other hospitals, and continuity of care during and after hospitalization. A poorly documented medical record may mask inadequate care. Since the medical record is the foundation for nearly all the direct patient-related standards in this manual, this chapter defines the following:

- Requirements for all medical records, whether inpatient or outpatient
- Specific requirements for inpatient records
- Specific requirements for outpatient records

**MR.1 The hospital has a medical record for each patient evaluated or treated.**

**MR.2 Each medical record contains sufficient information to perform the following:**

**MR.2.1** Identify the patient, including name, address, and date of birth

**MR.2.2** Promote continuity of care

**MR.2.3** Support the diagnosis

**MR.2.4** Justify the treatment

**MR.2.5** Document the patient’s course and results of treatment

**MR.3 The hospital and its medical staff have defined in writing the minimum acceptable scope of the history and physical examination, which may vary depending on the patient’s needs and the setting of care or the specialty.**

**MR.3.1** The hospital and its medical staff have defined in writing the minimum acceptable scope of the comprehensive history and physical examination for inpatient admission for adults and children, including inpatient surgery.

**MR.3.2** Outpatient surgery and other invasive procedures

**MR.3.3** Emergency room patients

**MR.3.4** Psychiatry admissions

**MR.3.5** Obstetrical admissions

**MR.3.6** Inpatient short-stay (less than 48 hours) patients

**MR.3.7** Hospital outpatient visits

**MR.4 Results of all diagnostic tests are documented in the patient’s medical record and are received within the timeframe established by each department that does diagnostic tests.**

**MR.4.1** The timeframes are defined for emergent and routine test results.

**MR.5 All diagnoses are recorded and updated according to the results of investigations and/or reassessments.**

**MR.6 All treatments, including medications administered, are recorded when given and are signed by the person providing the treatment.**
MR.7 The medical record documents that physicians and/or other health professionals explained to all patients the diagnosis and treatment and any follow-up steps.

MR.7.1 There is documentation that the physician or other health professional ensured that patients understood the message through feedback.

MR.7.2 There is documented evidence that patients were educated on their diagnosis or condition.

MR.7.3 When relevant to the patient’s diagnosis, there is documentation of education concerning diagnostic tests, treatments, medication, and use of any medical equipment.

MR.7.4 When relevant to the patient’s diagnosis, there is documentation of education that includes information on risk reduction: diet, exercise, smoking cessation, and other health-related practices.

MR.7.5 When relevant to the patient’s diagnosis or condition, education includes community resources available to the patient (diabetic, asthmatic).

MR.7.6 When relevant to the patient’s diagnosis or condition, education includes any special education classes.

MR.7.7 When relevant to the patient’s diagnosis or condition, education includes food and drug interactions.

MR.7.8 When relevant to the patient’s diagnosis or condition, education includes nutrition.

MR.7.9 When relevant to the patient’s diagnosis or condition, education includes physical rehabilitation.

MR.8 All diagnostic and therapeutic orders are authenticated by the appropriate department.

MR.8.1 There is a policy defining the types of verbal or telephone orders that must be authenticated and the time frame for authentication.

MR.9 A comprehensive operative note is entered in the medical record immediately after surgery or invasive procedures.

MR.10 The hospital has defined who is authorized to make entries in the medical record.

MR.11 The author of all entries in the medical record can be identified by name and title (physician, nurse, physical therapist).

MR.12 In event of transfer of the patient to another facility, a copy of the transfer summary written by the physician will go with the patient. The original is placed in the hospital record.

MR.12.1 The reason for the transfer is explained to the patient.

MR.13 The hospital uses standardized diagnosis and procedure codes.

MR.14 The hospital has a process for review of medical records. The process includes the following:

MR.14.1 Involvement of representatives of all disciplines who make entries in the medical record

MR.14.2 Review of the completeness (content) and legibility of entries
MR.14.3 Review of a representative sample

Inpatient Records

MR.15 A history and physical examination is recorded in the patient’s medical record within 24 hours of admission, or earlier, if indicated by the patient’s condition.

MR.16 The history and physical examination is recorded in the patient’s medical record prior to surgery or any invasive procedure.

MR.17 If the history and physical examination has been completed prior to admission, a legible copy may be used provided it is no more than 30 days old and the physician enters a note in the medical record defining any subsequent changes, based on reassessment of the patient.

MR.18 A comprehensive history and physical examination includes at least the following:

MR.18.1 The main complaint
MR.18.2 Details of the present illness
MR.18.3 Past history including
   MR.18.3.1 Previous admissions and surgery, if applicable
   MR.18.3.2 Allergies
   MR.18.3.3 Adverse drug reactions, if any
   MR.18.3.4 Medications the patient has been taking, if any
MR.18.4 Psychosocial history, including emotional, behaviour, and social status
MR.18.5 Family history
MR.18.6 For paediatric patients, the H&P must include the parent’s report or other documentation of the patient’s immunization status and a growth and development chart for ages established by department policy.
MR.18.7 A comprehensive current physical examination, including vital signs and positive findings
MR.18.8 A statement of the conclusion or impressions drawn from the admission history and physical examination
MR.18.9 The initial management plan, including investigations and treatment

MR.19 Medical progress notes are made by the medical staff with a frequency according to the severity of illness, hospital policy, and patient’s condition.

MR.19.1 In all acute care settings, physician’s progress notes are made at least once per day.

MR.20 Type of diet provided according to the patient’s condition is documented in the medical record.

MR.21 Records of discharged patients are completed within a period of time not exceeding 15 days of the date of discharge.
MR.22 Patient record must contain a copy of the discharge summary. The discharge summary must include at least the following:

MR.22.1 The reason for admission
MR.22.2 Significant findings, including investigations
MR.22.3 Procedures performed
MR.22.4 Any diagnoses made
MR.22.5 Medications or other treatments, if applicable
MR.22.6 Patient’s condition at discharge
MR.22.7 Discharge medications and follow-up instructions

MR. 23 There is a policy that is followed that defines where in the medical records all orders, including those for medications, must uniformly be written or recorded.

Outpatient Records

MR.24 The hospital defines the minimum content of outpatient medical records for new patients for comprehensive assessment.
MR.25 The hospital defines the minimum content of outpatient medical records for outpatient procedures.
MR.26 The hospital defines the minimum content of outpatient medical records for brief illness or injury-related visits.
MR.27 The hospital defines the minimum content of outpatient medical records for return visits.

10. Management of Information

Introduction

Modern health care, and its continuous improvement, is dependent on information. The hospital should have a plan to meet the information needs of its clinical and managerial leaders and to compare its performance with other databases when relevant. The plan should address these needs and should reflect the types of services offered.

IM.1 The hospital has a written plan or plans to meet information needs. The plan(s) is based on at least the following:

IM.1.1 The identified information needs of clinical and managerial leaders of the hospital
IM.1.2 The size and the types of services provided by the hospital
IM.1.3 Confidentiality and security of data and information and protection from loss or damage
IM.1.4 Determination of levels of required access to data and information
IM.1.5 Requirement for standardized diagnosis and procedure codes
IM.2 The plan is being implemented.
IM.3 Clinical and managerial staff participate in selecting, integrating, and using information management technology.
IM.4 The organization has a policy on the retention time of records, data, and information.
IM.5 Records and information are protected from loss, destruction, tampering, and unauthorized access or use.
IM.6 The hospital contributes to external databases in accordance with the law or regulation.
IM.7 The organization uses external reference databases, including infection control, for comparative purposes.

11. Human Resources

Introduction
Hospitals have many resources, including real estate, buildings, and equipment. In every hospital, however, the most valuable resource is its staff. With that in mind, the hospital must determine its personnel requirements. The responsibility of staff must be defined; they must be carefully selected; their competency must be evaluated before being allowed to work; their orientation must be completed; their continued competency must be periodically assessed; and they must be afforded continued training relating to their responsibilities. This chapter outlines the requirements for the following items related to human resources:

- A staffing plan
- Job descriptions for all types of employees
- An employee-specific file
- Periodic revaluation of the employee’s performance

HR.1 Each department has a written staffing plan. The plan defines the following:
HR.1.1 The total number of staff members needed to fulfil the department’s responsibility
HR.1.2 The types of staff members needed
HR.1.3 The required education, skills, knowledge, and experience required for each position
HR.1.4 The plan is periodically reviewed and updated as required, but at least every two years.

HR.2 Each employee has a current job description. The job description includes the required education, skills, knowledge, and experience and a description of the responsibilities of the individual.
HR.2.1 There is documentation in each employee’s file that the job description has been discussed with the employee.
HR.3 There is an implemented process that is uniformly applied for recruiting staff.
HR.4 There is an implemented process that is uniformly applied for evaluating the qualifications of new staff.
HR.5 There is an implemented process that is uniformly applied for appointing new staff members.
HR.6 There is an implemented process that is uniformly applied for revaluation of each category of employees, including the frequency of revaluation.

HR.7 A personnel file is maintained for each employee. Each file must contain, when applicable to that employee, the following seven elements:
- Copies of diplomas, licenses, certifications
- Work history
- Current job description
- Evidence of orientation to the hospital, the assigned department, and the specific job
- Evidence of initial evaluation of the employee’s competence to perform the assigned job
- In-service education received
- Copies of annual evaluations

HR.8 (5) There is a formal orientation program for all employees: The program should include three levels of orientation: hospital wide, departmental, and job specific.
HR.8.1 Orientation to hospital structure and administration, provided by hospital management.
HR.8.2 Orientation to hospital policies, including all environmental safety programs, infection control, and quality improvement.
HR.8.3 Orientation to the assigned department.
HR.8.4 Orientation to the specific job within the department.

HR.9 There are programs in each department for ongoing in-service training.
HR.9.1 The education is based on evaluation of the employees’ needs.

HR.10 All staff members who provide direct patient care have received training in basic cardiopulmonary resuscitation and the training is repeated at least every two years.

HR.11 There are facilities and materials appropriate to the identified training needs.
HR.11.1 There is a library with materials appropriate to the services provided by the hospital.

HR.12 The hospital surveys provider and other staff satisfaction at least once per year.
HR.12.1 The data from the survey are aggregated and analyzed at least once per year.
HR.13 Decision makers and other staff members are trained in the principles of information management, as appropriate to their responsibilities or job description.

12. Management and Leadership

Introduction

The leadership of any hospital includes its most critical components for fulfilling its mission. Typically this includes the governing body, administration, medical staff, and nursing. To provide quality and safe care, members of the leadership team must work collaboratively. They must understand the hospital’s mission and their own responsibilities and work to ensure that clear lines of authority are established and that there are effective means of communication. This chapter outlines the requirements for the following management and leadership areas:

• Development of a mission statement
• Processes for coordination and communication
• A clear organizational structure that defines authorities
• The responsibility of the hospital director
• The responsibility of department heads

ML.1 The hospital has a clear mission statement developed and agreed upon by the hospital council.
ML.1.1 The mission statement is made public.
ML.2 There is a clear system/process for coordination and communication between the director and the staff.
ML.3 The facility has a clear and written organizational structure with clear lines of authority.
ML.4 A full-time director is appointed by the governing body and is assigned to manage the hospital in accordance with applicable laws and regulations. The director has a clear written job description. The job description defines at least the following responsibilities:
ML.4.1 Providing oversight of day-to-day operations
ML.4.2 Ensuring that necessary policies and procedures are developed and approved by the governing body when required
ML.4.3 Ensuring that the hospital complies with all laws and regulations
ML.4.4 Providing oversight of human, financial, and physical resources
ML.4.5 Ensuring that there is a functional, including appropriate resources, hospital wide program for quality improvement and patient safety
ML.4.6 Ensuring appropriate response to reports from any inspecting or regulatory agencies, including accreditation
ML.4.7 Ensuring oversight of all contract services
ML.5 The hospital director has appropriate training and/or experience in health management as defined in the job description.
ML.6 The hospital director and all department managers ensure that there is a planned, written, and documented orientation program for all employees.
ML.7 A department head is assigned to each of the administrative and clinical departments. The responsibility of department heads includes at least the following:
ML.7.1 Providing a written description of the services provided by the department
ML.7.2 Ensuring coordination and integration of these services with other departments when relevant
ML.7.3 Recommending space, staffing, and other resources needed to fulfill the department’s responsibility
ML.7.4 Defining the education, skills, and education needed by each category of employee in the department
ML.7.5 Ensuring that there is an orientation and continuing education program for the department’s employees
ML.7.6 Developing and implementing a department quality improvement program

13. Medical Staff
Introduction
The medical staffs are the most important component for the provision of quality and safe care. The hospital must have processes to ensure that members of the medical staff are fully qualified to provide only those health care services that are based on their education, training, and experience and demonstrated competence. Since competence may change over time, there must be a clearly defined and uniformly applied process for periodic reevaluation of the performance of each individual member of the medical staff. This chapter defines the requirements for the following related to medical staff:
• A process to determine the qualifications of medical staff members and maintenance of a file containing all relevant information
• Definition of who may be a member of the medical staff
• A process to determine the specific clinical services (delineated clinical privileges) that each medical staff member is authorized to provide
• A process to periodically reevaluate the medical staff member’s continued competence to provide the authorized clinical services
• Medical staff participation in quality improvement and safety activities
• The responsibilities of department heads
MD.1 The hospital maintains a record for every member of the medical staff that contains a copy of all documents related to license, education, experience, and certification.

MD.2 Appointment of medical staff members is done according to the hospital policy, is approved by the governing council, and is in accordance with MOHP rules and regulations.

MD.3 The hospital has a written policy, approved by the governing council, for managing medical staff.

MD.4 The medical staff includes licensed physicians and dentists and may include other licensed individuals permitted by law to provide patient care services independently in the hospital.

MD.5 All medical staff members have delineated clinical privileges that define the scope of patient care services they may provide independently in the hospital.

MD.6 All medical staff members and all others with delineated privileges are subject to medical staff rules, regulations, and policies.

MD.7 All senior medical staffs participate in quality improvement activities in their department and in the hospital.

MD.8 The performance of all individual medical staff members is reviewed once per year to determine their continued competence to provide patient care services.

MD.9 The hospital has a functioning continuous medical education program. All medical staff members receive continuing medical education.

MD.10 Each department has a designated head.

MD.11 The head of the department is certified in an appropriate specialty and has appropriate experience.

MD.12 Each department head has a written job description defining the responsibilities, including active support of the quality improvement and patient safety program.

MD.13 In hospitals participating in professional graduate education programs, physicians in training are supervised by a qualified medical staff member in carrying out their patient care responsibilities.

14. Nursing Services

Introduction

Nurses are the only health care professionals who are with the patient 24 hours a day. Their role is critical in nearly all aspects of patient assessment and care. When nurses assume a more active role in evaluating patients and monitoring their response to treatment, outcomes of care are improved. The standards in this chapter set a framework for increasing the role of nursing services. This chapter defines the following:
The role and responsibility of the nurse director/executive, including being a member of the senior leadership team of the hospital

- An expanded role for nurses in assessing patients and creating a formal plan for nursing care
- Nursing participation in quality improvement and other important hospital committees

**NS.1** The hospital nurse director/executive is a registered nurse and is qualified by education and managerial experience, as required by the job description.

**NS.2** The nurse director is a member of the senior leadership team of the hospital.

**NS.2.1** The nurse director attends the senior leadership staff meetings.

**NS.3** The nurse executive is responsible for determining nursing standards of practice and their implementation. These standards include at least the following:

- A documented nursing assessment
- A documented nursing diagnosis or diagnoses
- A documented nursing care plan
- Documentation of nursing treatments and reassessments
- Evaluation of the effectiveness of nursing treatments

**NS.4** In conjunction with the leaders of the medical staff, the nursing executive determines the scope of nursing assessment.

**NS.4.1** There is a written description of the scope of nursing assessment that may vary by unit or type of patient.

**NS.4.2** Nurses document directly in the patient’s medical record.

**NS.5** The nurse director and other nursing leaders participate with the leader of the governing body, management, and medical staff in the development, ongoing review, and implementation of all relevant hospital plans, programs, and policies.

**NS.6** The nurse director identifies staffing needs and participates in recruiting plans.

**NS.7** The nurse director ensures that schedules assigning jobs to the staff members, according to the overall workload, are completed.

**NS.8** Nursing assignments are made on the basis of the job description and the evaluation of the individual nurse’s competence.

**NS.9** Nurses participate in hospital committees including, but not limited to, the following:

- Quality improvement
- Infection control
- Drug utilization
- Medical records
- Safety
NS.10 The nursing department develops and implements written policies and procedures guiding nursing care and specifies type of care they are permitted to provide. These policies and procedures include, but are not limited to, the following:

NS.10.1 Scope of nursing assessment
NS.10.2 Infection control
NS.10.3 Basic hygiene
NS.10.4 Safety
NS.10.5 Medication administration
NS.10.6 Parenteral therapy
NS.10.7 Skin care and prevention of pressure sores
NS.10.8 Administration of blood and blood products

NS.11 There is planned and documented orientation program for new nurses. The plan includes at least the following:

NS.11.1 Organization policies and procedures
NS.11.2 Nursing department policies and procedures
NS.11.3 Individual job description
NS.11.4 Nursing QI program
NS.11.5 Fire and disaster plan and safety training
NS.11.6 Infection control policies and procedures

NS.12 There is a nursing continuing training program in all nursing practice areas.

NS.13 There is a documented annual training review for all nursing staff in at least infection control, fire and disaster plan, and safety.

NS.14 Nursing care is an essential part of overall patient care process.

NS.15 Collaboration of nurses with physicians and other workers for patient care is planned and documented.

NS.16 Nurses participate in patient education, including during the discharge process.

Accreditation Scoring System

Facts about scoring and accreditation decisions

In January 1, 2004, as part of its Shared Visions-New Pathways initiative, The Joint Commission changed its scoring and accreditation decision process. The Joint Commission’s previous accreditation decision process was a score-based system that encouraged organizations to “ramp up” to do well on a survey to achieve a high score. The current accreditation decision process:

• Focuses on ongoing standards compliance
• Is more credible, assuring the public that accredited organizations have demonstrated full compliance with the standards
• Is based primarily on the number of standards that are scored not compliant
• Simplifies the compliance screening process in determining an accreditation decision
• Focuses less on “scores” and more on using the standards to achieve and maintain excellent operational systems.

**Elements of Performance**

Compliance with the standards is scored by determining compliance with Elements of Performance, which are specific performance expectations that must be in place for an organization to provide safe, high quality care, treatment and services. EPs are scored on a three-point scale: 0 = insufficient compliance, 1 = partial compliance, 2 = satisfactory compliance. Each standard has one or more EP. Each EP is labelled in the accreditation manuals and EPs all have the same weight. EPs are divided into three scoring categories:

**“A”** Elements of Performance usually relate to structural requirements (for example, policies or plans) that either exist or do not exist, and are scored either 0 or 2. “A” EPs may also address an issue that must be fully compliant even though it focuses on performance or outcome (e.g., National Patient Safety Goals). “A” EPs may also be related to a Condition of Participation that must always be fully compliant.

**“B”** Elements of Performance relate to the presence or absence of requirements and are usually answered yes or no. If the organization does not meet the requirements, the EP is scored 0. If the organization meets the requirements, but there is concern about the quality or comprehensiveness of the effort, the surveyor will review the applicable principles of good process design with the organization. If the applicable principles are met, the EP is scored 2. If none of the principles are met, the EP is scored 0. If more than one, but not all of the principles are met, the EP is scored 1.

**“C”** Elements of Performance are frequency-based EPs and are scored based on the number of times an organization does not meet a particular EP. A “C” EP is scored 2 if there are one or fewer occurrences of non-compliance; it is scored 1 if there are two occurrences of non-compliance; and it is scored 0 if there are three or more occurrences of non-compliance.

After an organization’s compliance with an EP is scored, its track record is evaluated as noted below. The track record illustrates the amount
of time that an organization has been compliant with an EP. This can affect the EP score.

<table>
<thead>
<tr>
<th>Score</th>
<th>Initial Survey</th>
<th>Full Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>4 months or more</td>
<td>12 months or more</td>
</tr>
<tr>
<td>1</td>
<td>2 to 3 months</td>
<td>6 to 11 months</td>
</tr>
<tr>
<td>0</td>
<td>Fewer than 2 months</td>
<td>Fewer than 6 months</td>
</tr>
</tbody>
</table>

EPs are then aggregated to determine standards compliance. Standards are scored on a non-numeric two-point scale (compliant or not compliant). More information on the scoring rules is included in the accreditation manuals.

**Compliant and Not Compliant Standards**

If a single EP is scored 0 (insufficient compliance), it automatically triggers a not compliant standard. However, if a single EP is scored 1 (partial compliance), it does not trigger a not compliant standard; 35 percent or more of the EPs under a specific standard would have to be scored 1 (partially compliant) for that standard to be considered not compliant. If standards are scored not compliant at the time of the on-site survey, an organization must demonstrate that it has corrected systems and processes to be in compliance with those standards by submitting Evidence of Standards Compliance. Organizations have 45 days to submit an ESC to The Joint Commission. Also, if required by the EP, the organization will also submit an indicator, or Measures of Success, that it will use to assess sustained compliance over time. Four months after approval of the ESC, the organization will submit data on its Measure of Success to demonstrate sustained compliance over time.

After the on-site survey, organizations do not receive an overall score or grid element score, and no scores are shared with the health care organization. The final accreditation decision will be made after The Joint Commission receives and approves an organization’s ESC submission and its Measures of Success (when required). However, surveyors will leave an accreditation report on-site. The report includes:

- Requirements for Improvement by priority focus area (processes, systems or structures important to providing safe quality care in a health care organization)
- The standard number, the text of the standard, the specific findings of the survey team and the EPs that are partially compliant or insufficiently
compliant. The organization must address all Requirements for Improvement, in the form of ESC, to be accredited

- Supplemental findings of EPs that were scored partially compliant but did not cause the standard to be scored not compliant. Supplemental findings do not require an ESC to be submitted.

**Accreditation decision categories**

**Accredited** — The organization demonstrates compliance with all of the standards at the time of the on-site survey, or it resolves Requirements for Improvement via an acceptable ESC submission.

**Provisional Accreditation** — All Requirements for Improvement have not been addressed in the ESC submission, or the organization has failed to achieve an appropriate level of sustained compliance as determined by a Measure of Success result (when required).

**Conditional Accreditation** — Number of standards scored not compliant is between two and three standard deviations above the mean number of not compliant standards for organizations in that accreditation program. The organization must undergo an on-site follow-up survey.

**Preliminary Denial of Accreditation** — Number of standards scored not compliant is three or more standard deviations above the mean number of not compliant standards for organizations in that accreditation program. There is justification to deny accreditation, but the decision is subject to appeal.

**Denial of Accreditation** — The organization has been denied accreditation, and all review and appeal opportunities have been exhausted.

**Preliminary Accreditation** — The organization demonstrates compliance with selected standards in the first of two surveys conducted under the Early Survey Policy Option 1. This decision remains in effect until one of the other official accreditation decision categories is assigned, based on a complete survey against all applicable standards approximately six months later.

**Quality Improvement plans**

Quality systems are an important component for the effective management of a hospital. The positive cultural shift is where staff at all levels move from a closed atmosphere to an educative environment where mistakes are openly reviewed and used to prevent the mistake being repeated. The cultural shift, a commitment to quality improvement is required, commencing at the senior management level and must be communicated to staff at all levels. The strategic plan, disseminated to all staff would be expected to highlight the commitment to quality
improvement and it is supported by quality improvement committee. There should be coordination, which may be managed via a committee with a chairperson, or conversely, a person may be appointed, part or full time dedicated to the role of quality co-coordinator. However structured, the quality committee(s) would be charged with the duty of establishing a quality improvement plan(s).

Quality improvement plans must have very clear objectives using key performance indicators as the measurement tools. These indicators can be established using the S.M.A.R.T. principles which are clearly Specific, Measurable, Achievable, Realistic and Time-bound. The statements should be written and have only one objective with input from all levels of staff. It is important that the objectives are realistic. Efforts to achieve the desired outcomes must be monitored and documented on a regular basis. All activities should be clearly documented, commencing with the management and / or quality improvement committee identifying the position the hospital is at in relation to quality improvement. Monitoring progress should be always done. Satisfaction questionnaires, surveys, complaints are collected. It is important to analyze data into meaningful statistics and then to identify deficits in planned interventions.

Once the intervention(s) have been operational for a period of time the integral part of the quality loop (plan, do, check, and act) must be completed. This needs the conduction of checks on the consequences of any introduced interventions. Documentation of the cycle and feedback to the department / staff involved is important to demonstrate the completion of the quality activity. However, hospitals frequently have day to day situations which require a reactive component and thus must also be documented and tracked. This may be achieved through the development of improvement logs. An improvement log is a form available to all staff whereby requests can be forwarded to the quality department outlining the need for improvement regarding specific issues. The above information is not intended to be all inclusive. Individual hospitals and each department have the responsibility to research information that allows them to comply with the accreditation standards specified below by the accreditation committee in the Lebanese ministry of Public Health.

**Example 1: standards applied for Lebanese hospitals**

**QS 1**

1.1 A current organigram (organizational chart) of the staffing structure of the hospital exists

1.2. A current organigram of the committee structure exists

**QS 2** An annual hospital wide quality improvement plan exists which includes sections for:
2.1 Management
2.2 Finance
2.3 Medical Services
2.4 Nursing services
2.5 General services
2.6 It must contain key performance indicators that are specific, measurable, achievable, and realistic and have timelines
2.7 Evidence of continual monitoring of this plan must be available
QS 3 A multi-disciplinary quality improvement committee exists with:
3.1 Terms of reference
3.2 List of members
3.3 Minutes of all meetings
3.4 Documented monitoring of the quality improvement plan is conducted at least quarterly
QS 4 An annual report is presented to the management of the hospital in relation to the quality improvement plan
QS 5 A staff member is designated as the quality improvement coordinator (however named) with specific time allocated to the role as reflected in their job description
QS 6
6.1 Each department conducts an annual assessment of the continuing education requirements of staff and forwards the report to either the education department (if applicable) or to the quality coordinator
6.2 Copies of each department’s education program are held by the quality improvement committee
QS 7 A documented policy and procedure for complaints exists for:
7.1 Patients
7.2 Staff
7.3 Visitors / others
7.4 Investigation and resulting actions from complaints are documented
QS 8
8.1 A system exists for determining patient and staff satisfaction
8.2 Analysis is conducted regarding patient and staff satisfaction
8.3 Documented planned intervention to address any deficits identified
8.4 Documented evidence is required to demonstrate that the actions have taken place and results have been re-audited
QS 9
9.1 An improvement log process is operational
9.2 The improvement log(s) show evidence of the quality feedback loop
QS10
10.1 There is a suggestion box for staff and patients
QS 11 Documented patients rights and responsibilities are available to all patients and relatives.
Example2: standards applied for Egyptian hospitals

QI.1 The hospital has a quality improvement and patient safety committee assigned to improving the quality of care at the hospital
QI.1.1 The committee is chaired by the hospital director
QI.1.2 The membership is multidisciplinary and includes senior members of the medical and nursing staff, other department representatives, and the QI coordinator
QI.1.3 There are terms of reference for the committee, which include the following:
   QI.1.3.1 Ensuring that all departments participate
   QI.1.3.2 Establishing hospital wide priorities for improvement
   QI.1.3.3 Ensuring that all required measurements are done
   QI.1.3.4 Reviewing the analysis of aggregate data, including the frequency of data collection and analysis
   QI.1.3.5 Using authority to direct action in response to identified quality improvement or patient safety issues
   QI.1.3.6 Reporting information both upward to leaders and downward to staff members.
QI.2 There is an assigned quality improvement coordinator whose role is to coordinate QI activities
QI.2.1 The QI coordinator is a member of all relevant hospital committees
QI.2.2 There is a written job description for the QI coordinator.
QI.3 The hospital has a written quality improvement and patient safety plan. The plan includes at least the following:
   QI.3.1 A description of the methodology to be used
   QI.3.2 The membership of the quality improvement and patient safety committee
   QI.3.3 Authority of the committee
   QI.3.4 Criteria for establishing priorities
   QI.3.5 Information flow
   QI.3.6 Description of required measurements.
QI.4 There is an incident-reporting policy describing a system with written procedures on the following:
   QI.4.1 List of reportable incidents
   QI.4.2 Persons responsible for initiating reports
   QI.4.3 How, when, and by whom incidents are investigated
   QI.4.4 Corrective action plan and assigned responsibilities.
QI.5 As part of their orientation, all employees receive basic training in the principles and practice of quality improvement.
QI.6 The hospital has developed, disseminated, and adopted clinical practice guidelines for priority clinical services and procedures provided
QI.6.1 Clinical practice guidelines are based on current professional literature
QI.6.2 Relevant staff is educated about the guidelines
QI.6.3 Clinical practice guidelines cover the three most common diagnoses in each medical department
QI.6.4 Clinical practice guidelines cover the three most common procedures in each medical department
QI.6.5 Clinical practice guidelines cover at least two high-risk diagnoses and two high-risk procedures (if applicable) in each medical department
QI.6.6 Each medical department develops and implements at least one additional clinical practice guideline each year
QI.6.7 Clinical practice guidelines are reviewed at least every two years and are revised when needed based on current professional literature
QI.6.8 As part of the quality improvement program, the hospital collects, aggregates, and analyzes data about compliance with the clinical practice guidelines.
QI.7 The hospital provides QI training to its staff.
QI.8 The hospital monitors clinical care by collection, aggregation, and analysis of data related to at least the following:
QI.8.1 Patient assessment
QI.8.2 Laboratory and radiology safety and quality control programs
QI.8.3 Surgical and invasive procedures
QI.8.4 Use of antibiotics, other medications, and medication errors
QI.8.5 Use of anesthesia and moderate and deep sedation
QI.8.6 Use of blood and blood products
QI.8.7 Medical records, including availability and content
QI.8.8 Infection control
QI.8.9 Adherence to rules on clinical research.
QI.9 Managerial monitoring includes at least the following:
QI.9.1 Procurement of routinely required supplies and medications essential to meet patient needs
QI.9.2 Reports as required by law and regulation
QI.9.3 Risk management
QI.9.4 Utilization management
QI.9.5 Patient and family expectations and satisfaction
QI.9.6 Staff expectations and satisfaction
QI.9.7 Patient demographics and diagnoses and procedures
QI.9.8 Finance
QI.9.9 Identified patient safety issues.
QI.10 Individuals with appropriate experience, knowledge, and skills systematically aggregate and analyze data in the hospital.
QI.11 **Intensive assessment** is done when significant unexpected events and undesirable trends and variation occur. Significant events that will be analyzed in detail include at least the following:

QI.11.1 Unexpected deaths
QI.11.2 Confirmed transfusion reactions
QI.11.3 Significant adverse drug reactions that cause harm to a patient
QI.11.4 Significant medication errors that cause harm to a patient
QI.11.5 Significant anesthesia events that caused harm to a patient
QI.11.6 Significant differences between pre- and post-operative diagnoses, including surgical pathology findings.

QI.12 The hospital data are analyzed and used by hospital management for decision-making.

QI.13 The governing body, hospital director, and heads of departments actively participate in the planning and monitoring of the quality improvement and patient safety program.

**Infection control plan**

*Example 1: standards applied for Lebanese hospitals*

The aim of an infection control (IC) program is to effectively facilitate a hospital wide prevention, surveillance and control of infections. The person who will be assigned the position of infection control officer (however named) should have the appropriate qualifications, not less than a Bachelor of Science (in nursing or some other health related field). Education sessions must be appropriately geared to the level of expertise and the roles and responsibilities of each member. The infection control education program must ensure that all staff members understand the principles of universal / standard precautions. Hospital management should ensure that all areas have sufficient sinks supplied with liquid hand soap, paper towels and a foot pedal bin available. Policies and procedures pertaining to infection control should be in the hospital wide format and be referenced to current theories and practice. It is mandatory for the infection control policies and procedures to be ratified and distributed by the infection control committee. The infection control committee should have an annual documented schedule of environmental audits. The results should be collated and analyzed and the quality loop is to be completed by a follow up audit to verify that the planned intervention(s) have indeed improved the situation. The above information is not intended to be all-inclusive. Thus individual hospitals and each Department have a responsibility to research and source information that allows them to comply with the standards below.

IC 1
1.1 A qualified individual with a minimum of a Bachelor of Science to be designated as the infection control officer
1.2 The person appointed to the role of Infection control officer (however named) is in a full time capacity
OR
1.3 The person appointed to the role is in a part time capacity and can demonstrate dedicated hours.

IC 2
2.1 A multi-disciplinary infection control committee exists
2.2 The infection control committee has access to a physician who has training and experience in the field of infectious disease at least on a consultancy basis
2.3 The committee meets at least quarterly
2.4 There is a list of members of the IC committee available in all departments
2.5 There are available terms of reference for the IC committee
2.6 Minutes of all meetings are retained
2.7 Decisions from issues discussed at all meetings can be tracked through documented outcomes.

IC 3
3.1 The infection control department has an annual budget
3.2 There is evidence that the department has input into the construction of the budget
3.3 The IC committee has regular financial reports that include actual expenditure and year to date results.

IC 4 A documented annual infection control audit includes details as follows but not limited to:
4.1 A yearly calendar of due dates of activities
4.2 Specified activities for each department
4.3 Corresponding results
4.4 Response to evidence of pathogens / pyrogens
4.5 Interventions following findings are documented
4.6 Follow up testing.

IC 5 All hand wash basins are equipped with liquid soap, paper towels and a foot-pedal bin.

IC 6 A policy and procedure manual exists which describes the infection control service at this hospital
6.1 Policies are clearly identified
6.2 Procedures are clearly identified
6.3 Policies and procedures are presented in a hospital wide, uniform manner
6.4 The index for the policy and procedure manual is accurate
6.5 Policies and procedures are referenced where appropriate
6.6 Infection control policies and procedures are ratified and distributed by the infection control committee
6.7 A document control system exists for the distribution of infection control policies and procedures
6.8 Policies and procedures are regularly reviewed. Policies and procedures should include but not be limited to:
6.9 Universal / standard precautions
6.10 Hand washing
6.11 Prevention and control of outbreaks of infection
6.12 Linen handling
6.13 Waste handling
6.14 Needle stick injury
6.15 Hazardous spills
6.16 Isolation procedures
6.17 Appropriate use of personal protective equipment and garments.
IC 7
7.1 Data has been collected and computerized for infection control activities in the hospital
7.2 Rationale for data collection has been documented
7.3 Documented evidence of planned interventions in response to data analysis
7.4 Statistical analysis of infection control data to occur at least 3 monthly
7.5 Collation of infection control data to include pharmacy and laboratory statistics
7.6 The department has collected data on the supply & availability of personal protective equipment for staff.
IC 8
8.1 A quality improvement plan that is consistent with the hospital wide QI plan is developed for the department
8.2 It must contain key performance/indicators that are measurable and realistic and have timelines
8.3 Evidence of continual monitoring of this plan must be available
8.4 Audit tools have been constructed specifically for this area.
IC 9 Brochures / pamphlets are available throughout the hospital for patients, staff and relatives on infectious conditions that include but are not limited to:
9.1 Hepatitis A
9.2 Hepatitis B
9.3 Hepatitis C
9.4 HIV
9.5 Typhoid
9.6 Tuberculosis
9.7 Urinary tract infections
9.8 Wound care
9.9 Gastroenteritis.

IC10
10.1 Evidence of a planned formal annual education program for all staff. Evidence of department specific education program as follows:
10.2 Medical
10.3 Nursing
10.4 Environmental services
10.5 Kitchen
10.6 General staff
10.7 Evidence exists that staff from the above areas have attended the infection control education programs.

Example 2: Prevention and Control of Infections (PCI) plan by JCI

The goal of an organization’s infection surveillance, prevention and control program is to identify and reduce the risks of transmitting and acquiring infections among patients, staff, doctors, contract, workers, volunteers, students and visitors. The infection control program may differ from organization to another however effective programs have in common identified leaders, appropriate policies and procedures, staff education, and coordination throughout the organization.

The following is a list of standards for an organization to be accredited by Joint Commission International:

PCI.1 The organization designs and implements a coordinated program to reduce the risks of nosocomial infections in patients and health care workers.

PCI.1.1 All patients, staff, and visitor areas of the organization are included in the infection control program.

PCI.2 The organization establishes the focus of the nosocomial infection prevention and reduction program.

PCI.3 The organization identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.

PCI.4 Gloves, masks, soap, and disinfectants are available and used correctly when required.

PCI.5 Cultures are routinely obtained from designated sites in the organization associated with significant infection risk.

PCI.6 One or more individuals oversee all infection control activities. This individual(s) is qualified in infection control practices through education, training, experience, or certification.
PCI.7 A designated individual or group monitors and coordinates infection control activities in the organization.

PCI.8 Coordination of infection control activities involves medicine, nursing, and others as appropriate to the organization.

PCI.9 The infection control program is based on current scientific knowledge, accepted practice guidelines, and applicable law and regulation.

PCI.10 Organization information management systems support the infection control program.

PCI.11 The infection control process is integrated with the organization’s overall program for quality improvement and patient safety.

PCI.11.1 The organization tracks infection risks, infection rates, and trends in nonsocomial infections.

PCI.11.2 Monitoring includes using indicators related to infection issues that are epidemiologically important to the organization.

PCI.11.3 The organization uses risk, rate and trend information to design or modify processes to reduce nonsocomial infections to the lowest possible levels.

PCI.11.4 The organization compares its infection control rates with other organizations through comparative databases.

PCI.11.5 The results of infection monitoring in the organization are regularly communicated to staff, doctors, and management.

PCI.11.6 The organization reports information on infections to appropriate external public health agencies.

PCI.12 The organization provides education on infection control practices to staff, doctors, patients, and, as appropriate, family and other caregivers.

PCI.12.1 All staff receives an orientation to the organization’s infection control policies and practices.

PCI.12.2 All staff is educated in infection control when new policies are implemented and when significant trends are noted in surveillance data.

**NCQA accreditation: a guide for school-based health centers (SBHSs)**

The National Committee for Quality Assurance (NCQA) Managed Care Organization Accreditation Program evaluates managed care organizations (MCOs) to assess how well they manage their members’ care through their delivery systems-network providers, hospitals, and administrative services.

The NCQA, an independent non-profit organization that evaluates and reports on the quality of health plans, has the most widely used accreditation program in the United States. Managed care organizations that are seeking accreditation frequently do so because public or private purchasers require evidence of an external quality review. Today, school-
based health centers (SBHCs) that provide services to members in managed care plans may be required to provide information, participate in site reviews, and in other ways cooperate with policies and procedures that are required of the MCOs for accreditation purposes.

The NCQA Managed Care Organization Accreditation program is nationally recognized as an evaluation that health care purchasers, regulators, and consumers use to compare health plans. The accreditation process is considered rigorous and comprehensive. There are six categories that NCQA uses to evaluate MCOs: quality improvement, physician credentials, members' rights and responsibilities, preventive health services, utilization management, and medical records. Data relevant to these six categories are collected from health plan documents, participating provider interviews, medical record reviews, and data information programs such as HEDIS 3.0.

**Standards for Quality Management and Improvement:**

According to the NCQA 1997 Surveyor Guidelines, the objective of a quality improvement (QI) program for an MCO is to monitor and improve clinical care for its members. A quality improvement program should include short and long-term goals, describe the activities for reaching those goals, establish a time frame for accomplishing goals, and develop a mechanism for evaluating progress. Nine out of thirteen standards in this category are relevant to SBHCs.

**Standard QI 1 Program Structure**

The MCO must define quality improvement program responsibilities and assign responsibilities to appropriate individuals. An outline of the QI program should include:

- description of its governing body
- strategy for integrating public health goals
- designated physician who has significant involvement in the implementation of the QI program
- designation of a committee that directs and is actively involved in QI activities
- annual QI work plan or schedule of activities (i.e., projects and activities, monitoring for identified issues, and planning QI program evaluations)
- description of QI program resources (e.g., personnel, analytical capabilities, data resources) that are appropriate to meet needs.

Note: Under this standard, the MCO must provide evidence that it has considered public health goals in developing activities (i.e., immunization and screening programs, smoking cessation classes, child safety classes).
Standard QI 3 Health Services Contracting

MCO contracts with individual practitioners and providers should identify requirements for network participation. MCO contracts with practitioners should require the following:

- practitioner agreement to cooperate with the MCO's QI program and activities
- practitioner permission for MCO to access their members' medical records to the extent that the law permits; and
- MCO agreement that practitioner may communicate with patients regarding treatment alternatives without being penalized for providing information on medically necessary or appropriate care alternatives for patient

MCO contracts with providers should require the following:

- providers agree to cooperate with the MCO's QI program and activities; and
- providers permit MCO access to their members' medical records to the extent that the law permits.

Note: NCQA defines practitioner as an individual who provides care and defines provider as an organization such as a hospital, or home health agency.

Standard QI 4 Availability of Practitioners

The MCO has standards for ensuring sufficient numbers and diverse types of practitioners in its network. A practitioner access plan outlines strategies for eliminating barriers (i.e., linguistic and cultural needs/preferences) to access, maintaining an adequate practitioner network, and assuring the availability of primary care practitioners and specialty care practitioners for its members. The organization defines network primary care practitioners, establishes (availability) standards for the number and geographic distribution of practitioners, collects and analyzes data to measure performance against standards, identifies and implements interventions to improve performance, and measures the effectiveness of interventions.
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**Standard QI 5 Accessibility of Services**

MCO must document that it has policies and procedures to assure members access to primary care services, urgent care services, and member services. Standards should provide for timely preventive care, primary care, and urgent care appointments; timely emergency care; access to after-hours care; and responsiveness of member service telephone lines and/or other telephone services. This standard also assesses an MCO's role in collecting and evaluating data, implementing interventions to improve performance, and measuring the effectiveness of interventions.
Standard QI 6 Member Satisfaction

MCO must have a system for assuring member satisfaction. Components of this system include member satisfaction surveys, procedures for evaluating member complaints, procedures for changing practitioners or sites of service, and voluntary disenrollments policies. To meet this standard, the MCO must use appropriate scientific methods. The plan should inform practitioners and providers of member satisfaction activity results.

Document reviewed: Health plan documents
Interviews: Participating practitioners and health plan staff

Standard QI 7 Health Management Systems

MCO must document its efforts to improve the health status of members with chronic conditions. The plan must identify members with chronic conditions, refer members to appropriate care, and inform practitioners about health management programs.

Document reviewed: Health plan documents
Interviews: Participating practitioners and health plan staff

Standard QI 8 Clinical Practice Guidelines

MCO must adopt and disseminate practice guidelines for providing care to members with acute and chronic conditions. MCOs should demonstrate the following:

• clinical guidelines are based on reasonable medical evidence
• practitioners are involved in adoption of guidelines
• mechanisms are developed to review guidelines every two years
• distribution of guidelines to practitioners
• MCO performance is measured against at least two guidelines
• decisions made on utilization management, member education, covered benefits and other clinical issues are consistent with guidelines.

Document reviewed: Health plan documents
Interviews: Participating practitioners and health plan staff

Standard QI 9 Scope and Content of Clinical Quality Improvement Activities
The quality improvement program's composition reflects the MCO's delivery system and important clinical issues of its members. The MCO analyzes at least three clinical conditions that are relevant to its membership. The MCO selects three clinical conditions from the following four areas (one clinical condition should be from behavioural health services): 1) primary care services; 2) high-volume specialty services; 3) behavioural health services; and 4) institutional services (home health, skilled nursing facility, free-standing surgery centre, and inpatient hospital services.) The MCO must monitor underutilization, over utilization, and continuity and coordination of care for its members.

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<td>External reporting system documents (i.e., HEDIS, state, or Medicaid reporting requirements) --which SBHCs may be required to submit data and other documents at the health plan level</td>
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**Standard QI 11 Intervention and Follow-Up for Clinical Issues**

MCO evaluates opportunities for quality improvement, implements appropriate interventions, and measures the effectiveness of interventions through methodical follow-up.

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**Standards for Preventive Health Services:**

The MCO should have guidelines for promoting preventive health services at various stages of a member's life. The guidelines are to explicitly state measures the MCO, its practitioners, and providers take for the prevention and early detection of illness and disease. Preventive health guidelines should be specific to the age, sex and risk status of group members and address the goals of managed care:

- primary prevention: decreasing (lessening) the incidence of illness, disease, and accidents; and
- secondary prevention: reducing the impact of a potentially serious disease or illness through early detection.

Three out of five standards in this category are relevant to SBHCs and are summarized.

**Standard PH 1**
MCO has preventive health guidelines that outline standards for prevention and early detection of illness and disease. The guidelines should address frequency of interventions and conditions for which interventions are required. There should be guidelines for the following categories:

- preventive care on infants up to 24 months;
- preventive care for children and adolescents, two through 19 years;
- prenatal and perinatal care
- preventive care for adults, 20 through 64 years; and
- preventive care for the elderly, 65 and older.

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**Standard PH 2**

MCO has a process for distributing preventive health guidelines and providing revisions to its existing and new practitioners. Distribution of guidelines enables practitioners to be proactive in providing services to members.

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**Standard PH 4**

MCO has a procedure for annually measuring (member) compliance by its members with the current preventive care guidelines.

The MCO should evaluate no less than four of the eight following preventive services:

- childhood immunizations: DTP (diphtheria and tetanus toxoids with pertussis vaccine), OPV (oral poliovirus vaccine), HIB (hemophilus influenza B conjugate vaccine), and MMR (measles, mumps, and rubella vaccine);
- childhood immunizations: hepatitis B vaccine;
- adult immunizations (one of the following): influenza vaccine, pneumococcal vaccine, hepatitis B vaccine, diphtheria and tetanus toxoid, and rubella screening for women in their childbearing years;
- coronary artery disease risk factor screening and/or counseling (any one of the following): cholesterol, exercise, and/or hypertension;
- smoking cessation;
- cancer screening: breast and/or cervix;
- prenatal care; and
- risk factors in appropriate populations: motor vehicle injury counseling, lead toxicity screening, sexually transmitted disease screening/prevention, human immunodeficiency virus (HIV)
screening/prevention, unintended pregnancy prevention, or alcohol and other drug abuse screening/prevention.

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**Standards for Medical Records:**

Medical records are a source of data that documents the quality of health care a patient receives from a participating managed care practitioner. MCOs should promote medical record keeping standards among its practitioners that demonstrate the MCO's commitment to quality patient care, organizational accountability, continuity of care, and patient confidentiality.

**Standard MR 1**

MCO has policies and procedures that require its practitioners to have record keeping systems that promote patient confidentiality; facilitate communication and continuity of care; and maintain current, detailed, and organized standards for documentation. Medical record standards should require information on a patient's past medical treatment, past and current health status, and treatment plans. All standards should apply to electronic and paper medical record keeping systems. Practice sites should receive a copy of standards.

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**Standard MR 2**

MCO policies ensure that primary care practice medical records are reviewed at least once every two years and that record keeping practices comply with organizational standards. The MCO should have a mechanism for evaluating the effectiveness and quality of patient care and if practitioner is not in compliance, have action improvement plans.

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Standard MR 3

This standard establishes medical record criteria that the MCO should promote to attain consistency among providers. There is a medical review summary sheet with 21 elements that NCQA encourages MCOs to use in conducting medical record reviews. The summary sheet provides a framework for medical record conformity with professional medical practice and appropriate health management. Four out of the following six elements are considered critical and should be present in 90 percent of records reviewed with the two remaining elements in at least 60 percent:

- Record of illnesses and medical conditions on problem list
- Documentation of allergies and medication
- Record of past history (if patient has been seen at least three times)
- Documentation of diagnosis consistent with findings
- Record of treatment plans and that they are consistent with diagnoses; and
- No indication that patient is inappropriately placed at risk by a diagnostic or therapeutic problem.

Twelve of the following fifteen elements should be present in 90 percent of records reviewed with the remaining three in at least 60 percent (the following elements complete the 21 elements) of records:

- Documentation of patient's name or ID number on every page
- Documentation of patient's biographical information (address, employer, home and work telephone numbers, an marital status)
- Documentation of author identification for medical record entries. Author identification can be handwritten, stamped, or electronic
- Legibility of medical records by someone other than writer
- Documentation for patients 14 and older regarding the use of cigarettes, alcohol, and substances (if patient has been seen at least three times, inquiry about substance abuse history)
- Documentation that history and physical exam records contain subjective and objective information appropriate to patient's presenting complaints
- Documentation that the appropriate laboratory tests and other studies are ordered
- Documentation on encounter forms which indicate follow-up care, calls, or visits
- Documentation that problems from previous visits are addressed at follow-up visits
- If there is a request for consultation, documentation that consultant s were reviewed for underutilization and overutilization
- Note from consultant in medical record for consultation request
• Primary care physician (PCP) initials on consultation, lab, and imaging reports in chart to verify PCP review. Consultations, abnormal lab and imaging study results should have notation in record for follow-up plans.

• Documentation that children’s immunization records are up to date and for adults, documentation of an appropriate history is in medical records.

• Indication that preventive screening and services are provided in compliance with MCO’s practice guidelines.

• Note: the fifteenth element was not listed on the retrieved web page on May the 10th, 2007, from: http://www.healthinschools.org/sbhcs/papers/NCQAguide.asp.

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<td>Sample medical record chosen by NCQA</td>
<td>Health plan staff</td>
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**Standards for Utilization Management:**

According to NCQA, the objective of a utilization management (UM) program is to equitably distribute limited resources among members according to medical need and appropriateness (of care). A UM program may or may not encompass formal preauthorization, concurrent review, discharge planning, retrospective review, and case management. Nine out of fifteen standards in this category are relevant to SBHCs and are summarized.

Note: Unlike the standards under the Quality Management and Improvement category, standards under the Utilization Management category are not titled (labelled).

**Standard UM 4**

A MCO must have guidelines for making timely UM decisions regarding the urgency of the clinical situation. Each clinical situation may involve initial determinations, concurrent review, or retrospective review. Each of these categories has guidelines for the amount of time an MCO has to provide patients and practitioners with verbal and written notification of the confirmation or denial of services. MCO has a process for expediting appeals for denied services when a member's life or health status is in jeopardy. The MCO measures actual decision making time against standards. If MCO is not meeting standards, it takes action to improve performance. Under this standard, the MCO should have policies and procedures for paying and covering necessary emergency services based on criteria outlined in the NCQA manual.
### Standard UM 5

MCO has procedures for obtaining relevant clinical information to support UM decision making and consulting with a member's physician when determining coverage based on medical necessity.

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### Standard UM 6

MCO documents reasons for service denials; provides members and practitioners written notification for reason of denial, and provides information about the MCO appeals process.

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### Standard UM 8

MCO demonstrates that it is identifying and addressing areas of dissatisfaction with UM processes through member and practitioner satisfaction surveys and complaint analyses.

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### Standards for Credentialing and Recredentialing:

According to NCQA, credentialing and recredentialing is essential to selection and evaluation of plan practitioners. NCQA surveyors review MCO credentialing files for MDs, DOs, DPMs, DDSs, and DCs. MCOs that allow nurse practitioners to participate in provider networks as primary care practitioners must establish policies, procedures and standards for credentialing nurse practitioners, but NCQA surveyors will not review the nurse practitioner files. They will only establish that the MCO has put
credentialing policies and procedures in place. MCOs are not required to credential practitioners who provide services only within an inpatient hospital setting (i.e., pathologists, radiologists, anesthesiologists, emergency room physicians, etc.) or specialists who practice within free-standing facilities (i.e., mammography centres, urgent care centres, and surgicenters.) MCOs are required to credential dentists only if dentists perform services under the MCO’s medical benefits. Twelve out of thirteen standards in this category are relevant to SBHCs and are summarized.

**Standard CR 1**

MCO policies and procedures outline the processes and criteria for credentialing and recredentialing MDs, DOs, DDSs, DPMs, DCs, and other independent licensed practitioners who contract with the MCO and see their members in an outpatient setting. Documentation should include the following information: what practitioners are covered; criteria and sources of verification; process for making decisions; arrangements that delegate credentialing and recredentialing to other organizations; authorization from practitioners to review information submitted (by professional associations/boards) to support applications; procedures for notifying practitioners of discrepancies between information submitted by practitioner and information obtained from other sources; provisions for practitioners to amend incorrect information; responsibility and participation of medical director (or other designated professional) in credentialing program; and process for protecting the confidentiality (to the extent of the law) of the practitioner's information acquired in the credentialing process.

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**Standard CR 2**

MCO has a credentialing committee that makes credentialing recommendations. The committee should promote participation from practitioners to make recommendations, provide advice on credentialing and recredentialing decisions and processes, and assist in modifying criteria.

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**Standard CR 3**

MCO verifies (at a minimum) the following information when credentialing practitioners: current valid license; status of hospital clinical privileges; valid DEA or CDS certificates (as applicable); board certification; work history; current and adequate malpractice...
insurance (according to MCO policy); and information on professional liability claims. Verification of a practitioner's education and training should include: for MDs and DOs -- graduation from medical school and completion of a residency; for DCs -- graduation from chiropractic college; for DDSs -- graduation from dental school and completion of specialty training (as applicable); and DPMs -- graduation from podiatry school and completion of a residency. If practitioner is board certified, the preceding information does not have to be verified.

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Note: NCQA does not require practitioners to be board certified.

**Standard CR 4**

MCO has an application for membership. The application should require statements from the applicant regarding:
- explanations for any inability to execute essential functions of the position, with or without accommodations
- no record of present illegal drug use
- explanation of any loss of license/felony convictions
- explanation of any loss or limitation of privileges or disciplinary action
- statement by applicant that information on application is accurate and complete.

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Note: Credentialing decisions are not solely based on the application.

**Standard CR 5**

Before making credentialing decisions, MCO obtains information on applicant from the following agencies: National Practitioner Data Bank; State Board of Medical Examiners; Federation of State Medical Boards or Department of Professional Regulations (if available); and State Board of Dental Examiners. The MCO should have also inquired about previous sanctions by Medicaid. The information should be filed with practitioner's credentialing files.

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Note: A Medicaid inquiry is not applicable for dentists.
Standard CR 6

MCO has procedures for conducting initial site visits to all potential primary care practitioners and all obstetricians/gynecologists. Office (site) reviews are based on such criteria as physical accessibility, physical appearance, sufficiency of waiting and examining room space, and availability of appointments. Credentialing files should include documentation of the following:

- practitioner's site was evaluated against MCO standards (criteria)
- practitioner's medical record keeping practices were evaluated for compliance with MCO standards (i.e., documentation and confidentiality practices).

Documents reviewed: Credentialing files and other health plan documents.

Interviews: Health plan staff.

Standard CR 7

An MCO must recredential its practitioners at least biennially. The recredentialing process should verify the following information: valid state license; status of hospital clinical privileges; valid DEA or CDS certificate (as applicable); board certification (if practitioner states he/she is board certified); current and appropriate malpractice insurance (according to MCO policy); explanation of professional liability claims (if any); current, signed statement by applicant explaining reasons for any inability to perform essential position functions with or without accommodation and lack of current illegal drug use.

Documents reviewed: Credentialing files and other health plan documents.

Interviews: Health plan staff.

Standard CR 8

Prior to recredentialing, MCO practitioner applications should provide information from the following agencies: National Practitioner Data Bank; State Board of Medical Examiners; Federation of State Medical Boards or Department of Professional Regulations (if available); and State Board of Dental Examiners. The MCO should inquire about sanctions by Medicaid and include information into the practitioner's recredentialing file.

Documents reviewed: Credentialing files and other health plan documents.

Interviews: Health plan staff.

Note: A Medicaid inquiry is not applicable for dentists.
Standard CR 9
An MCO should base primary care practitioner recredentialing decisions on performance monitoring data that evaluates the practitioner's professional performance, judgment, and clinical competence. Using three of the six following performance-monitoring sources will meet this standard:
- Member complaints;
- Quality improvement activity information;
- Utilization management;
- Member satisfaction;
- Medical record reviews administered under Standard MR 2;
- Site visits administered under Standard CR 10

Documents reviewed: Interviews:
Credentialing files and other health plan documents. Health plan staff.

Standard CR 10
Appropriate MCO staff should visit all primary care practitioners, obstetrician/gynecologists, and other high-volume specialists (dentists and other specialists can be included if they are considered as high-volume specialists by MCO) during the recredentialing process. MCO staff reviews facility, equipment, staffing, and medical record keeping practices for:
- Any changes that may affect members’ quality of care or service, and
- Conformity with MCO standards.

Documents reviewed: Interviews:
Recredentialing files and other health plan documents. Participating practitioners and health plan staff.

Standard CR 11
MCO has policies and procedures which enables the organization to alter relationships with practitioners based on quality of care and service issues. Policies and procedures should outline the organization's actions for improving a practitioner's performance prior to termination, reporting quality deficiencies that could lead to a practitioner's suspension or termination, establishing an appeals process, and informing practitioners of this process.

Documents reviewed: Interviews:
Health plan documents Health plan staff.
Standard CR 12

MCO has policies and procedures for conducting initial and upcoming evaluations of network providers. Evaluations ensure that the provider is in compliance with state and federal regulatory bodies and is accredited by the appropriate accrediting body before the MCO contracts with provider. If a provider has not received accreditation, MCO should have standards for provider participation and an assessment tool for appropriately evaluating provider. The MCO should confirm (at least every three years) that the provider remains in good standing with state and federal regulatory bodies and, if applicable, the appropriate accrediting bodies.

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Note: Providers are hospitals, home health agencies, skilled nursing facilities and nursing homes, and freestanding surgical centers.

Standards for Members' Rights and Responsibilities:

MCO policies should promote organizational-wide respect for members, create mechanisms to ensure member confidentiality, and provide members with information on the health plan and its practitioners and providers. The MCOs members' rights and responsibilities policies should outline member entitlements and MCO expectations. Three out of nine standards in this category are relevant to SBHCs.

Standard RR 1

MCO policies and procedures outline the organization's commitment to treating members with respect and acknowledging their rights and responsibilities as members. The policies under this standard address:

- Members' rights to receive information on the MCO, its services, its practitioners and providers, and members' rights and responsibilities;
- Members' rights to be treated with respect and dignity and the right to privacy;
- Members' rights to take an active role with practitioners in making decisions regarding their health care;
- Members' rights to discuss treatment options for their health condition, regardless of cost or benefit;
- Members' rights to make complaints or appeals about the MCO or services provided;
- Members' responsibility to provide information that the MCO and its practitioners and providers need to appropriately care for members; and
Members' are responsibility to follow their practitioner's instructions for agreed upon care.

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**Standard RR 2**

MCO distributes policies on members' rights and responsibilities to all members and network practitioners.

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**Standard RR 7**

MCO has policies and procedures that protect the confidentiality of member information and records by setting standards for MCO employees and participating practitioners and providers. Policies and procedures should ensure member privacy through employee confidentiality agreements, practitioner and provider contract language, and a platform that allows members the ability to approve or deny the release of their information by the MCO, except when the release is requested by law.

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**URAC Health Utilization Management Standards**  
© 2004 URAC Health UM Standards, Version 4.2

URAC, an independent, non-profit organization, is well-known as a leader in promoting health care quality through its accreditation and certification programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

Note: This document is intended to provide a basic understanding of the accreditation standards. It does not include interpretive information,
scoring information, or other guidance necessary for a detailed understanding of the standards and the accreditation process. This information is contained in the Program Guide for this accreditation program, which may be purchased on URAC’s Web site at www.urac.org, or by calling (202) 216-9010.

Note: To achieve URAC Health Utilization Management Accreditation, an organization must comply with both URAC’s Core Standards and Health Utilization Management Standards. Both sets of standards are included in this document.

Note: Defined terms appear in *italics* throughout this document. A definitions section follows the standards.

**Core Standards**

Version 1.1

**Organizational Structure**

**Standard CORE 1**

The *organization* has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the *organization*.

**Standard CORE 2**

*Organization's* documents address:

(a) Mission statement;
(b) Organizational framework for program;
(c) A description of the service delivery model;
(d) The population served; and
(e) Organizational oversight and reporting requirements of the program.

**Policies and Procedures**

**Standard CORE 3**

The *organization*:

(a) Maintains and complies with written policies and procedures that govern all aspects of its operations; and
(b) Maintains a master list of all such policies and procedures.

**Standard CORE 4**

The *organization* reviews policies and procedures no less than annually and revises as necessary.

**Standard CORE 5**

All policies and procedures include:

(a) Effective dates, including the date of the most recent revision; and
(b) Signature of reviewing and approval authority.

**Inter-Departmental Coordination**

**Standard CORE 6**
The organization establishes and implements mechanisms to promote collaboration, coordination, and communication across disciplines and departments within the organization, with emphasis on integrating administrative activities, quality improvement, and where present, clinical operations.

**Information Management**

**Standard CORE 7**

The organization implements information system(s) (electronic or paper) to collect, maintain, and analyze information necessary for organizational management that:

(a) Provides for data integrity;
(b) Provides for data confidentiality and security;
(c) Includes a disaster recovery plan; and
(d) Includes a plan for storage, maintenance, and destruction.

**Business Relationships**

**Standard CORE 8**

The organization maintains signed written agreements with all clients describing the scope of the business arrangement.

**Oversight of Delegated/Sub-Contracted Functions**

**Standard CORE 9**

Prior to delegating functions to another entity, the organization conducts a review of the potential contractor’s policies and procedures and capacity to perform delegated functions. The organization outlines and follows criteria and processes for approving contractors.

**Standard CORE 10**

The organization establishes and implements criteria and processes for an assessment prior to the delegation of functions.

**Standard CORE 11**

The organization enters into written agreements with contractors that:

(a) Specify those responsibilities delegated to the contractor and those retained by the organization;
(b) Require that services be performed in accordance with the organization’s requirements and URAC standards;
(c) Require notification to the organization of any material change in the contractor’s performance of delegated functions;
(d) Specify that the organization may conduct surveys of the contractor, as needed;
(e) Require that the contractor submit periodic reports to the organization regarding the performance of its delegated responsibilities;
(f) Specify recourse and/or sanctions if the contractor does not make corrections to identified problems within a specified period;
(g) Specify the circumstances under which activities may be further delegated by the contractor, including any requirements for obtaining permission from the organization before any further delegation; and

(h) Specify that, if the contractor further delegates organizational functions, those functions shall be subject to the terms of the written agreement between the contractor and the organization and in accordance with URAC standards.

**Standard CORE 12**
The organization implements an oversight mechanism for delegated functions that includes:

(a) A periodic review (no less than annually) of the contractor’s policies and procedures and documentation of quality activities for related delegated functions;

(b) A process to verify (no less than annually) the contractor’s compliance with contractual requirements and policies and procedures; and

(c) A mechanism to monitor financial incentives to ensure that quality of care or service is not compromised.

**Staff Qualifications**

**Standard CORE 13**
The organization has written job descriptions for staff that address:

(a) Required education, training, and/or professional experience;

(b) Expected professional competencies;

(c) Appropriate licensure/certification requirements; and

(d) Scope of role and responsibilities.

**Standard CORE 14**
Staff meets qualifications as outlined in written job descriptions.

**Standard CORE 15**
The organization implements a policy to:

(a) Verify the current licensure and credentials of licensed or certified personnel/consultants upon hire, and thereafter no less than every 3 years; and

(b) Implement corrective action in response to adverse changes in licensure or certification status.

**Staff Management**

**Standard CORE 16**
The organization has a training program that includes:

(a) Initial orientation and/or training for all staff before assuming assigned roles and responsibilities;

(b) Ongoing training as needed to maintain professional competency;

(c) Training in URAC Standards as appropriate to job functions;

(d) Training in state and regulatory requirements as related to job functions;
(c) Documentation of all training provided for staff;
(f) Conflict of interest;
(g) Confidentiality;
(h) Organizational structure; and
(i) Delegation oversight, if necessary.

**Standard CORE 17**

The organization provides staff with:

(a) Written operational policies and procedures appropriate to their jobs; and

(b) Clinical decision support tools as appropriate.

**Standard CORE 18**

The organization maintains a formal assessment program for individual staff members that include an annual performance appraisal.

**Clinical Oversight**

**Standard CORE 19**

The organization designates at least one senior clinical staff person who has:

(a) Current, unrestricted clinical license(s) (or if the license is restricted, the organization has a process to ensure job functions do not violate the restrictions imposed by the State Board);

(b) Qualifications to perform clinical oversight for the services provided; and

(c) Post-graduate experience in direct patient care; and

(d) Board certification (if the senior clinical staff person is an M.D. or D.O.).

**Standard CORE 20**

The senior clinical staff person:

(a) Provides guidance for all clinical aspects of program;

(b) Is responsible for clinical aspects of program; and

(c) Has periodic consultation with practitioners in the field.

**Regulatory Compliance**

**Standard CORE 21**

The organization implements a regulatory compliance program that:

(a) Tracks applicable laws and regulations in the jurisdictions where the organization conducts business; and

(b) Ensures the organization's compliance with applicable laws and regulations.

**Quality Management Program**

**Standards CORE 22**

The organization maintains a quality management program that promotes objective and systematic monitoring and evaluation of consumer and client service and health care services.

**Standard CORE 23**
The organization employs staff and provides resources necessary to support the day-to-day operations of the quality management program.

**Standard CORE 24**
The organization has a written description for its quality management program that:

(a) Is approved by the organization’s governing body;
(b) Defines the scope, objectives, activities, and structure of the quality management program;
(c) Is reviewed and updated by the quality management committee at least annually;
(d) Defines the roles and responsibilities of the quality management committee; and
(e) Designates a senior-level management member with the authority and responsibility for the overall operation of the quality management program and who serves on the Quality Management Committee.

**Standard CORE 25**
The organization has a mechanism to respond on an urgent basis to situations that pose an immediate threat to the health and safety of consumers.

**Quality Management Committee**

**Standard CORE 26**
The organization has a quality management committee that:

(a) Is granted authority for quality management by the organization’s governing body;
(b) Is accountable to the organization’s governing body;
(c) Meets at least quarterly;
(d) Maintains approved minutes of all committee meetings;
(e) If applicable, includes at least one participating provider or receives input from a participating provider committee (such as a Physician Advisory Group);
(f) Provides guidance to staff on quality management priorities and projects;
(g) Approves the quality improvement projects to undertake;
(h) Monitors progress in meeting quality improvement goals; and
(i) Evaluates the effectiveness of the quality management program.

**Quality Management Documentation**

**Standard CORE 27**
The organization, as part of its quality management program, provides written documentation of:

(a) Ongoing monitoring for compliance with URAC Standards;
(b) Objectives and approaches utilized in the monitoring and evaluation of activities;
(c) Identification of key indicators and measures of consumer and client service, which may include clinical care, complaint rates, and adverse events;
(d) The implementation of action plans to improve or correct identified problems;
(e) The mechanisms to communicate the results of such activities to staff;
(f) The mechanisms to communicate the results of such activities to the governing body or to corporate management; and
(g) Tracking and trending of data related to consumer and client service and health care services.

Quality Improvement Projects

Standard CORE 28
At any given time, the organization maintains at least two ongoing quality improvement projects that:
(a) Focus on consumers and/or clients;
(b) Relate to key indicators of quality as described in Standard 27(c); and
(c) Rely on data that is statistically valid, reliable, and comparable over time.

Standard CORE 29
If a quality improvement project is clinical in nature, then the organization involves a senior clinical staff person in judgments about clinical aspects of performance.

Standard CORE 30
For each quality improvement project, the organization utilizes statistically valid techniques to:
(a) Develop quantifiable measures;
(b) Measure its current level of performance; and
(c) Establish goals for quality improvement.

Standard CORE 31
For each quality improvement project, the organization:
(a) Designs and implements strategies to improve performance; and
(b) Establishes projected timeframes for quality improvement.

Standard CORE 32
For each quality improvement project, the organization periodically measures progress in meeting quality improvement goals.

Financial Incentives

Standard CORE 33
If the organization has a system for reimbursement, bonuses, or incentives to staff or health care providers based directly on consumer utilization of health care services, then the organization implements mechanisms
addressing how the organization will ensure that consumer health care are not compromised.

**Communications**

**Standard CORE 34**

The organization follows marketing and communication practices that include:

(a) Mechanisms to clearly and accurately communicate information about services to consumer and clients; and

(b) Safeguards against misrepresentations about the organization’s services.

**Standard CORE 35**

The organization implements a communication plan to inform consumers and clients of their rights and responsibilities, including:

(a) How to obtain services; and

(b) Their rights to submit a grievance or appeal, and how to do so.

**Satisfaction**

**Standard CORE 36**

The organization implements a mechanism to collect or obtain information about consumer satisfaction with services provided by the organization.

**Standard CORE 37**

Consumer satisfaction results are shared with the Quality Management Committee (see Core 26).

**Access to Services**

**Standard CORE 38**

The organization establishes standards to assure that consumers and clients can obtain services.

**Standard CORE 39**

The organization defines and monitors its performance with respect to the requirements established under Core 38 and, as appropriate, acts to improve access to services.

**Standard CORE 40**

Information about the ability of consumers to access services is reported to the Quality Management Committee (see Core 26).

**Complaints and Appeals**

**Standard CORE 41**

The organization maintains a system to receive and respond in a timely manner to complaints and, when appropriate, inform consumers of their rights to submit an appeal.

**Standard CORE 42**

The organization maintains a formal appeal resolution process that includes:

(a) Written notice of final determination with an explanation of the reason for the determination;
(b) Notification of the process for seeking further review, if available; and
(c) A reasonable, specified timeframe for resolution and response.

**Standard CORE 43**
Analysis of the complaints and appeals is reported to the Quality Management Committee (see Core 26).

### URAC Health Utilization Management Standards
**Version 4.2**

#### Staff Qualifications and Oversight
**Standard UM 1**
The organization ensures that utilization management staff (including non-clinical administrative staff) is supported by explicit, written clinical review criteria and review procedures.

**Standard UM 2**
As part of the staff performance assessment required by Core 18, the organization reviews case files for each member of the utilization management staff.

**Standard UM 3**
The organization has a mechanism to ensure that the utilization management process, including decisions made by staff and reviewers, are not influenced by conflicts of interest.

#### Review Criteria
**Standard UM 4**
The organization utilizes explicit clinical review criteria or scripts for pre-review screening that are:

(a) Developed with involvement from appropriate providers with current knowledge relevant to the criteria or scripts under review;

(b) Based on current clinical principles and processes; and

(c) Evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts under review, and updated if necessary.

#### Accessibility of Review Services
**Standard UM 5**
The organization provides access to its review staff by a toll free or collect telephone line at a minimum from 9:00 a.m. to 4:00 p.m. of each normal business day in each time zone where the organization conducts at least two percent of its review activities.

**Standard UM 6**
The organization maintains processes to:
(a) Receive communications from providers and patients during the business day and after business hours; and
(b) Respond to communications within one business day.

Standard UM 7
The organization conducts its outgoing communications related to utilization management during providers’ reasonable and normal business hours, unless otherwise mutually agreed.

Standard UM 8
The organization:
(a) Requires utilization management staff to identify themselves by name, title, and organization name; and
(b) Upon request, verbally informs patients; facility personnel; the attending physician and other ordering providers; and health professionals of specific utilization management requirements and procedures.

Onsite Review Services
Standard UM 9
For on-site review services, the organization:
(a) Requires on-site reviewers to carry a picture ID with full name and the name of the organization; and
(b) Schedules reviews at least one business day in advance, unless otherwise agreed.

Standard UM 10
For on-site review services, the on-site reviewers follow reasonable hospital or facility procedures, including checking in with designated hospital or facility personnel.

Confidentiality
Standard UM 11
The organization implements mechanisms to ensure that patient-specific information obtained during the utilization management process will be:
(a) Kept confidential in accordance with applicable laws;
(b) Used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment;
(c) Shared only with those entities who have authority to receive such information; and
(d) Shared only with those individuals who need access to such information in order to conduct utilization management and related processes.

Standard UM 12
If provider-specific data is to be released to the public, the organization implements policies to exercise due care in compiling and releasing data that address:
(a) How data is obtained and verified using valid methodologies;
(b) How the subjects of such disclosures are informed of the disclosures;
   (c) How potential users of the information are informed about the uses and limitations of the data; and
   (d) How the release of the data complies with applicable confidentiality laws and regulations.

**Pre-Review Screening**

**Standard UM 13**
For pre-review screening, the organization limits use of non-clinical administrative staff to:
   (a) Performance of “review of service requests” for completeness of information;
   (b) Collection and transfer of non-clinical data;
   (c) Acquisition of structured clinical data; and
   (d) Activities that do not require evaluation or interpretation of clinical information.

**Standard UM 14**
All scripts or algorithms used for pre-review screening are:
   (a) Approved by the medical director or clinical director (or designate); and
   (b) Reviewed (and updated if necessary) no less than annually.

**Standard UM 15**
Licensed health professionals monitor non-clinical administrative staff performing pre-review screening.

**Standard UM 16**
The organization does not issue non-certifications based on pre-review screening.

**Initial Clinical Review**

**Standard UM 17**
Individuals who conduct initial clinical review:
   (a) Are health professionals; and
   (b) Possess an active professional license or certificate.

**Standard UM 18**
Individuals who conduct initial clinical review have access to consultation with:
   (a) Licensed doctor of medicine or doctor of osteopathic medicine;
   (b) Licensed health professional in the same licensure category as the ordering provider; or
   (c) Health professional with the same clinical education as the ordering provider in clinical specialties where licensure is not issued.

**Standard UM 19**
The organization does not issue non-certifications based on initial clinical review.
Peer Clinical Review

Standards UM 20

The organization conducts peer clinical reviews for all cases where a certification is not issued through initial clinical review or pre-review screening.

Standard UM 21

Individuals who conduct peer clinical review:

(a) Are health professionals?

(b) Are qualified, as determined by the medical director or clinical director, to render a clinical opinion about the medical condition, procedures, and treatment under review; and

(c) Hold a current and valid license:

(i) In the same licensure category as the ordering provider;

(ii) Or as a doctor of medicine or doctor of osteopathic medicine.

Peer-to-Peer Conversation

Standard UM 22

Health professionals that conduct peer clinical review are available, by telephone or in person, to discuss review determinations with attending physicians or other ordering providers.

Standard UM 23

When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred, the organization provides, within one business day of a request by the attending physician or ordering provider, the opportunity to discuss the non-certification decision with the clinical peer reviewer making the initial determination (or with a different clinical peer), if the original clinical peer reviewer cannot be available within one business day.

Timeframes for Initial UM Decision

Standard UM 24

For prospective review, the organization issues a determination:

(a) As soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of request for a utilization management determination, if it is a case involving urgent care; or

(b) Within 15 calendar days of the receipt of request for a utilization management determination, if it is a non-urgent case. (This period may be extended one time by the organization for up to 15 calendar days provided that the organization determines that an extension is necessary because of matters beyond the control of the organization and notifies the patient, prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision. If a patient fails to submit necessary information to decide the case, the notice of extension must specifically describe the required
information, and the patient must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.)

**Standard UM 25**
For retrospective review, the organization issues a determination within 30 calendar days of the request for a utilization management determination. (This period may be extended one time by the organization for up to 15 calendar days provided that the organization determines that an extension is necessary because of matters beyond the control of the organization and notifies the patient, prior to the expiration of the initial 15 day calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision. If a patient fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the patient must be given at least 45 calendar days from receipt of notice to respond to the plan request for more information.)

**Standard UM 26**
For concurrent review, the organization adheres to the following timeframes:

(a) For reductions or terminations in a previously approved course of treatment, the organization issues the determination far enough in advance of the reduction or termination to allow for an appeal of the determination to be completed; and

(b) For requests by a patient to extend a current course of treatment, the organization issues the determination within:

(i) 24 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments; or

(ii) 72 hours of the request for a utilization management determination, if it is a case involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.

**Notice of Certification Decisions**

**Standard UM 27**
For certifications, the organization provides notification to the attending physician or other ordering provider, facility rendering service, and patient.

**Standard UM 28**
Notices of certification include tracking information (such as a reference number) for the certification.

**Standard UM 29**
Upon request from the attending physician or other ordering provider, facility rendering service, or patient, the organization provides written notification of any certification.
Standard UM 30
Confirmation of certification for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

Notice of Non-Certification Decisions

Standard UM 31
For non-certifications, the organization issues written notification of the noncertification decision to the patient and attending physician or other ordering provider or facility rendering service.

Standard UM 32
Written notification of a non-certification includes:
(a) The principal reasons for the determination not to certify;
(b) A statement that the clinical rationale used in making the non-certification decision will be provided, in writing, upon request; and
(c) Instructions for initiating an appeal of the non-certification.

Standard UM 33
Upon request from the patient, attending physician, or other ordering provider or facility rendering service, the organization provides the clinical rationale for the non-certification, including the specific clinical review criteria upon which the noncertification was based.

UM Procedures

Standard UM 34
The organization does not reverse a certification determination unless it receives new information that is relevant to the certification and that was not available at the time of the original certification.

Standard UM 35
The organization ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the patient’s condition or on necessary treatment and is charge planning activity (i.e., not routinely conducted on a daily basis).

Appeals Considerations

Standard UM 36
The organization maintains a formal process to consider appeals of noncertifications that includes:
(a) The availability of standard appeal for non-urgent cases and expedited appeal for cases involving urgent care; and
(b) Written policies and procedures that:
(i) Clearly describe the appeal process, including the patient’s, provider’s, or facility rendering service’s right to appeal;
(ii) Provide for explicit timeframes for each stage of the appeal resolution process; and
(iii) Are available, upon request, to any patient, provider, or facility rendering service.

**Standard UM 37**

The organization allows the patient, provider, or facility rendering services at least 180 calendar days after the receipt of a notice of non-certification to initiate the appeals process by telephone or written notification.

**Standard UM 38**

As part of the appeals process, the organization provides the patient, provider, or facility rendering service the opportunity to submit written comments, documents, records, and other information relating to the case.

**Standard UM 39**

As part of the appeals process, the organization and individuals considering the appeal take into account all documents, records, or other information submitted by the patient, provider, or facility rendering service relating to the case, without regard to whether such information was submitted or considered in the initial consideration of the case.

**Standard UM 40**

Appeals considerations are conducted by health professionals who:

(a) Are clinical peers;

(b) Hold an active, unrestricted license to practice medicine or a health profession;

(c) Are board-certified (if applicable) by:

   (i) A specialty board approved by the American Board of Medical Specialties (doctors of medicine); or

   (ii) The Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors of osteopathic medicine);

(d) Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate; and

(e) Are neither the individual who made the original non-certification, nor the subordinate of such an individual.

**Standard UM 41**

The organization observes the following timeframes for appeal:

(a) Expedited appeals are completed (i.e., written notification of the appeal decision issued) as soon as possible, and no later than 72 hours after the initiation of the appeal process;

(b) Standard appeals are completed (i.e., written notification of the appeal decision issued) within 30 calendar days of the initiation of the appeal process.

**Standard UM 42**

Written notification of adverse appeals determinations includes:

(a) The principal reasons for the determination to uphold the non-certification;
(b) A statement that the clinical rationale used in making the appeal decision will be provided, in writing, upon request; and
(c) In the case of expedited appeals, the method to initiate the standard appeal process.

**Standard UM 43**
The organization keeps a record for each appeal that includes:
(a) The name of the patient, provider, and/or facility rendering service;
(b) Copies of all correspondence from the patient, provider, or facility rendering service and the organization regarding the appeal;
(c) Dates of appeal reviews, documentation of actions taken, and final resolution; and
(d) Minutes or transcripts of appeal proceedings (if any).

**Information Upon Which Utilization Management is Conducted**

**Standard UM 44**
The organization, when conducting routine prospective review, concurrent review, or retrospective review:
(a) Accepts information from any reasonably reliable source that will assist in the certification process;
(b) Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services
(c) Does not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;
(d) Does not routinely request copies of all medical records on all patients reviewed;
(e) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and
(f) Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or providers.

**Standard UM 45**
For prospective review and concurrent review, the organization bases review determinations solely on the medical information obtained by the organization at the time of the review determination.

**Standard UM 46**
For retrospective review, the organization bases review determinations solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

**Standard UM 47**
The organization implements policies and procedures to address situations in which it has insufficient information to conduct a review. Such policies and procedures provide for:

(a) Procedural timeframes that are appropriate to the clinical circumstances of the review (i.e., prospective, concurrent, retrospective reviews);
(b) Resolution of cases in which the necessary information is not provided to the organization within specified timeframes; and
(c) Processes by which the organization issues an administrative noncertification due to lack of information.

**Standard UM 48**

The organization, for review purposes other than an appeal or a legal request, reimburses reasonable costs of medical record duplication, unless otherwise provided for by contract or law.

**DEFINITIONS**

(Defined terms appear in *italics* throughout the standards.)

**Adverse Event**: An occurrence that is inconsistent with or contrary to the expected outcomes of the organization's functions.

**Advisory Board of Osteopathic Specialists (ABOS)**: American Osteopathic Association (AOA) certification agent organized in 1939 for the purpose of establishing and maintaining standards of osteopathic specialization and pattern of training.

**American Board of Medical Specialties (ABMS)**: Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

**Appeal**: Formal request for review or reconsideration of an organizational determination (i.e., services have been denied, reduced, etc.)

*Note*: Specific terms used to describe appeals vary, and are often determined by law or regulation.

**Appeals Consideration**: Clinical review conducted by appropriate clinical peers, who were not involved in peer clinical review, when a decision not to certify a requested admission, procedure, or service has been appealed. Sometimes referred to as “third level review.”

**Attending Physician**: The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a patient in a hospital or other health care facility.

**Board-Certified**: A certification – approved by the American Board of Medical Specialties, the American Osteopathic Association, or another organization as accepted by URAC – that a physician has expertise in a
particular specialty or field. To the extent that future URAC standards include other certifications, URAC will specify further approved boards.

**Case involving urgent care:** Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or b) in the opinion of a physician with knowledge of the consumer’s medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case. (Note: This definition is derived from the Department of Labour’s definition of “claim involving urgent care.”)

**Case Management:** A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs using communication and available resources to promote quality cost-effective outcomes.

**Certification:** A determination by a utilization management organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

**Claims Administrator:** Any entity that recommends or determines to pay claims to enrollees, physicians, hospitals, or others on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions. Claims administrators may be insurance companies, self-insured employers, third party administrators, or other private contractors.

**Client:** A business or individual that purchases services from the organization.

**Clinical Decision Support Tools:** Protocols, guidelines, or algorithms that assist in the clinical decision-making process.

**Clinical Director:** A health professional who: (1) is duly licensed or certified; (2) is an employee of, or party to a contract with, a utilization management organization; and (3) who is responsible for clinical oversight of the utilization management program, including the credentialing of professional staff and quality assessment and improvement functions.

**Clinical Peer:** A physician or other health professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the ordering provider.

**Clinical Rationale:** A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient’s condition or
treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

**Clinical Review Criteria:** The written screens, decision rules, medical protocols, or guidelines used by the utilization management organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health benefit plan.

**Comparable:** Data about performance is compared to an historical baseline (which may be internal) and ongoing progress is recorded in regular intervals (e.g., monthly, quarterly, or annually). External benchmarks also may be used for purposes of comparison.

**Complaint:** An expression of dissatisfaction or a complaint regarding the organization’s products or services. Sometimes referred to as “grievance.”

**Concurrent Review:** Utilization management conducted during a patient’s hospital stay or course of treatment (including outpatient procedures and services). Sometimes called “continued stay review.”

**Consumer:** An individual person who is the direct or indirect recipient of the services of the organization. Depending on the context, consumers may be identified by different names, such as “member,” enrollee,” “beneficiary,” “patient,” “injured worker,” “patient, provider, or facility rendering service,” etc. A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

**Contractor:** A business entity that performs delegated functions on behalf of the organization. IG: Clarify that this term applies to an entity other than the applicant that performs functions that relate to the standards.

**Delegation:** The process by which the organization permits another entity to perform functions and assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.

**Discharge Planning:** The process that assesses a patient’s needs in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge or transfer from current services or level of care.

**Enrollee:** An individual who participates in and is covered by a health plan.

**Expedited Appeal:** An appeal of a non-certification in a case involving urgent care.

**Facility Rendering Service:** The institution or organization in or by which the requested admission, procedure, or service is provided. Such facilities may include, but are not limited to: hospitals; outpatient surgical facilities; individual practitioner offices; rehabilitation centers; residential treatment
centers; skilled nursing facilities; laboratories; imaging centers; and other organizational providers of direct services to patients

**Health Professional:** An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.

**Initial Clinical Review:** Clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification. Sometimes referred to as “first level review.”

**License:** A license or permit (or equivalent) to practice medicine or a health profession that is 1) issued by any state or jurisdiction in the United States; and 2) required for the performance of job functions.

**Medical Director:** A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and who is an employee of, or party to a contract with, a utilization management organization, and who has responsibility for clinical oversight of the utilization management organization’s utilization management, credentialing, quality management, and other clinical functions.

**Non-Certification:** A determination by a utilization management organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

**Non-Clinical Administrative Staff:** Staff who do not meet the definition of health professional (including intake personnel).

**Ordering Provider:** The physician or other provider who specifically prescribes the health care service being reviewed.

**Organization:** A business entity that seeks accreditation under these standards.

**Patient:** The enrollee, covered person, or consumer who requests or for whom a request for certification has been filed. The term “patient” may include an agent or representative authorized to act on the patient’s behalf.

**Interpretive Note for term Patient:** Try to clarify when the term “patient” includes an agent or representative authorized to act on the patient’s behalf (sometimes defined in benefit contract or by law).

**Peer Clinical Review:** Clinical review conducted by appropriate health professionals when a request for an admission, procedure, or service was not approved during initial clinical review. Sometimes referred to as “second level review.”
Pre-Review Screening: Automated or semi-automated screening of requests for authorization that may include: (1) collection of *structured clinical data* (including diagnosis, diagnosis codes, procedures, procedure codes); (2) asking scripted clinical questions; (3) accepting responses to scripted clinical questions; and (4) taking specific action (*certification* and assignment of length of stay explicitly linked to each of the possible responses). It excludes: (1) applying clinical judgment or interpretation; (2) accepting unstructured clinical information; (3) deviating from script; (4) engaging in unscripted clinical dialogue; (5) asking clinical follow-up questions; and (6) issuing non-*certifications*.

Principal Reason(s): A clinical or non-clinical statement describing the general reason(s) for the non-*certification* determination (“lack of medical necessity” is not sufficient to meet this).

Professional Competency: The ability to perform assigned professional responsibilities.

Prospective Review: *Utilization management* conducted prior to a patient’s admission, stay, or other service or course of treatment (including outpatient procedures and services). Sometimes called “pre-certification review” or “prior authorization.”

Provider: A *licensed* health care facility, program, agency, or *health professional* that delivers health care services.

Quality Improvement Project: An organization-wide initiative to measure and improve the service and/or care provided by the organization.

Quality Management Program: A systematic data-driven effort to measure and improve *consumer and client* services and/or health care services.

Peer-to-Peer Conversation: A request by telephone for additional review of a *utilization management* determination not to certify, performed by the peer reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the patient.

Interpretive Note: Retrospective medical necessity determinations are considered utilization management (and subject to these standards).

Review of Service Request: Review of information submitted to the utilization management organization for health care services that do not need medical necessity *certification* nor result in a non-*certification* decision.

Second Opinion: Requirement of some health plans to obtain an opinion about the medical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.

Staff: The organization’s employees, including full-time employees, part-time employees, and consultants.
**Standard Appeal:** An appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals of expedited appeals.

**Statistically Valid:** Based on accepted statistical principles and techniques.

**Structured Clinical Data:** Clinical information that is precise and permits exact matching against explicit medical terms, diagnoses or procedure codes, or other explicit choices, without the need for interpretation.

**Utilization Management (UM):** Evaluation of the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the provisions of the applicable health benefit plan; sometimes called “utilization review.”

**Written Agreement:** A document – including an electronic document – that specifies the terms of a relationship between the organization and a client, consumer, or contractor. May include a contract and any attachments or addenda.

**Written Notification:** Correspondence transmitted by mail, facsimile, or electronic medium.

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**AAAHC standards for Office-Based Surgical Accreditation (OBSA):**

The Accreditation Association for Ambulatory Healthcare (AAAHC) was incorporated in 1979 and is best known for accrediting ambulatory surgery centers, birthing centers, community health centers and large medical group practices. AAAHC stresses patients' rights, governance, quality of care, environment of the facility and professional records.

The AAAHC OBSA process is divided into eight (8) Core Standards that apply to all facilities and, for our purposes, five (5) Adjunct Standards.

**Core Standards:**

1) **Rights of Patients:** Looks for mechanisms to be in place to assure patients are treated with respect, consideration, privacy and dignity; assesses patient satisfaction; and confirms that patients are provided with sufficient information regarding their diagnosis, treatment and prognosis.

2 & 3) **Governance and Administration:** These two (2) standards, surveyed together, evaluate the nature of the facility's governing body; its financial integrity and future planning; fee schedule determination; hospital-physician relationships including credentialing, appointment and delineation of privileges; tracks the number of patient visits/procedures, and the number
of adverse outcomes, as well as the adequacy of personnel and the personnel mix.

4) **Quality of Care Provided**: Appraises the number, specialty and qualifications of providers in the organization, including professional and nonprofessional staff, along with their length of service and reason for separation.

5) **Quality Management and Improvement**: Concentrates on the process and procedures of the organization's Quality Management and Improvement Program, including the structure of the responsible committee, its chain of command and the number and substance of the Quality Improvement projects. This Standard also looks at clinical outcomes, monitors incident reports and adverse results as well as evaluates the efficacy of the Peer Review and Risk Management Programs. Medical Necessity and Utilization Management are also monitored.

6) **Clinical Records**: This Standard addresses the clinical record file and retrieval system, concentrates on the appropriateness of the allergy and drug sensitivity awareness plan and the symmetry and ease of access of document placement in the patient file.

7) **Professional Improvement**: Seeks compliance with appropriate norms for continuing education, certification and confirmation of licensure. It also evaluates clinical staff activities.

8) **Facilities and Environment**: This Standard provides for a comprehensive evaluation of the facility's physical architecture, licensure, structural safeguards, hazardous waste handling system, emergency plans and backup systems. It also seeks compliance with emergency signage, fire drills and the Americans with Disability Act.
Adjunct Standards:

1) Anesthesia Services: This Standard looks at types of anesthesia administered in the facility, the professional discipline and qualifications of the anesthesia provider and the appropriateness of the monitoring protocol. It is also concerned with calibration of equipment and those safety conventions in place.

2) Surgical Services: Examines what types of procedures are performed at the facility and by which disciplines; evaluates the physical structure and equipment for quality and sufficiency; and confirms the presence of protocols for dealing with transfers, the availability of blood supplies and environmental controls to assure a safe and sanitary surgical environment. Also inspected are emergency power sources and appropriate PACU facilities and conventions.

3) Pharmaceutical Services: This Standard seeks to insure that records and security are maintained for the control and safe dispensing of drugs, and that expired medications are disposed of in a timely and appropriate manner to protect safety.

4) Pathology and Medical Laboratory Services: In those facilities performing such services, the number and type of laboratory tests will be studied, and evidence will be sought of a CLIA waiver.

5) Diagnostic Imaging Services: This standard examines the number, type and quality of diagnostic images; the responsible parties for reading and interpreting the images; the filing and retrieval availability of the records; the safety policies to protect patients and staff, and the proper handling of hazardous materials. It also seeks to ensure that all equipment is up to date and has been licensed and calibrated properly.
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7. Hospital Accreditation

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Hospital accreditation is becoming an increasingly vital global process; as a result, health care quality is witnessing improvements in all aspects of the care process. Patients, providers, and the public do feel the need to better understand the purpose and outcome of the accreditation process. This chapter intends to enable readers to determine the background of hospital accreditation, understand the importance of accreditation, identify concepts and methodologies used in accreditation, learn the general principles of hospital accreditation, and have a clearer idea of the standards, the foundations of any accreditation process. Accreditation in Kyrgyzstan, a developing country, is used as model hoping to encourage other organizations in similar environmental settings to consider doing the same.

Background of Hospital Accreditation

Healthcare quality assurance can be divided into three eras. The first took place in the United States in 1917, the year when surgeons refused to operate in hospitals, which did not afford minimal quality standards in their day-to-day operations. Eventually, this initiative shaped the course to accreditation.

Worth noting is that the initial period of quality was derived from a professional initiative, private and self-sought. It was structure directed, in an attempt to make certain that doctors were pleased with their work conditions. Consequently, excellence in medical practice and service delivery was not a topic or a concept. In brief, quality relied on what the physicians wanted. At that time, the objective of accreditation was to give doctors a suitable environment to accomplish quality, but from their own perspectives. They influenced hospitals to provide them with pleasing working conditions.

The second era concurred with the economic pressure of the 1970s. Western governments became aware of the rising costs of healthcare. Epidemiologists, regulators, managers, and economists started analyzing medical practices. The lack of evidence that health indicators got better with increasing health spending, and the unjustified variance that was recorded in doctors’ practices urged them to create the rhetoric of “professionally led quality assurance of medical practice”. The latter was a system to organize medical prescription using utilization reviews, practice guidelines, and
consensus conferences. The emphasis had switched from structure to process. Hence, this era of quality assurance was launched outside the medical profession.

Questioning the legitimacy of their medical decisions and compliances with practice guidelines, the second era never earned professional authenticity from doctors. The medical profession did not feel involved with the concerns of this period of quality assurance.

The third and last period of quality assurance that started in the mid-1980s witnessed a transfer in focus from process to outcome. However, in all its three different periods, quality assurance never seemed to accomplish the objectives for which it was set. Hence, the primordial question: How can accreditation succeed to achieve what quality assurance could not?

Hospitals provide valuable services, but unfortunately can also be places where inappropriate care leads to unwanted incidents. Accreditation plays an essential role in safeguarding patients from such mischief and in integrating the hospitals’ self indwelling quality endeavours. In addition to that, the increasing awareness of the public about quality issues has centred the significance of accreditation. Serious public health problems like the transfusion of blood, which was strongly suspected to be contaminated, to hemophiliac patients in France, in 1984, has steered for a crisis of public trust in the ethics of both the political and medical worlds. This enhanced a powerful demand for accountability and more clarity. As a result, major reforms in the structure of public health and healthcare fields have taken place, one of which is accreditation.

**Hospital accreditation**

Accreditation constitutes one of the essential approaches for enhancing quality in health care. The accreditation movement is flourishing worldwide as a result of globalization, and specifically, the global growth of the exchange in health services. It will prospectively evolve as a means for an international classification and recognition of hospitals. When implemented adequately, accreditation can empower the crucial leadership and guiding function of national health authorities. It can easily be specified as a process through which credit is awarded. Realizing this credit depends on a thorough inspection of the ability to fulfil a public demand which is excellence in health care. Accreditation is the bridge leading the way to excellence and supremacy.

Hospital accreditation is thought about as an external evaluation process. However, this denies the actual fact that there is a broad diversity of currently used accreditation processes. Accreditation is not a fixed concept, and is continuously evolving at conceptual and systematic levels. In Spain, hospital accreditation is mandatory and is performed by health inspectors.
This is a case where accreditation is really an external evaluation. In Canada, however, hospital accreditation is executed by a self-ruling association, upon the demand of hospitals which voluntarily yield to the accreditation process.

In Canada, accreditation has evolved over time. The initial hospital’s self-evaluation report consisted of the sum of the individual departmental reports without any consideration for their interrelation. This process was non-participative, with very rare opportunities for feedback from key staff. In 1995, the accreditation process has been altered. The emphasis has steered upon the patient, on the received services, and on the patients’ caregivers, when it previously focused on administrative structures, and specialized medical and technical services. The centre of attention now is the organization as a whole. Each organization has to specify its patient population and generate multidisciplinary teams to fulfil the patients’ needs. These changes establish an innovative client-based approach to service quality. Quality is now defined and shaped by users themselves, as requested by the basic standard of patient satisfaction.

The objectives of accreditation are: (1) to assess the quality and safety of healthcare; (2) to assess a healthcare organization’s ability to ensure continuous improvement in the quality of overall patient care; (3) to formulate clear recommendations/action plans when needed; (4) to involve professionals at all stages of the quality initiatives; (5) to provide external recognition of the quality of care provided at health care organizations; and (6) to improve public confidence. Accreditation is therefore a symbol representing a commitment to quality. Its ultimate message is to remove uncertainty about the organization’s commitment to delivering quality care.

It is obvious that the hospital accreditation’s main intent is to improve patient care to an optimal quality level. And the first goal of the quality improvement process is to achieve maximal decrease in morbidity and mortality with providers’ scarce resources. The accreditation system and its standards offer chief doctors and hospital staff efficient ideas to ensure their objectives. The chief role of these standards is to afford a model for operations, a “guide on how to do it”. Accreditation standards comprise structural standards describing needed resources, process standards revealing how path operations may be carried out in the best way, and outcome standards showing if joining of the formers is running in the right way.

Hospital accreditation is in deed the tool to ensure an on-going quality and safety betterment of health care, preventing the occurrence of unwanted incidents. Accreditation is a formal acknowledgement that organization’s qualification exists to offer superior health care and that the personnel are doing their job at or above an approved level. An accreditation program allows providers to accomplish provided services with effectiveness and
efficiency, and reduction in unnecessary costs. In addition, accreditation and hospital evaluation will tremendously assist the patient in making the proper and intelligent choice. It is important to fully inform the patient of what he/she can expect in terms of his/her hospitalization’s outcome. This can be accomplished once hospitals are classified in a standardized manner throughout a health care system. Decision-making is not exclusive to the patients, but also to policy makers, managers, clinicians, and various stakeholders. This is done by publicizing data on health care quality, ensuring a credible reporting system and appropriate performance measurement. Accreditation gives strength to community trust by emphasizing hospital’s devotedness to afford reliable and quality care to the community.

Adopting practice guidelines and standards through accreditation levels up the health care field, making things easier for third party administrators, insurance companies, public sector undertakings, and companies desiring to make contractual agreements with hospitals.

It is true that accreditation makes hospitals liable to professional bodies, patient advocates, government, and the whole society, but it is also a structural tool for organizational growth, enhancing management practices, strategic planning and self-evaluation. Accountability mechanisms in a hospital can be established by clearing up roles and responsibilities, levelling performance expectations with the hospital’s capabilities, and identifying the management’s structure. An appropriate monitoring system should resolve issues of non-performance.

Accreditation is becoming a prerequisite for reimbursement by governments. Non-accredited healthcare organizations are disqualified from being implicated in competitive bidding, when managed care is invading health care systems including hospitals. Soon, accreditation will become a mandatory process. Hospitals should be prepared, or else their survival is at stake.

Accreditation is not a goal by itself. The goal is to enhance the quality of services provided in a hospital. The emphasis of accreditation should focus on the overall hospital system. Educational programs are very essential to the success of the accreditation process, all the staff should be involved in such activities. The hospital’s management should be aware that accreditation standards are constantly evolving. The accreditation’s final verdict relies on a consensus among surveyors, and the standards used for accreditation should reflect the average standing of hospitals in a particular country.
Aspects of accreditation design and process implementation

This section describes twelve different options of accreditation design and implementation processes.

Purpose: One of the initial steps in designing an accreditation model is to reach a consensus on the goal of accreditation. Determining the overall purpose is a prerequisite for identifying such things as the potential life span of the accreditation effort. The goal or purpose can vary from a relatively short-term promotion of a particular type of service, to a long-term, institutionalized process that focuses on assuring consistent compliance with quality or regulatory/legal requirements of health care provision. The latter option can be linked to establish health insurance (public or private) financing schemes.

Incentives: Another essential aspect of accreditation is the design of a sustainable, yet meaningful incentive. Some accreditation models merely exploit non-monetary incentives such as public recognition, performance feedback and skill building opportunities. Others incorporate additional incentives like provision of equipment, increased operational budgets for the facility or even small monetary rewards. Finally, some models focus on monetary incentives provided through performance-based budget allocations and/or service reward systems. These models are correlated with health insurance finance schemes.

Unit of Accreditation: The unit of accreditation may be individual providers, but the latter is often referred to as certification. Another possibility is to award accreditation to one type of health facility within the health system. For instance, if the accreditation's objective is to strengthen preventive and primary health care, its focus will then be only on primary care clinics. On the other hand, if the goal was to rationalize use of expensive curative procedures, the unit of accreditation may be hospitals. Finally, other models comprise multiple types of healthcare facilities in order to ensure an effective continuum of care.

Accreditation Body: The group of people who assess level of performance and grant accreditation can be either internal or external to the institution that owns or manages the unit being assessed. The use of internal accreditation bodies is usually linked to institutional supervision structures, and is part of an internal quality effort. However, other accreditation models seek to maximize objectivity of the assessment and use external assessors. An external accreditation body reinforces the credibility of the process and...
is particularly suitable for services provided under sophisticated health management and financial schemes. An intermediate option that increases credibility of accreditation processes, and allows for a closer follow-up in areas where standards are not met, is an accrediting body made up of a combination of internal and external assessors. When building such a group, a healthcare organization may choose to include university faculty affiliates, members of professional associations, or community and civil society representatives.

**Staffing:** Planning, coordination, and implementation of responsibilities for accreditation may simply be added to the already existing responsibilities and tasks of the organization's staff. This is especially applicable when the accreditation effort is small in geographic coverage, technically focused, and built upon internal supervision systems. However, when the accreditation program is more complex and an effective supervision system is not in place, it is often necessary to have full-time staff dedicated solely to the assessment activities. Design of internal accreditation bodies might take a variety of forms depending on the complexity of the accreditation process and the availability of resources. They may use their own staff on a full, part-time or seasonal basis.

**Range of Services:** The range of services included in an accreditation strategy can significantly impact its level of complexity and resource requirements. Based on institutional priorities and resource availability, it may be necessary to restrict the process to one type of service or related function, this describes the focused accreditation approach. However, it is programmatically difficult to completely focus on just one isolated type of service. Another option is to include a comprehensive range of health services or all services provided at a given facility-level.

**Management:** An effective accreditation program requires planning and coordination, and technical, administrative, and financial support. These functions could be performed in a centralized way, from just one managerial unit, or in a decentralized manner in which there is substantial delegation of the managerial functions to the regional, provincial or district level. In the latter case, local authorities (state/provincial secretaries of health, or district/municipal mayors or secretaries of health) assume control of the process or have significant responsibilities and are largely involved in the design, planning, and implementation of the accreditation initiative. The central, provincial, and district levels can also jointly manage the accreditation program.
Process: An accreditation process may be limited to the verification of compliance with pre-established standards through an external review and assessment. In this case, if the standards are met, the accrediting body simply grants the accreditation to the facility. On the other hand, if the standards are not met, the reviewers provide detailed feedback on the status of the facility and identified performance issues. Other accreditation processes, in addition to the review and feedback, offer technical assistance on demand in order to overcome the shortcomings identified. Finally, some accreditation models provide proactive support and follow-up to help the facilities successfully perform at the level of accreditation standards. Approaches such as facilitative supervision or performance improvement are typically used in this facilitated accreditation process.

Sectoral Coverage: Many accreditation programs in developing countries are restricted to one sector of health care provision be it public, private-for-profit or NGO. Another option for sectoral coverage is quality accreditation for more than one sector. In some instances, different but complementary accreditation strategies may be implemented across sectors using different set of standards. A third option is to apply one set of criteria and processes across all sectors providing health services.

Geographical Coverage: Accreditation strategies range from much localized to national scales of coverage. A locally implemented strategy might focus on one or more districts in a select number of provinces. This is particularly appropriate when a particular model of accreditation is first being tested with the intention of scaling-up later. Other models seek coverage and implement on a regional, state, or provincial scale. This option is relevant in decentralized environments in which provincial or state units have significant levels of political, technical and administrative decision-making power. Schemes implemented for national coverage throughout a given country may be linked to nationwide health provision and financing schemes.

Type of standards: Standards are statements of expectations that define the structure, processes and outcomes that must be firmly established in a hospital so that it may provide quality of care. They describe what has to be regulated in a hospital in order to warrant that the quality of care delivered is independent of individuals or chance. Some accreditation programs focus primarily on inputs and process standards, on outcome standards, or on a combination of both types of standards. Structure and process standards tend to be more detailed, whereas outcome standards are usually less detailed. However, outcome standards are frequently more difficult to assess and monitor, and might not accurately represent the actual
quality of care provided. More detailed sets of standards for inputs and processes are typically required when basic infrastructure elements are not in place and the technical competence of the staff is substandard due to deficient pre-service training or introduction of new procedures. Standards may be minimal, defining the bottom level or base, or more detailed and demanding, defining various levels of achievement.

**Definition of standards:** There are a variety of approaches to defining standards. Accreditation standards usually incorporate evidence-based technical norms and protocols. This may happen in a top-down process in which standards are defined at a central level by groups of experts in relevant fields. Standards, on the other hand, could also be developed based on client preferences and definitions of quality as explored through qualitative or quantitative market research methods. This latter approach helps set the stage for increased levels of community involvement and ownership in quality initiatives. Increasingly however, accreditation standards are developed using a combination of both approaches, with the addition of the front-line provider’s perspective.

**Principle of Standards**

In writing down hospital standards, most countries come up with what suit best their individual needs. This does not imply that this is the right way to do it. Standards should be primarily based on what is assumed to be relevant practice to the end users. Health care standards definitions must carry credibility, acceptability, and appropriateness. In any part of the world, when health professionals attempt to formulate their own standards, they have to take into consideration the following issues:

**Key concepts**, which support all standards irrespective of how their content is represented, should be requested. Such concepts might consist:

- Standards’ focus presents a clear documented requirement for the patient’s involvement in the care process. It must reveal the respect for patient rights where transparent explanations are given regarding the process of care. This implies it is customer-focused
- Accountability of health care providers for continuous improvement, quality monitoring and quality in patient care is a requirement
- Management should demonstrate clear managerial processes, optimal resource utilization, an operation-wide participation in strategic planning, and the implementation of risk management
- Outreach which is the liaison with other health care providers in the community to insure a cooperative planning and adequate referrals into and out of health care organizations.
The type of standards should be clearly defined. Standards are categorized as being structure, process, or outcome standards. It has to be acknowledged that standards may not be entirely one type or the other; however, one should be able to pinpoint the general type. It should be recognized that one type is superior to the other and any standard may be appropriate at any given point in time, in any country.

- Structure standards delineate an organization’s capacity to offer quality care.
- Process standards represent how one is doing in performing an activity.
- Outcome standards picture the level or degree of approved performance achieved according to pre-established specifications and/or requirements.

The scope of the standards should be clearly defined. A series of questions should be asked here:

- Do standards mantle the whole operation of range of activities or the whole health care organization, or are they focused on parts of the organizations’ operations/activities?
- Do the standards focus on patients/clients groups or on departments?

There should be intent toward covering and improving health care within the entire organization (be it a network, a single facility, a health care plan, or even a regional service).

The content of the standard should be clearly structured and comprehensive.

- Basic structure standard might include such requirement as: defined governance for the organization which has a clearly established role, safety standards, pharmacy standards, clinical record standards, basic patient rights (consent), standards related to medical staff (organization, practice, evolution, competences), and a defined management for the organization.
- Departmental / functional standards: if a health care organization is organized by departments and/or functions (specific units or operation; e.g. pharmacy, diagnostic imaging, laundry / linen; operating room, etc…), then standards could be applied to each department / function (including both clinical and non-clinical departments, as will as governance and management). Departmental standard standards might address such questions as: What does the department do? (Functions and activities should be clearly specified). What are the policies and procedures that guide the delivery of services within the department? (Key policies and procedures could be specified). Whom does the department serve? (Patients and populations served, other departments served, and those who are not
served). Who provides services within the department? (Competences required of staff; evaluation of performance). How is the delivery of service evaluated? (Mention here the presence of quality improvement projects and the role of the department’s mission or statement of purpose).

- Clients/ patient care process standards ought to be patient-focused, that is to track the patient from the time of entry into the hospital until the time of departure or referral elsewhere. Such standards might invoke specific elements of the patient care process such as admission, appraising the patients’ needs for care, planning care, evaluating care, delivering care, planning for discharge/transfer. These standards could be functional to individuals or patients’ groups, such as those requiring medical care, surgical care, cancer care, obstetrics and gynecology, mental health, rehabilitation, etc… Standards could also be functional to patients receiving in–patient care as well as those being treated on an ambulatory or outpatient basis.

- Standards should be formulated through a well-defined process. There would be a well-defined peer involvement (those who will use the standards) when standards are prepared. There should be recognition and integration, where appropriate, of relevant laws and regulations of regional or national government. A process for ensuring that standards are tested through a pilot program prior to their full implementation should be provided. There should be evidence of appropriate research being done to ensure that standards are up- to- date and based on sound information and practice. There would be a consultation process to ensure that stakeholder groups have the opportunity to advice in the standards. A defined process for evaluating and revising standards on a regular basis should be presented.

- Standards should be amenable to measurement of performance. Measurement of compliance with standards may take a variety of forms from use of sophisticated mathematical / numerical scales to verbal descriptions of compliance. Compliance may be assessed by the surveyors (external experts who visit the organizations) or through a self-assessment process combined with surveyors’ assessment. What would be most important is that there should be a clear description of how compliance is measured by surveyors. It is recommended that a plan exists to include a basic set of indicator measures. All these standards require evidence of performance (or qualitative indicators) that are simple, inexpensive and easy to observe by surveyors.

So far our discussion tackled general principles of standards that are developed by the country’s own health professionals, however, it is also important to query internationally developed standards by well-established accreditation bodies to have a better comprehension about accreditation standards. This is informational for any country that is applying for accreditation by one of the international accrediting bodies.
In evaluating a provider’s performance, the main required
documentation is compliance with accreditation standards, which assess the
quality of providers’ efforts. The standards are developed by an
Accreditation Committee on basis of best achieved providers’ experience
and consented by the Board of the accrediting body. Standards will be
regularly revised in response to altering circumstances so they always
symbolize the uppermost reachable level of quality for patients. The Joint
Commission for instance sets standards that focus on whether the
“organization is doing the right things and whether it is doing them well”.

“…The standards are organized around important patient care and
organization functions, and also address important contemporary issues, like
pain management and emergency preparedness. In the development of the
standards, the Joint Commission obtains input from health care
professionals, health care organizations, consumers and employers.
Periodically the standards are updated to include new developments in
health care delivery, for example, emergency department overcrowding and
staffing effectiveness. Through Joint Commission International, the Joint
Commission also develops standards for health care organizations
throughout the world”.

Over the last ten years, the Joint Commission’s standards were
dramatically altered. The new and reviewed standards refract more patient-
centeredness, with bigger emphasis on patient rights. The joint Commission
substituted old standards regarding committee meeting minutes with others
that relate to strategic planning, managing information, and resources for
continuous quality improvement. These changes were so intrinsic that by
1996, eighty percent of the standards were eliminated from the Joint
Commission’s 1986 manual. The following table compares some of the
changes that occurred in the process of standards’ development.

<table>
<thead>
<tr>
<th>Old Standards</th>
<th>New Standards</th>
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<tbody>
<tr>
<td>Focus on capability</td>
<td>Focus on performance</td>
</tr>
<tr>
<td>Organized by department and discipline</td>
<td>Organized by function to focus on integrated performance of the organization</td>
</tr>
<tr>
<td>Detailed, prescriptive</td>
<td>Flexible, encourage innovation</td>
</tr>
<tr>
<td>Emphasize policies</td>
<td>Emphasize outcomes</td>
</tr>
</tbody>
</table>

An on-going updating process of the standards definitions is essential
for self-improvement and valid self-assessment. The healthcare industry like
any other industry these days is not static but continuously progressing.
An experience from Kyrzgyzstan

Kyrzgyzstan received financial aids from the United States Agency for International Development (USAID) in 1991, and decided after that to implement human and financial resources to achieve accreditation. The Licensing and Accreditation Committee has developed the following list of priority areas for accreditation standards development, trying to find the most effective and tailored approach to achieve hospital accreditation in a developing country, Kyrgyzstan:

1) Hospital management
2) Staff policy and working regulations
3) Financial and economic management
4) Patient rights and hospital development
5) Emergency care
6) Surgery and anesthnesia
7) Out-patient care
8) Maternal and child health
9) Public health, epidemiology and environmental control
10) Para-clinical services (x-ray, laboratory and ECG)
11) Clinical procedures and services
12) In-patient care
13) Pharmaceutical care
14) Management Information System (MIS)
15) Biomedical equipment
16) Plant (facility) standards
17) Safety
18) Quality assurance and continuing quality improvement.

The accreditation standards of the above mentioned priority areas will be listed as they appeared (just with minor editing) in the “Licensing and Accreditation Manual for Hospitals”, originally prepared for USAID by Gregory C. Becker, Abt Associates, Bruce Ente, Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), and the Committee for Accreditation and Licensing, Republic of Kyrgyzstan. Full Compliance (graded 2 points), Partial Compliance (graded 1 point), and Non Compliance (graded 0 points) scores, which appeared in squares following each substandard, will not be listed. Five priority areas’ standards were not included in the internet downloaded and therefore can not be included. These are the: Clinical procedures and services; Pharmaceutical care; Biomedical equipment; Safety; Quality assurance and continuing quality improvement.
Hospital Management

The main goal of all health care providers is to provide the highest quality of patient care services that is possible given existing resources. The Chief Doctor and the Management Staff of each hospital must have as their primary mission the establishment and maintenance of hospital environment that:

- seeks to meet the health care needs of the community it serves
- encourages staff to continually strive to provide high quality patient care
- promotes the most efficient use of available human, equipment, and pharmaceutical resources
- encourages the professional and technical advancement of all staff members
- finds creative methods to increase the resources available for the provision of health care services.

The following conditions are to be applied to all hospitals of all levels and specialties of service. In order to achieve accreditation, hospitals must be in compliance with all standards. Compliance is to be at a level that is appropriate for the size and mission of the hospital. Size, mission, and range of technical services provided (for example, a 200 bed hospital providing general care, or, a national hospital providing specialty cancer treatment) are to be based on population, epidemiological, and geographical need as determined by the National Ministry of Health in consultation with appropriate Oblast health departments. Hospitals must be in compliance with all standards at the time of survey with the exception of those standards that have a future effective date. Standards with a future effective date are provided for informational purposes so that hospitals may come into compliance by the effective date. Hospitals in compliance with these standards in advance of the effective date will receive special recognition by the Accreditation Commission.

1.1 Every hospital shall have the following management and administrative structure. In the case of large hospitals, an individual shall staff these functional positions with full time responsibility for the function. In the case of smaller hospitals, a single staff member may have responsibility for more than one functional area performing the duties of each on a part-time basis.

1.1.1 Physician-in-Chief
1.1.2 Deputy for Clinical Services
1.1.3 Deputy for Financial Management
1.1.4 Deputy for Staff Management
1.1.5 Deputy for Plant and Utility Operations Management
1.1.6 Deputy for Outpatient Services
1.1.7 Chief Nurse.

1.2 Every hospital shall be governed by a Board of Directors. This Board of Directors shall be composed of members of the community served by the hospital, representatives of the Oblast Health Department, representatives of the medical and nursing staff, and the Physician-in-Chief. The size and mission of the hospital shall determine the size and composition of the Board of Directors. The Board of Directors shall be responsible for:

1.2.1 The development of major policies for the operation and management of the hospital
1.2.2 Assuring that the hospital provides services that meet the needs of the community it serves
1.2.3 Assuring that the hospital is operated on a financially sound basis
1.2.4 Approving all written policies and procedures to be followed by the hospital.

1.3 The day-to-day management of the hospital shall be the responsibility of the Physician-in-Chief. The Physician-in-Chief shall report to the appropriate authority within the Ministry of Health or Oblast health authority. After enabling legislation, the Physician in-Chief shall report to the Board of Directors. Although the Physician-in-Chief is responsible for all hospital operations, authority to carry out these functions shall be delegated to the appropriate staff member. Specific duties of the Physician-in-Chief shall include but not be limited to:

1.3.1 The development of quality assurance rules covering the delivery of health services, and assuring that all quality assurance efforts are problem solving and educational in nature. Punishment or sanctions will only be imposed in cases of significant negligence or misconduct
1.3.2 Assuring that all staff hired and equipment and supplies procured is in accordance with priorities established according to effect on morbidity and mortality
1.3.3 Assuring the development of written rules to assure the safety of all patients and staff
1.3.4 The development of long and short-term plans for the operation and financing of the hospital, and how these plans will meet anticipated future needs of the community
1.3.5 The hospital must have a written manual that defines hospital policies and Standard Operating Procedures and that is regularly revised and updated. The written plan for health services must be made known and available to all health personnel. The plan for health services should describe the following:
1.3.5.1 The population served, including age groups and other relevant characteristics of the patient population
1.3.5.2 The hours and days the facility operates
1.3.5.3 The methods used to carry out initial screening and/or triage
1.3.5.4 The intake or admission process, including how the initial contact is made with the patient and the family or significant others
1.3.5.5 The basic therapeutic programs offered by the facility, such as inpatient, day bed, outpatient, therapeutic education, and other services
1.3.5.6 The means by which the facility provides, or makes arrangements for the provision of, the following:
   (a) Other medical, special assessment, and therapeutic services
   (b) Patient education services, whether provided from within or outside the facility;
   (c) Emergency services and crisis interventions; and,
   (d) Discharge and aftercare, including post-therapy planning and follow-up evaluation
1.3.6 The establishment and effective operation of a Management Information System (MIS) that will monitor and allow the timely analysis of statistical data including: bed/days, average length of stay, number of outpatient visits, number of admissions, number of immunized patients, instances of patient death, and instances of nosocomial infections
1.3.7 Assuring that all staff members receive continuing medical and technical education and training
1.3.8 Assuring that the hospital is operated on a financially sound basis to the degree possible given available resources
1.3.9 Contracting with all outside providers such as transport, pharmaceutical, medical equipment companies
1.3.10 The improvement and renovation of capital resources if sufficient funding is possible

1.4 Day-to-day management of patient care services shall be the responsibility of the Deputy for Clinical Services (DCS). The DCS shall report to the Physician-in-Chief. Responsibilities of the DCS shall include:

1.4.1 The establishment and monitoring of an "Outcome Indicator" based clinical Quality Assurance program. This program will be based on monitoring the results of patient care by tracking such global indicators as patient deaths, nosocomial infection, and readmission rates. More specific outcome indicator monitoring is to be developed and implemented in each hospital department. For example, for monitoring anesthesia services, incidences of anesthesia related death, and peripheral or central nervous system damage will be monitored. When adverse outcomes are encountered, investigations will be carried out to determine the cause. Measures will then be instituted to minimize or prevent future negative outcomes
1.4.2 Assuring that Medical Economic Standards will not be used to monitor patient care quality as this system is too labour intensive and provides little in the way of quality improvement. In times of economic crisis, the excessive use of human resources to monitor adherence to these protocols is counter productive. Also, effective therapies that creatively use existing resources to treat patients are punished under Medical Economic Standards despite achieving positive patient outcomes.

1.4.3 Current and prospective planning of clinical and diagnostics procedures and their execution and control

1.4.4 Planning and control of in-house pharmaceuticals consumption

1.4.5 Evaluation of clinical operations of all hospital departments

1.4.6 Planning and carrying out hospital training, hospital conferences, and seminars on clinical topics

1.4.7 Assuring patient satisfaction with all services. Methods of determining and measuring satisfaction may include interviews and patient surveys

1.5 Day-to-day management of the hospital's revenues and expenses shall be the responsibility of the Deputy for Financial Management (DFM). The DFM shall report to the Physician-in-Chief. Responsibilities of the DFM shall include:

1.5.1 Determining, planning and monitoring the hospital budget

1.5.2 Accounting and the control of all income and expenses

1.5.3 Development of a written staff chart specifying such items as number of positions, salaries, bonuses, etc…

1.5.4 Preparing quarterly and annual financial reports, and presenting them to the Physician-in-Chief and the Board of Directors

1.6 The Deputy for Staff Management (DSM) shall report to the Physician-in-Chief. Responsibilities of the DSM shall include:

1.6.1 The development of rules for contracting with facility staff members (physicians, nurses, laboratory workers) and development of their working instructions

1.6.2 Assuring that all staff members receive continuing medical and technical education and training

1.6.3 Assuring that all staff is hired in accordance with priorities established according to effect on morbidity and mortality

1.7 Day-to-day operation and control for the hospital building, mechanical systems, and logistics shall be the responsibility of the Deputy for Plant and Utility Operations Management (DPUOM). The DPUOM shall report to the Physician-in-Chief. Responsibilities of the DPUOM shall include:

1.7.1 Conducting and keeping current a complete inventory of hospital equipment
1.7.2 Determining hospital needs in terms of equipment and supplies, and prioritizing those needs according to their effect on the goal of reducing morbidity and mortality

1.7.3 Contracting with all outside providers such as transport, pharmaceutical, medical equipment companies

1.7.4 The improvement and renovation of capital resources if sufficient funding is possible.

**Staff Policy and Working Regulations**

2.1 The Deputy for Staff Management reports to the Chief Physician is responsible for the implementation and coordination of personnel policies and procedures and to accomplish the following tasks:

2.1.1 Filling all Staff positions
2.1.2 Develop a written organizational plan for personnel services
2.1.3 Maintain personnel records
2.1.4 Disseminate employment information to staff
2.1.5 Develop staff orientation programs
2.1.6 Assure employee compliance with personnel rules
2.1.7 Supervise the processing of employment-related forms
2.1.8 Prepare an annual written statistical report concerning personnel functions

2.2 Personnel policies and procedures must be developed, adopted, and maintained to promote the objectives of the hospital and to provide for an adequate number of qualified personnel during all hours of operation. Personnel policies must include procedures for recruiting, selecting, contracting, promoting, and terminating staff. Personnel policies and procedures must apply to all employees and must be made available to, and discussed with, all new employees. Information on the following items must be included in the written policies and procedures:

2.2.1 Employee benefits
2.2.2 Recruitment and contracting
2.2.3 Promotion orientation
2.2.4 Training and staff development
2.2.5 Employee grievances
2.2.6 Safety and employee injuries
2.2.7 Relationships with employee organizations
2.2.8 Disciplinary measures
2.2.9 Termination mechanisms
2.2.10 Wages, hours, and salary administration
2.2.11 Rules and conduct
2.2.12 Lines of authority and organizational structure
2.2.13 Performance appraisals

2.3 A personnel record must be kept on each staff member and should contain the following items, as appropriate:

2.3.1 Application for employment
2.3.2 Verification of all training and experience, and licensure, certification, registration, and/or renewals
2.3.3 Wage and salary information, including all adjustments
2.3.4 Performance appraisals
2.3.5 Initial and subsequent health clearances
2.3.6 Disciplinary actions
2.3.7 Commendations

2.4 Selection of personnel must be based upon criteria that are demonstrably related to the job under consideration. For each position in the facility, there must be a written job description that specifies the duties and responsibilities of the position and the minimum level of education, training, and/or related work experience required or needed to fulfil it. Each job description must specify the following items:

2.4.1 Position title
2.4.2 Department, service, or unit
2.4.3 Direct supervisor's title
2.4.4 Employees supervised
2.4.5 Tasks and responsibilities of the job
2.4.6 Location of the job and the materials and equipment used, if any

2.5 Performance appraisals must be related to the job description and job performance. The criteria used to evaluate job performance must be valid, reliable, and objective. When there is a discrepancy between the staff member's actual job performance and the criteria for optimal job performance, the staff member must be informed of the skills, knowledge or attitudes expected and should be encouraged to perform the job according to these optimal levels of job performance. Appropriate training programs should be considered.

2.6 Appropriate staff training and development programs must be provided for administrative, medical, and support personnel. Staff training and development should be under the supervision and direction of a qualified person or committee. This person or committee may delegate responsibility for any part of the program to appropriately qualified individuals. Staff development programs should reflect all administrative and service changes in the facility and should prepare personnel for promotions and greater responsibilities.

2.7 Appropriate orientation programs should be provided for all new employees. Included in these orientation programs should be such topics as hospital policies, all procedural manuals, and department specific written policies.
2.8 A continuous professional education program must be providing to keep the professional staff informed of significant clinical and administrative developments and skills. The facility's staff development programs should include opportunities to participate in education programs outside the facility, such as workshops, institutes, seminars, and formal continuing education programs.

2.8.1 The facility should communicate and collaborate as much as possible with other hospitals as well as national and local professional organizations in this effort to provide continuing education programs.

2.9 The results of patient care evaluations or quality assurance activities must be an important part of the staff development programs.

2.10 A mechanism must be provided for evaluating the effectiveness of staff education and in-service training programs at least annually.

2.11 The role of the physician is to provide diagnostic and treatment procedures as well as other health care services in accordance with the internal rules of the hospital. Physicians are required to record all patient data including information of prescribed pharmaceuticals and their doses, examinations and treatments required and given, diagnosis and prognosis into the patient medical record on a timely basis. In addition, physicians are required to:

2.11.1 Determine the type and necessary number of diagnostics tests and treatments.

2.11.2 Explain to the patient all the risks involved with the prescribed diagnostic test and treatments, the benefits of those procedures, as well as the results of not being treated.

2.11.3 To determine the clinical diagnosis and decide the venue for further treatment (out-patient, in-patient, or home-care).

2.11.4 In case if any difficult diagnosis or treatment procedure, the physician has a right and an obligation to call a consultant. If addition, the physician is required to consult to other physicians when requested.

2.11.5 Be able to provide first aid.

2.12 Sufficient numbers of qualified nurses are on duty at all times to provide appropriate patient care.

2.12.1 Nursing service assignments are commensurate with the qualification of nursing personnel to meet nursing care needs of patient.

2.13 The role of the nurse is to help physicians in their work during diagnostic procedures and treatment, and to provide health services in accordance with staff position obligations and nursing rules approved by Physician-in-Chief.

2.14 There is an organized nursing department integrated into the total hospital administration which maintains the quality of nursing care, and ensures optimum professional practice.
2.14.1 A qualified head nurse with adequate preparation and experience as an administrator directs the nursing service
2.14.2 The nursing director has the responsibility and authority necessary to assure quality nursing care
2.14.3 All department head nurses are accountable to the nursing director
2.14.4 Organizational structure of the nursing department provides nursing service administration during all shifts. In the absence of the nursing director, a qualified registered nurse will act in her absence
2.14.5 The nurse administrator provides formal liaison required between the medical staff and the nursing services
2.14.6 The nursing department has a written organizational plan that delineates lines of authority, accountability and communication

2.15 The nursing department has the responsibility of:
2.15.1 Reviewing and approving nursing policies and procedures that relate to qualification and employment of nurses
2.15.2 Establish standards of nursing care and evaluating that care
2.15.3 Encourage nursing personnel to participate in staff educational programs and attend required meetings
2.15.4 Develop a job description for each nursing position
2.15.5 Perform a written evaluation of the performance of nursing personnel at defined intervals
2.15.6 Assuring that nursing personnel assigned to work in specialized areas such as surgery or intensive care units have appropriate orientation, training, and/or experience
2.15.7 Written policies and procedures that reflect optimum standards of nursing practice must be developed by the nursing department. These written policies and procedures should be reviewed annually and revised as necessary

2.16 Nursing department personnel are prepared through appropriate education and training programs
2.16.1 Education programs for the nursing department are ongoing and designed to augment knowledge of new developments and maintain competence
2.16.2 Training needs are identified through periodic assessments of nursing care provided at the facility

2.17 The role of the sanitary attendants is to provide support services in accordance with staff position regulations and rules approved by Physician-in Chief, and to work in accordance with the safety rules for patients and medical staff.
Financial and Economic Management

The Finance and Economic Service (FES) Unit of a health facility provides collection, timely procurement, accounting, accumulation and efficient use of financial and economic resources for a stable operation of the facility in compliance with standards. The major goal of the FES is the development and maintenance of a sound financial status for the hospital.

3.1 The FES unit must be an integral part of hospital operations, and work in a close contact with all departments of the facility for all financial matters.

3.2 The FES must maintain formal relations with financial and other relevant bodies of the administrative territory and any other appropriate government agencies.

3.3 The structure of the FES, regardless of its capacity, must have or cover the following functions:
   3.3.1 Material procurement
   3.3.2 Accounting
   3.3.3 Economic (financial management)

3.4 The number of employees in each section of the FES is based on the workload of the facility.

3.5 Every employee of FES has received training appropriate to the job, and has a document certifying completion of training.

3.6 The FES is equipped with proper equipment appropriate to the volume and character of work done by the unit.

3.7 The FES is headed by a Chief Accountant who reports to the head of the facility.

3.8 The primary duties of the Chief Accountant are:
   3.8.1 Planning, forecasting, allocation of funds among departments
   3.8.2 Timely utilization of available funds
   3.8.3 The development and implementation of any and all contracts between the hospital and its staff, external vendors, or other organizations
   3.8.4 The education of hospital personnel and hospital departments in financial responsibilities (logging, reporting, inventory, etc.)
   3.8.5 Determining facility personnel costs based on staff job ratings and in accordance with needs based on the volume of work of the facility
   3.8.6 The preparation of job descriptions for each employee of the FES unit
   3.8.7 The organization of financial operations on a timely basis
   3.8.8 The monitoring and control over the correct use of financial and material resources in departments and in the facility as a whole.
3.8.9 Conducting systematic analyses of financial and economic activity according to established indices and the timely informing of the leadership of the facility

3.8.10 The development, implementation and control over rules and procedures of logging and reporting financial and economic activity of departments

3.8.11 Assuring the daily control, recording and monitoring of financial activity of all sources (budget, insurance companies, contracts, paid services, investments, credits, sponsors, etc.)

3.8.12 Assuring the monitoring and timely collection of all monies owed to the facility for services rendered. Implementing the use of various measures necessary to assure the collection of all monies owed to the facility

3.8.13 Assuring the timely and full settlement and payment of monies owed to other institutions for their services as a measure of maintenance of the facility image (timeliness, responsibility, accuracy, observance of own commitments and obligations)

3.8.14 Monitoring on a monthly basis all bank accounts of the facility

3.8.15 Determining the costs of medical and other services provided at the facility

3.8.16 Updating cost of services analyses on an annual basis taking into account inflation, use of new equipment, apparatus, methods of treatment, medical and other techniques

3.8.17 Determining the costs of new medical services before their implementation

3.8.18 To be aware of trends and changes in any financial issues relating to the hospital (legislative, normative, pricing, labor payment, etc.)

3.8.19 To be aware of current insurance practices and any changes to those practices (change of costs, violation and timeliness of settlements, lifting of some payments, determination of payments with appropriate payrolls, etc.)

3.8.20 Assuring the systematic, and if necessary, immediate, briefing of hospital management staff financial and economic activities

3.8.21 The Quarterly presentation of approved reports about the financial and economic activities of the hospital to management staff, Oblast health officials, or board of directors as appropriate

3.9 Financial and economic resources of the facility may come from several sources. These sources are monitored on a regular basis by the FES. Income from these sources is tracked in specific ledgers, and changes to regulations and procedures for each source are monitored. The following sources are monitored:

3.9.1 Income from the local, Oblast, or National Budget

3.9.2 Payments from health funds
3.9.3 Payments from insurance companies involved in voluntary health insurance

3.9.4 Payments for supplementary services (including but not limited to: above standard food, room refrigerator, TV-set, above standard room, private or semi-private toilets, bathrooms with cold and hot water, phone, special care by Chief Physician, car rental, etc…)

3.9.5 Payments for lease of premises, territory, transport and equipment

3.9.6 Returns from any sales of surplus production delivered to auxiliary hospitals

3.9.7 Funds from sponsors, investments, charities, etc…

3.10 The FES has an established system of coordinated financing, procurement, spending of funds, inventory and write-off

3.10.1 The procedures for financing, procurement, and spending of funds are written in a manual available to staff

3.11 The Chief Accountant has the authority to disburse hospital monies to pay recurring expenses (food, supply of medicines, payroll, payment of contracts on heating, lighting, water supply, transport, communication and others), as well as purchase and write-off low value equipment in amounts less than 5 minimal salaries

3.12 Any purchases, payments, or write-off of equipment, with a value of over five minimal salaries must be made only with the written approval of the leadership of the facility (Chief Doctor and Board of Directors)

3.13 Any expense or payment with a value of over thirty minimum salaries must have the written approval of the Treasury in the case of a government hospital, or with the permission of the hospital’s board of directors in the case of an autonomous or private facility

3.14 Financial Activities of the hospital are frequently and routinely analyzed. Results of these analyses are summarized and reported to the Chief Physician within 3 days of completion, and to the board of directors on a quarterly basis

3.15 The following analyses are done:

3.15.1 Balance sheet (annual)
3.15.2 Statement of Revenue and Expenses (quarterly)
3.15.3 Accounts Payable (monthly)
3.15.4 Accounts Receivable (monthly)
3.15.5 Current Liabilities/Total Debt (every six months)
3.15.6 Inventory of Capital Goods (every two years)
3.15.7 Inventory of Consumable Goods (annual)
3.15.8 Inventory Turnover (every six months).
Patient Rights and Hospital Development

Each hospital must assure that each patient has the following rights:

4.1 A patient has the right to select the physician who will provide their care, if that physician is available

4.2 In a case of scheduled hospitalization, the patient has a right to choose a health facility

4.3 In the reception department of the health facility, the patient and if possible, his closest relatives must be informed about the guaranteed scope of medical care covered by the health fund, and about any additional services to be covered by the patient himself. This briefing of the patient and family will be conducted by a nurse. The occurrence of the briefing must be recorded in the registration journal and the patient's history, and must be signed as a confirmation by the patient or his/her relatives

4.4 The patient has a right to be informed of his/her diagnosis and the nature, scope, and risks of the prescribed treatment. This briefing is to be given by the attending physician

4.5 At the time of discharge from the hospital, the patient must be asked to indicate the level of satisfaction with the quality of service and medical care received. This information must be recorded in the patient’s medical record. The attending physician and the head of department are responsible for obtaining and recording this information

4.6 The patient has a right to familiarize himself with the internal routine of the facility, and to get formal information about paid services

4.7 Patients not covered under the system of mandatory or voluntary health insurance are responsible to pay all costs of treatment, according to the Law "On mandatory health insurance of citizens in the Kyrgyz Republic", Chapter 1, Article 8. Any such patients must be informed of this responsibility at the time of admission

4.8 All patients, regardless of coverage by health insurance or ability to pay have the right to emergency medical treatment

4.9 All patients must be informed about any risks associated with any surgical interventions, anesthesia and treatment or diagnostic interventions. A statement, signed by the patient acknowledging being informed of risks must be included in the patient’s medical record

4.10 All disputes between a patient and the hospital must be settled in compliance with the Law "On health insurance of citizens in the Kyrgyz Republic", Chapter 8, Articles 34-35.
Emergency Care

5.1 Rayon and municipal hospitals have an organized Department of Emergency Care. This emergency department has the primary responsibility or providing initial medical care in emergent cases of acute disease or trauma. In localities that are adequately covered by independent emergency units or are covered by a hospital designated as an emergency hospital, the hospital may be exempted from the requirement to have an organized emergency care department by the Oblast or Municipal Health

5.2 To serve the emergency medical needs of the locality served by the hospital, the emergency care department must have a specially equipped ambulance staffed with a feldsher and driver (in rural areas) or a mobile team consisting of physician, feldsher, driver and janitor

5.3 There is at least one ambulance for each 10,000 population in the locality served by the emergency department. Mobile teams may be of general purpose or specialized ones, such as cardiology, pediatric, psychiatric, traumatology, etc…

5.4 The emergency department maintains close contacts with all health facilities and ambulance stations of the city and/or rayon

5.5 The emergency department is headed by a Department Head or Chief Doctor with length of such service not less 5 years and special training.

5.6 The Department Head is responsible for the overall direction and supervision of the department. Other duties include:

5.6.1 The supervision of all department staff, including assuring that all duties are performed

5.6.2 Assuring the continuous improvement of professional skills of every employee via conduction of seminars, clinical conferences

5.6.3 Assuring that all staff is sent for refresher courses each 5 years

5.6.4 Assuring and monitoring the daily supply of medication and equipment

5.6.5 Maintain relations and communications with ambulance stations and other health facilities

5.6.6 Perform monthly, quarterly, and annually analyses of the performance of emergency department on the basis of report data

5.6.7 Report on the performance of the emergency department to the Chief Physician of the hospital on a quarterly basis

5.7 The feldsher of emergency care is hired by the Chief Doctor and must have a diploma from a recognized feldsher training program

5.8 Duties of the feldsher include: delivery of primary medical care in urgent and emergent cases; all kinds of injections; transportation of
any wounded patients; temporary immobilization in fractures; artificial breathing mouth-to-mouth and with use of apparatus for artificial breathing; indirect heart massage; ECG; stomach lavage, giving of irrigating enema; express methods of determination of Hb, blood sugar, protein, urine and bile

5.9 Emergency care physicians are hired by the Chief Doctor must have higher medical education, and special training in emergency care or related specialty of not less than 1 year

5.10 Duties of emergency care physicians include: delivery of primary medical and first doctoral care in urgent and emergent situations; all kinds of injections; bandaging and dressing of wounds; temporary immobilization of fractures; artificial breathing mouth-to-mouth and with use of apparatus for artificial breathing; indirect heart massage; ECG and reading; tracheostomy; bladder catheterization; puncture of abdominal and pleural cavities; express methods of determination of Hb, blood sugar, protein, urine bile; stomach lavage, irrigating enema

5.11 If a patient coming through the emergency department requires hospitalization, the patient must be referred to the reception department of hospital with a referral form, which includes diagnosis, what kind of care was provided and a recommendation on the specialty department the patient should be treated by

5.12 After examining a patient and his/her referral form, the physician of the reception department continues to deliver any needed procedures. The physician of the reception then calls the head of the specialty department (or in case of absence of the head, calls for the physician-on-duty), in order to jointly make the decision about the hospitalization of the patient. If the diagnosis is in doubt, then a call is made for consultants from other departments to clarify the diagnosis

5.13 If the reception department has no physician, then the nurse on duty calls immediately for the head of the department that the patient has been referred to

5.14 If several patients come to the hospital at the same time requiring emergency care, the physician of the reception department decides the sequence of delivery of medical care based on severity of need and the principals of triage

5.15 Delivery of medical care to patients and victims of natural or man-made disasters is conducted by the hospital according to the preplanned measures of Civil Defense. The head of the emergency care department will be in charge of communications with Civil Defense officials, and will direct the hospital’s emergency efforts until the arrival of the Hospital Chief Physician.
Surgery and Anesthesia

6.1 Surgical and anesthesia are clearly structured services of the hospital. These services may be organized into an integrated department, or may be under the control of distinct specialties as the Department of Surgery and the Department of Anesthesia. In either case, the organizational structure is clearly defined and responsibilities are clearly assigned.

6.1.1 The organizational structure of surgery and anesthesia services is specified in a written document.

6.1.2 This organizational document is readily available to hospital staff.

6.2 Surgical and anesthesia services must work in close contact with other hospital services and departments. Communications between surgery and anesthesia services and the other departments of the hospital must be formally organized.

6.2.1 Communications procedures must be specified in a written document.

6.2.2 This document (which may be combined with the document referred to in 6.1.1 and others) is present in all medical specialty departments and is available to all staff.

6.3 Surgery and Anesthesia Services are managed by a Head of Department (or two heads of department in the case of separate services), with a service length of not less than 5 years, and who has a proper attestation category.

6.4 The duties of the Head of Department include:

6.4.1 Direct control over the performance of department and fulfillment of the duties of every employee of the department.

6.4.2 Maintenance and improvement of the material and technical base of the department in compliance with the requirements of sanitary norms.

6.4.3 Assuring that the equipment of the department is maintained in proper working order.

6.4.4 Prioritizing the selection of essential medication, supplies, and medical equipment for the department based on severity of need and impact on patient welfare in terms of reducing morbidity and mortality. Assuring, to the extent possible given financial constraints, the procurement of these items according to priority.

6.4.5 Assuring that the department meets sanitary and epidemiology standards required by the Ministry of Health, and safety standards required by relevant government agencies.

6.4.6 Assuring that all employees of the department participate in regular skills improvement training courses.
6.5 Young physicians with less than one year of experience must work under the direct supervision of a physician with at least five years of experience.

6.6 In order to provide correct and effective anesthesia, the following must be in place:

6.6.1 All patients needing to undergo surgery (except for emergency surgery) must be scheduled with the surgical and anesthesia services at least two days before surgery.

6.6.2 A list of patients scheduled for surgery shall be developed the day before the surgery. This list must be shared between all surgical and anesthesia services, and all other relevant departments.

6.6.3 Before the use of any anesthesia (except in the case of extreme emergency) a physician performs a complete physical examination of the patient. This examination must include measurement of Hb., blood pressure, hematocrit, clotting time, and red blood cells. Patients over 40 years of age (and other cases where indicated) must have an ECG performed within 48 hours prior to the surgery. The results of these examinations are reviewed by the anesthesiologist no less than 12 hours before surgery.

6.6.4 An anesthetist checks readiness, sterility, and working condition of equipment to be used immediately prior to surgery.

6.6.5 After use, equipment such as laryngoscopes, oxygen containers, masks, tubes, etc. must be sterilized by a nurse.

6.6.6 After surgery, patients are held in a recovery area under the direct supervision of an anesthetist. Patients will stay in the recovery area until the anesthetist determines that the patient is no longer under the effect of anesthetic agents.

6.7 Care of patients after surgery includes but is not limited to:

6.7.1 Appropriate nursing care.

6.7.2 Close monitoring of all surgical wounds to assure proper healing and absence of infection.

6.7.3 A minimum of one post-surgery visit to the patient by the anesthetist to check for any post-anesthesia effects. This visit will occur during the period of time between 24 to 48 hours after release from the recovery area.

6.7.4 Any pathology studies of tissues removed during surgery are reported to the appropriate physician and are recorded in the patient’s medical record.

6.8 In order to improve the quality of anesthesia and surgical services, certain indicators will be monitored on a continuous basis. When unacceptable occurrences are noted through this monitoring process, the head of department will investigate the causes of the occurrences and institute corrective measures. The following indicators will be monitored: Sentinel Event Indicators: These indicators represent serious undesirable...
patient outcomes. Each occurrence of these events must be investigated thoroughly.

6.8.1 Cardiac or respiratory arrest during surgery
6.8.2 Cardiac or respiratory arrest during the post anesthesia recovery period
6.8.3 Post anesthesia neurological complications (Central Nerve System and/or peripheral)
6.8.4 Repeat surgery for same aliment
6.8.5 Post-surgical infections
6.8.6 Heart attack or stroke within 7 days following surgery.
6.8.7 Death within 7 days following surgery. Rate Based Indicators: These events are monitored over time. Increase in frequency of occurrences may indicate a quality problem, and requires investigation into underlying causes
6.8.8 Pre-planned surgery not taking place at scheduled time
6.8.9 Patients not prepared properly for surgery.

Outpatient Care

The main objective of the Out-Patient Care Department is to provide high quality care in close co-operation with all other hospital departments. All Out-Patient Departments of any size or type of hospital must comply with the following standards.

7.1 The Out-Patient Department must be staffed by specially trained physicians, nurses, medical attendants in number and specialty that conform to the volume of patients treated by the department and the overall mission of the hospital

7.2 The Out-Patient Department must have the following facilities:
7.2.1 Registration - where patients are entered into the appropriate registry; assigned to the appropriate physician or care giver; billing, insurance or other payment documents are begun; and a medical record is either begun in the case of a new patient, or retrieved from storage in the case of a returning patient. The medical record and payment document must follow the patient in an efficient manner, and be returned to Registration or the Financial Office at the end of the patient visit
7.2.2 Treatment and diagnostics rooms - where patients are examined and treated in conditions appropriate for their severity and type of illness or injury. These rooms must be equipped to the extent possible with equipment appropriate to conditions treated. Rooms must be of sufficient number that patients and staff are not forced to wait long periods for access to a treatment room
7.2.3 Para-clinical Services - must be readily available to the Out-Patient Department. Lab, X-ray, and other diagnostic services must either be present in the Out-Patient Department, or, must be easily accessible in the hospital itself. In the case of sophisticated para-clinical services such as CAT scan or EEG, these services must be readily available in an accessible diagnostic centre. In the case of smaller hospitals, the range of para-clinical services that must be provided at the hospital is correspondingly smaller, with patients either referred to a higher level of facility for treatment, or, with a greater use made of external diagnostic facilities.

7.2.4 Physiotherapy services - must be present in sufficient range and quantity to meet the needs of patients served.

7.3 Relations with a diagnostic centre must be developed for the procurement of those para-clinical services that are not available at the hospital.

7.3.1 Protocols for the referral of patients and the transfer of medical records must be established and functioning. Protocols for the return of the patient to the Out-Patient Department of the hospital along with the timely reporting of diagnosis and any other relevant patient information from the diagnostic centre back to the hospital out-patient department must be established and maintained.

7.4 A medical record is maintained for every patient who receives ambulatory care services. The following information is documented in each patient's medical record:

7.4.1 Patient identification
7.4.2 Relevant history of the illness or injury and of physical findings
7.4.3 Diagnostic and therapeutic orders
7.4.4 Clinical observations, including the results of treatment
7.4.5 Reports of procedures and tests, and their results
7.4.6 Diagnosis or impression
7.4.7 Patient disposition and any instructions given to the patient and/or family for care

7.5 Written policies and procedures specify support systems, staffing, appointments, scheduling, telephone advice, triage, communication, and waiting time have been developed and are available to and understood by all staff.

7.6 Mechanisms for internal (other hospital departments) and external (other hospital, polyclinic, etc.) referral are established.

7.6.1 Responsibility for the care of the patient is established and documented when the patient is referred to practitioners or providers of services internal or external to the organization.

7.6.2 The hospital provides mechanisms for effective communication among providers of care within the organization and with other health care providers.
provider organizations and individuals to whom patients are referred or transferred

7.7 Continuity of care is assured. A mechanism is established and functioning that assures that a patient referred to a different provider or other health care facility is accompanied by a medical record abstract

7.8 The care of each patient at any level of treatment or facility is managed by a primary care physician. The primary care physician is responsible for coordinating the care provided by specialists while the patient is hospitalized, and for assuring that all follow-up care is completed on an out-patient basis once the patient is discharged from the hospital

7.9 Out-patient department staff members participate in vigorous programs of medical and technical education and training. In order to raise the professional competency and increase public respect of primary care physicians, out-patient department staff members must be strongly encouraged to increase their skills in accordance with the training and education program developed by the administration of the hospital. Out-patient staff members may receive this training either in the hospital or in acceptable outside training facilities. Hospitals are encouraged to cooperate in the development of training programs, to share resources, and to open training programs to other hospital staff members on a barter basis

7.10 Emergency equipment, drugs, and supplies are present in the out-patient department and readily accessible to medical staff. Amount and type of equipment and drugs is appropriate for the type and size of hospital

7.11 Emergency equipment, drugs, and supplies and emergency drug storage areas are checked at least daily when ambulatory care service are provided and after each use to confirm that all items are immediately available in usable condition.

Maternal and Child Health

Maternal and Child Health Services may be integrated into the range of services offered by a full service general hospital, or, they may be delivered by a specialty hospital. Such specialty hospitals may be combined Maternal and Child Health Hospitals, or, they may be separate facilities such as maternity houses and pediatric hospitals. In what ever form the hospital may take, it must be recognized that patients using these facilities have special needs that not only include the trauma or illness common to all patients, but that there are other important considerations. For example, the combined needs of a mother and newborn child in a child birthing center, and the fears and bewilderment of a child undergoing medical treatment outside of the home. Hospitals must not only be structured to meet these
special needs, but the staff of these facilities must demonstrate a commitment to both the physical and emotional welfare of their patients.

8.1 Heads of Maternal and Child Health departments, regardless of hospital structure, are responsible for the general performance of their individual departments. Areas of responsibility include but are not limited to:

8.1.1 Assuring the performance of the full scope of job responsibilities by all medical and non-medical personnel

8.1.2 Assuring the existence of proper conditions for the delivery of treatment services

8.1.3 Assuring that all staff is provided opportunities for improvement of their technical qualifications, and that staff are encouraged to participate in these training programs

8.1.4 Implementation and continuous monitoring of safety rules

8.1.5 Implementation and continuous monitoring of sanitary and anti-epidemic measures

8.1.6 Implementation and monitoring of measures for the prevention of intra-hospital infection

8.1.7 Maintenance of interrelationships with out-patient and para-clinical services

8.1.8 Monitoring and analysis of patient care activities, and the implementation of corrective actions

8.1.9 Monitoring the development of improved methods of examination and treatment, and implementing those methods that are appropriate for the type of patient treated by the hospital, and the scope of services offered. Maternity House/Department of Obstetrics and Gynecology Maternity houses are intended to provide a full scope of specialized, highly qualified services to pregnant women, post-partum women and newborns. Obstetrics and Gynecology Departments of general hospitals may provide a combination of these services up to the comprehensive scope of the specialty hospital depending on the mission of the hospital and the needs of the community it serves

8.2 Although the primary focus of the hospital or department is obstetrics and gynecology, women patients of this service may have additional unrelated medical problems. In such cases, the chief physician will assure the arrangement of consultations by other specialists as necessary

8.3 Premises, basic areas and auxiliary premises must comply with SNIPs and sanitary norms

8.3.1 The supply of hot and cold water is mandatory

8.4 The maternity service must be staffed with appropriate number of Ob/Gyns, neonatalogists, and anesthetist-reanimators who have passed a proper training
8.5 Each department must have a separate reception block to conduct primary examinations of patients

8.5.1 Functions performed in the reception block include: making preliminary diagnoses; measuring temperature, blood pressure, and other vital signs; performing sanitary and hygienic treatments; performing urgent analyses; recording patient medical history and beginning other documentation (journal of admission and registration of patients, medical record, etc.); and, referring the patient to the appropriate specialty department

8.6 Maternity houses are required to have the following departments. Obstetric and Gynecology Departments of general hospitals will have those departments necessary to deliver the range of services outlined in the Mission Statement of the hospital, and based on the needs of the community served:

8.6.1 Department of normal pregnancy
8.6.2 Observation department (septic complications)
8.6.3 Gynecology department
8.6.4 Department of pregnancy pathology
8.6.5 Newborn departments
8.6.6 Surgery block
8.6.7 Intensive care unit
8.6.8 Procedure rooms

8.7 The Gynecology Department admits women with various gynecologic pathologies. The department must have wards, procedure rooms, examination rooms, small surgery room, and physical therapy room

8.8 The Department of Normal Pregnancy admits women with uncomplicated pregnancy. Patients enter the pre-delivery ward where an Ob/Gyn specialist performs and examination, determines period of delivery and prescribes treatment if necessary.

8.8.1 A physician continuously observes patients in the pre-delivery ward

8.8.2 At labor woman is moved into a delivery room which has equipment, instruments, and medication necessary for performing non-complicated deliveries, and for providing emergency stabilization for those deliveries becoming urgent or complicated

8.9 The Department of Pregnancy Pathology admits pregnant women with various deviations from normal pregnancy. The department delivers treatment and preventative services, and prepares pregnant women with complications to undergo delivery

8.10 The Observation Department admits febrile women, women with labour started outside the maternity house, and pregnant women with extra-genital pathology. The department must have pre-delivery, post-partum wards, delivery room, boxes, procedure rooms, personal hygiene rooms,
physical therapy rooms, and other auxiliary rooms in a number sufficient to meet the needs of patients served

8.11 At term, the patient is first seen in the reception department and is examined by a physician who fills in the medical history and determines the specialty department that will handle the patient. At this time, a midwife makes a primary sanitary treatment, weighs the patient, measures blood pressure, takes required analyses and completes required documentation

8.11.1 The patient is then admitted to the observation department. At onset of labour, the woman is transferred to the delivery room where both an Ob/Gyn and neonatologist control the delivery

8.11.2 After delivery, initial sanitary treatments are performed on the newborn after which he/she is transferred to the Newborn Department

8.11.3 Observation and treatment of the post-partum woman is conducted by the Ob/Gyn specialist

8.11.4 Prior to discharge, the woman must be counselled about family planning and IUD use

8.12 Any facility performing obstetrical services on a regular basis must have a Newborn Department

8.12.1 The newborn department must have an intensive care unit for the treatment of severely sick newborns. If the department is small, it must have formal arrangements made for the speedy transfer of sick newborns to an appropriate facility

8.12.2 The department is staffed with neonatologists, child nurses, and other paraprofessionals. Neonatologists and nurses are required to have passed special training in newborn care

8.12.3 Neonatologists and nurses of the intensive care unit must also have passed special training in neonatal intensive care and reanimation

8.13 The newborn department must include a room for collecting and pasteurizing breast milk

8.14 At any delivery, the Ob/Gyn specialist delivers the child, and the neonatologist is present for emergency care of baby. In the delivery room, non-emergent newborns undergo a primary sanitary treatment, weighing, and first breast-feeding. In complicated deliveries, the neonatologist must take part in the delivery and provide emergency care to the newborn before transferring him/her to the neonatal intensive care unit

8.15 In order to improve the quality of obstetrical and gynecological services, certain indicators will be monitored on a continuous basis. When unacceptable occurrences are noted through this monitoring process, the head of department will investigate the causes of the occurrences and institute corrective measures. The following indicators will be monitored: Sentinel Event Indicators: These indicators represent serious undesirable patient outcomes. Each occurrence of these events must be investigated thoroughly.
8.15.1 Patients diagnosed with eclampsia
8.15.2 Full term infants admitted to neonatal intensive care
8.15.3 Neonatal death of infants weighing 500 grams or more
8.15.4 Maternal Mortality
8.15.5 Post-partum infections: Rate Based Indicators: These events are monitored over time. Increase in frequency of occurrences may indicate a quality problem, and requires investigation into underlying causes.
8.15.6 Cesarean section performed after failed attempt at vaginal delivery
8.15.7 Total stillborns
8.15.8 Birth Trauma
8.15.9 Total infections; Children's Hospital/Pediatric Department of General Hospital

8.16 General management of the work of the department is conducted by the Head of the Department. Duties of the Department Head include but are not limited to:
8.16.1 Perform an examination of every new patient within 24 hours of admission
8.16.2 Examine critically ill patients on a daily basis
8.16.3 Assure that all patients receive consultations from appropriate specialists
8.16.4 Assures that patients requiring care at a higher technical level than is available at this hospital be referred to a higher level hospital
8.16.5 Assures that those patients requiring a less intensive level of care are referred to long-term care facilities or are treated on an outpatient basis.
8.16.6 Assures that all staff strictly follows ethics and dendrological principles
8.16.7 Assures that the department maintains a warm and supportive psychological climate appropriate to the unique needs of children and their families
8.16.8 Assures that all reasonable efforts are made to maximize child patient contact with parents and siblings (including encouraging a parent to stay at the facility with the child if possible), and maximizing opportunities for out-door activities and home visits

8.17 The attending physician is responsible for the over-all care of the patient. Duties of the attending physician include but are not limited to:
8.17.1 Examining all patients for whom he/she has primary responsibility on a daily basis
8.17.2 Prescribes the use of all para-clinical services and follows up the results of all test performed. The attending physician is responsible for assuring that all tests ordered are performed, and that the results of all tests are recorded in the patient’s medical record
8.17.3 Verifying the correctness of the admission diagnosis within 3 days

8.17.4 Assures that all treatments given the patient are correct according to clinical diagnosis, severity of patient's state, weight, age and results of analyses

8.17.5 Monitors the fulfilment of prescriptions by charge and procedure nurses

8.17.6 At discharge, the attending physician writes down a detailed excerpt of the patient’s medical history with recommendations on further treatment and follow-up of the patient in polyclinic

8.17.7 The attending physician must keep in close communications with the parents of a sick child to fully explain the diagnosis, and all requires examinations, treatments, and dietetics

8.18 The Chief Nurse of the department guides and supervises the nurses and assistant nurses of the department. Other duties include but are not limited to:

8.18.1 Controlling the accuracy and timeliness of prescribed examinations and treatments given by nursing staff

8.18.2 Ordering medications, bandages, and other supplies from the hospital drug-store, and assuring their delivery to the department

8.18.3 Dispensing of medication to procedure and charge nurses and monitoring of their correct distribution to patients (dosage, timeliness, frequency of intake, etc…)

8.18.4 Controls correctness and timeliness of sampling and delivery of results to the department

8.19 The Charge nurse sorts out examinations and physician's prescriptions from the patient’s medical record, and according to these orders, dispenses medicines, makes intramuscular and subcutaneous injections, and performs other required manipulations in accordance with the profile of the department. Additional duties of the charge nurse include but are not limited to:

8.19.1 The collection of urine and feces for diagnostic analyses

8.19.2 Nasal and pharyngeal smears

8.19.3 Delivering collected biomaterials to proper laboratories, bringing back the results of analyses, and recording them in the proper medical records

8.20 Nurses perform all intravenous injections (infusions, blood sampling for biochemistry, etc.), and assist the attending physician in performing methods of examination and treatment

8.20.1 At night, the nurse continuously monitors patients, especially those severely ill who must be checked at least every 30 minutes for severely ill patients on normal wards, and on a continuous basis for those in
intensive care. At the first signs of trouble or a worsening of their state, the nurse calls for the on-duty doctor.

8.21 The Department Tutor explains to child patients the rules and schedule of work of the department. She spends time with patients in playing room or wards when they are not busy with procedures and examinations.

8.21.1 Each department must have a set of toys and books suitable for different ages of children being treated

8.21.2 At appropriate times and climatic conditions, the tutor takes children outdoors.

8.22 Paraprofessional personnel perform the sanitary treatments of all patients in the department.

8.22.1 They regularly examine stool, urine output of patients, wash them, and report any pathologic discharges that may appear to the attending physician and on-duty nurse.

8.22.2 Janitors regularly clean wards, and clean and disinfect toilets.

8.23 In the reception room, all patients have a preliminary examination conducted, which includes temperature, blood pressure, and an assessment of the severity of the patient’s condition.

8.23.1 Patients in critical condition and requiring urgent treatment receive needed care in the reception room before being transferred to the intensive care unit or other appropriate ward.

8.23.2 A medical record is begun (or updated) for all patients entering the reception room. Recorded in this record will be the patient’s condition, preliminary diagnosis, and any tests or treatments performed.

8.23.3 In case of critical patient condition and an unclear diagnosis, appropriate specialists must be called for urgent consultations, and urgent medical analyses must be ordered, performed, and reported.

8.24 In the case of suspected infectious disease, the patient must be put in a private room (box) or isolation room.

8.24.1 When the diagnosis of infectious disease is confirmed, the patient is transferred to the infectious disease department, and an urgent notice is sent the SES.

8.24.2 Patients with suspected infectious disease are treated out of turn and if necessary, hospitalized as soon as possible. In no case should such patients wait in the reception room longer than 30 minutes.

8.25 In order to improve the quality of obstetrical and gynecological services, certain indicators will be monitored on a continuous basis. When unacceptable occurrences are noted through this monitoring process, the head of department will investigate the causes of the occurrences and institute corrective measures. The following indicators will be monitored:

Sentinel Event Indicators: These indicators represent serious undesirable
patient outcomes. Each occurrence of these events must be investigated thoroughly

8.25.1 Death of a patient
8.25.2 Unexpected decline in patient condition and admission to the intensive care unit
8.25.3 Divergence between clinical and post-mortem diagnosis. Rate Based Indicators: These events are monitored over time. Increase in frequency of occurrences may indicate a quality problem, and requires investigation into underlying causes
8.25.4 Nosocomial infections
8.25.5 Repeat admissions of patients for related conditions
8.25.6 Number of referrals to higher-level hospital.

Public Health, Epidemiology, and Environment Control

9.1 Public Health, Epidemiology, and Environmental Control (PHEEC) functions are managed by a formal department of the hospital
9.1.1 The head of the PHEEC department reports directly to the Physician-in-Chief of the hospital
9.2 The PHEEC department is responsible for:
9.2.1 The creation and maintenance of safe conditions for patients and staff
9.2.2 Developing and maintaining hospital wide measures for the prevention of nosocomial infections
9.2.3 Developing and maintaining hospital wide measures for the control of infectious diseases
9.2.4 The monitoring of food safety
9.2.5 Assuring that all patient beds meet national norms and standards for space and required furniture, lighting, heat, and ventilation;
9.2.6 Assuring a continuous and sufficient supply of centralized cold and hot water
9.2.7 Assuring continuous and sufficient operation of sewage disposal
9.2.8 Assuring the timely and sanitary disposal of trash and other solid waste
9.2.9 Assuring the safe and timely disposal of medical waste and biological hazards
9.2.10 Assuring the cleanliness and sanitary state of all hospital buildings and rooms
9.2.11 Assuring the proper function and cleanliness of all toilets of the facility, particularly patient care areas
9.2.12 Assuring the operation of heating and ventilation systems;
9.2.13 Assuring that all renovations to existing hospital buildings are carried out in a manner that is safe for both patients and staff;

9.2.14 Assuring that renovations to existing buildings and construction of new buildings are done in compliance with national regulations.

9.3 Technological and methodological advances in health and labor safety are monitored by the department, and implemented as appropriate

9.4 A regular program of disease prevention and detection for hospital staff is developed and implemented

9.4.1 Health certificates for all personnel are kept up-to-date

9.5 There are written guidelines for the observance of aseptic and antiseptic regulations in all departments as well as in a Centralized Sterilization Department, surgical and maternity blocks, infection departments, laundries, kitchens, procedure rooms, drug-stores

9.6 The PHEEC regularly tests the efficacy of the disinfection chambers and monitors the completeness of coverage of treatment (somatic, surgical, infection, maternity, pediatric departments)

9.7 The PHEEC assures the supply of detergent and disinfecting agents, and distributes them to according to priority of need

9.8 The sanitary and technical state of the catering block is inspected on a weekly basis

9.8.1 An evaluation of conditions of transportation and storage of food products is conducted on a monthly basis

9.9 A program of sanitary education is developed and presented to all support personnel (laundry, catering, etc.) on a twice yearly basis

9.10 Health education on issues covered by PHEEC is presented to the medical personnel of all departments on a yearly basis

9.11 In order to improve the quality of inpatient services, certain indicators will be monitored on a continuous basis. When unacceptable occurrences are noted through this monitoring process, the head of department will investigate the causes of the occurrences and institute corrective measures. The following indicators will be monitored: Sentinel Event Indicators: These indicators represent serious undesirable patient outcomes. Each occurrence of these events must be investigated thoroughly

9.11.1 Occurrences of food poisoning

9.11.2 Sewage shut-down

9.11.3 Absence of running water

Rate Based Indicators: These events are monitored over time. Increase in frequency of occurrences may indicate a quality problem, and requires investigation into underlying causes

9.11.4 Complaints of insufficient cleaning of linens.
Para-clinical Services

10.1 Para-clinical Services (laboratory, x-ray, and Functional Diagnostics) are an integral part of hospital services, and are of the type and capacity sufficient to the needs of the hospital as determined by number of patients treated, severity of illness, and mix of specialty services provided.

10.2 The service (or services) is headed by a certified specialist (physician), trained in the relevant field. The director of Para-clinical Services reports directly to the Deputy for Clinical Services.

10.3 The Para-clinical Service Director(s) is responsible for the overall functioning of the department(s). Duties include:

10.3.1 Assuring the qualifications of service staff members;

10.3.2 Make recommendations to the Physician-in-Chief on the presence of adequate labor conditions including availability of appropriate work space, the availability of sufficient equipment, and the presence of sufficient numbers of trained personnel.

10.3.3 Assuring the development and implementation of written facility internal rules covering all aspects of department operations.

10.3.4 Developing and carrying out personnel training (both in-house and in cooperation with other hospitals).

10.3.5 Implementing and monitoring safety regulations and public health requirements.

10.3.6 Assuring that all diagnostic tests and procedures ordered in the hospital are performed accurately, and in a timely manner.

10.3.7 Assuring that the results of all diagnostic tests and procedures ordered in the hospital are reported accurately, and in a timely manner.

10.3.8 Assuring that all diagnostic testing equipment is calibrated and tested for accuracy on a regular scheduled basis by the state standards agency/medical technical agency or other appropriate organization.

10.3.9 All x-ray devises and rooms must be adequately shielded to prevent unnecessary exposure to patients and staff.

10.4 There are sufficient qualified personnel with documented training and experience to supervise and conduct the work of all Para-clinical services in a manner appropriate to the size and mission of the hospital.

10.5 Each Para-clinical service has at least one qualified medical technician on duty or available at all times. In larger hospitals the laboratory, x-ray, and ECG services each require one technician on duty at all times. In smaller hospitals, one technical may cover all services during off hours (nights, weekends) if that technician is capable of performing basic tests in each of the three technical areas.
10.6 There are regularly scheduled in-services educational programs for all Para-clinical services staff

10.6.1 All technical staff is provided with at least one external training program in central training sites per 3 years. Hospital Para-clinical service departments are encouraged to cooperate on the development of in-house training programs. These programs could be opened to staff from other hospitals. This type of cooperative effort could allow each hospital to meet the requirement for each staff member to attend one external training program on a regular basis.

10.7 There must be written policies and procedures that govern the operation of Para-clinical services provided by the facility. These written policies and procedures should be developed by the facility's professional staff, and should be reviewed regularly and revised as necessary.

10.7.1 Policies should require that Para-clinical services be performed only upon the written order of a professional staff member with appropriate clinical privileges.

10.7.2 Written orders should contain a concise statement of the reason for the request.

10.7.3 Policies should delineate the procedures involved in preparing patients for Para-clinical services, and delineate the procedures for conducting diagnostic examinations in areas other than the service department.

10.7.4 Policies should delineate the procedures for caring for patients with special needs including those patients who require special management, those who are critically ill, and those who require isolation.

10.8 In the case of the hospital's inability to perform any of its usual or required diagnostic tests because of broken or missing equipment, a lack of supplies, or a lack of reagents, the Director of Para-clinical Services must do the following:

10.8.1 Immediately request the repair or replacement of the critical equipment to the proper authority, or, immediately requisition replacement supplies and/or reagents.

10.8.2 Advise hospital physicians of the tests that may not be performed, the nature of the problem, and the expected solution.

10.8.3 Hold an emergency meeting with the Deputy for Clinical Services and any relevant chief specialists to determine alternatives to the unavailable test, and procedures to be followed to assure the highest level of patient care possible. Alternatives may include but are not limited to: a) referring patients to another hospital or diagnostic center; b) performing alternative diagnostic tests, perhaps in combination with other investigatory methods; c) requesting that the patient or a family member purchase the required supplies or reagents.
10.8.4 Advise all medical staff of the hospital of the alternative diagnostic procedures to follow during the period when the test remains unavailable.

10.8.5 Continue regular and persistent follow-up of the request or requisition for repair or replacement of the critical component.

10.9 Based on the number of patients cared for by the hospital, the laboratory has equipment, supplies, and reagents available in amounts sufficient to carry out the following tests *:
- amylasemia
- direct bacterioscopy
- bacterioscopy (tuberculosis)
- basic coagulogram
- cholesterol
- creatinine
- pregnancy test
- Chagas test
- acid phosphatase and alkaline phosphatase
- Gram, Giemsa staining
- blood glucose
- blood group (ABO and RH)
- hemogram
- hematocrit
- hepatogram
- complete urinalysis
- fecal parasitology
- total protein
- Coombs test
- occult blood in feces
- clotting time and bleeding time
- prothrombin time
- triglycerides
- uremia
- sedimentation rate
- qualitative VDRL

*Based on Pan American Health Organization Recommendations, 1991

10.10 Referral Hospitals (Oblast level) must, in addition to the tests listed above, have sufficient equipment, supplies, and reagents to carry out the following tests *(capacity for performing tests must be based on number and type of patients cared for):
- Australian antigen (AU antigen)
- carcino-embryonic antigen (CEA)
- antistreptolysin O

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• calcemia
• creatine phosphokinase (CPK)
• estriol
• ferremia
• follicle-stimulating hormone (FSH)
• luteinizing hormone (LH)
• prolactin
• C-reactive protein
• thyroxin (T4)
• triiodothyronine (T3)
• thyrotropin (TSH)
• uricemia

*Based on Pan American Health Organization Recommendations, 1991

10.11 X-ray departments of small hospitals at an absolute minimum must be equipped with one piece of fixed equipment with a capacity of at least 100 mA, with a Potter Bucky devise. Hospitals of over 100 beds must have at a minimum one piece of fixed equipment with at least 200 mA capacity, a Potter Bucky devise, a serialograph, and a radioscopy screen or image intensifier and closed-circuit television.

10.12 A radiologist should ordinarily provide an authenticated report for all examinations to enhance consistency in interpretations and reports of radiologic findings.

10.13 In order to assure patient care quality, certain performance indicators must be constantly monitored. When results of these observations reach unacceptable levels, the Director of Para-clinical Services must investigate the causes of unacceptable results. Corrective measures must be determined and implemented. All such investigations must be reported to the Deputy for Clinical Services. When necessary, the Deputy for Clinical Services must assist in developing and implementing corrective measures, particularly when departments outside Para-clinical services are involved. The Para-clinical Service must monitor the following indicators:

10.13.1 Time required performing and reporting results on urgent diagnostic tests
10.13.2 Specimens lost
10.13.3 Percentage of films damaged, or otherwise unusable
10.13.4 Percentage of tests repeated because of questionable results
10.13.5 Improper collection of samples
10.13.6 Specimens, films, or results mislabeled
10.13.7 Failure to perform test required
10.13.8 Incorrect diagnostic test ordered
10.13.9 Patient adverse reaction to diagnostic procedure.
**Inpatient Care**

**11.1** Heads of in-patient care departments, regardless of hospital structure, are responsible for the general performance of their individual departments. Areas of responsibility include but are not limited to:

11.1.1 Assuring the performance of the full scope of job responsibilities by all medical and non-medical personnel

11.1.2 Assuring the existence of proper conditions for the delivery of treatment services

11.1.3 Assuring that all staff is provided opportunities for improvement of their technical qualifications, and that staff are encouraged to participate in these training programs

11.1.4 Implementation and continuous monitoring of safety rules

11.1.5 Implementation and continuous monitoring of sanitary and anti-epidemic measures

11.1.6 Implementation and monitoring of measures for the prevention of intra-hospital infection

11.1.7 Maintenance of interrelationships with out-patient and para-clinical services

11.1.8 Monitoring and analysis of patient care activities, and the implementation of corrective actions

11.1.9 Monitoring the development of improved methods of examination and treatment, and implementing those methods that are appropriate for the type of patient treated by the hospital, and the scope of services offered

**11.2** The following structures must be in place in a hospital to deliver in-patient care:

11.2.1 The materials and equipment of the hospital must be in compliance with the GOST requirements appropriate for the level and specialty of the hospital

11.2.2 Sanitary conditions must be in compliance with all applicable national sanitary and epidemiological regulations

**11.3** The hospital will have all treatment and patient lodging facilities necessary to meet the needs of the patients served by the hospital

**11.4** The department must be staffed with appropriate number of specialists who have passed a proper training

**11.5** In the reception room, all patients have a preliminary examination conducted which includes temperature, blood pressure, and an assessment of the severity of the patient’s condition

11.5.1 Patients in critical condition and requiring urgent treatment receive needed care in the reception room before being transferred to the intensive care unit or other appropriate ward
11.5.2 A medical record is begun (or updated) for all patients entering the reception room. Recorded in this record will be the patient’s condition, preliminary diagnosis, and any tests or treatments performed.

11.5.3 In case of critical patient condition and an unclear diagnosis, appropriate specialists must be called for urgent consultations, and urgent medical analyses must be ordered, performed, and reported.

11.6 In the case of suspected infectious disease, the patient must be put in a private room (box) or isolation room.

11.6.1 When the diagnosis of infectious disease is confirmed, the patient is transferred to the infectious disease department, and an urgent notice is sent the SES.

11.6.2 Patients with suspected infectious disease are treated out of turn and if necessary, hospitalized as soon as possible. In no case should such patients wait in the reception room longer than 30 minutes.

11.7 Departments supporting the provision of patient care shall include the following: (Total compliance includes: formal organization of the department; the existence of written operating policies; the equipping and staffing of the department to a level adequate to meet the needs of the patients served by the hospital)

11.7.1 Laboratory
11.7.2 Radiology
11.7.3 Dietary
11.7.4 Central Sterilization
11.7.5 Functional Diagnostics
11.7.6 Post-mortem Examinations
11.7.7 Drug-store (pharmacy)
11.7.8 Medical Library

11.8 General management of the work of the department is conducted by the Head of the Department. Duties of the Department Head include but are not limited to:

11.8.1 Perform an examination of every new patient within 24 hours of admission
11.8.2 Examine critically ill patients on a daily basis
11.8.3 Assure that all patients receive consultations from appropriate specialists
11.8.4 Assures that patients requiring care at a higher technical level than is available at this hospital is referred to a higher level hospital
11.8.5 Assures that those patients requiring a less intensive level of care are referred to long-term care facilities or are treated on an outpatient basis
11.8.6 Assures that all staff strictly follows ethics and dendrological principles
11.9 The attending physician is responsible for the over-all care of the patient. Duties of the attending physician include but are not limited to:

11.9.1 Examining all patients for whom he/she has primary responsibility on a daily basis
11.9.2 Prescribes the use of all para-clinical services and follows up the results of all test performed. The attending physician is responsible for assuring that all tests ordered are performed, and that the results of all tests are recorded in the patient’s medical record
11.9.3 Verifying the correctness of the admission diagnosis within 3 days
11.9.4 Assures that all treatments given the patient are correct according to clinical diagnosis, severity of patient's state, weight, age and results of analyses
11.9.5 Monitors the fulfilment of prescriptions by charge and procedure nurses
11.9.6 At discharge, the attending physician writes down a detailed excerpt of the patient’s medical history with recommendations on further treatment and follow-up of the patient in polyclinic
11.9.7 The attending physician must keep in close communications with the patient to fully explain the diagnosis, and all requires examinations, treatments, and dietetics

11.10 The Chief Nurse of the department guides and supervises the nurses and assistant nurses of the department. Other duties include but are not limited to:

11.10.1 Controlling the accuracy and timeliness of prescribed examinations and treatments given by nursing staff
11.10.2 Ordering medications, bandages, and other supplies from the hospital drug store, and assuring their delivery to the department
11.10.3 Dispensing of medication to procedure and charge nurses and monitoring of their correct distribution to patients (dosage, timeliness, frequency of intake, etc…)
11.10.4 Controls correctness and timeliness of sampling and delivery of results to the department

11.11 The Charge nurse sorts out examinations and physician's prescriptions from the patient’s medical record, and according to these orders, dispenses medicines, makes intramuscular and subcutaneous injections, and performs other required manipulations in accordance with the profile of the department. Additional duties of the charge nurse include but are not limited to:

11.11.1 The collection of urine and feces for diagnostic analyses
11.11.2 Nasal and pharyngeal smears
11.11.3 Delivering collected biomaterials to proper laboratories, bringing back the results of analyses, and recording them in the proper medical records

11.12 Nurses perform all intravenous injections (infusions, blood sampling for biochemistry, etc.), and assist the attending physician in performing methods of examination and treatment

11.12.1 At night, the nurse continuously monitors patients, especially those severely ill who must be checked at least every 30 minutes for severely ill patients on normal wards, and on a continuous basis for those in intensive care. At the first signs of trouble or a worsening of their state, the nurse calls for the on-duty doctor

11.13 Paraprofessional personnel perform the sanitary treatments of all patients in the department

11.13.1 They regularly examine stool, urine output of patients, wash them, and report any pathologic discharges that may appear to the attending physician and on-duty nurse

11.13.2 Janitors regularly clean wards, and clean and disinfect toilets

11.14 In order to improve the quality of inpatient services, certain indicators will be monitored on a continuous basis. When unacceptable occurrences are noted through this monitoring process, the head of department will investigate the causes of the occurrences and institute corrective measures. The following indicators will be monitored: Sentinel Event Indicators: These indicators represent serious undesirable patient outcomes. Each occurrence of these events must be investigated thoroughly

11.14.1 Death of a patient
11.14.2 Unexpected decline in patient condition and admission to the intensive care unit
11.14.3 Divergence between clinical and post-mortem diagnosis

Rate Based Indicators: These events are monitored over time. Increase in frequency of occurrences may indicate a quality problem, and requires investigation into underlying causes

11.14.4 Nosocomial infections
11.14.5 Repeat admissions of patients for related conditions
11.14.6 Number of referrals to higher level hospital.
Medical Information System (MIS)

Purpose of the MIS is to collect, register, accumulate, transfer, analyze, calculate major performance indices, and to review and make decisions on improvement of activities of individual departments and the institution as a whole. The emphasis of the MIS department must be the constructive use of data by the hospital itself, not just the collection of data to be sent to the Ministry of Health.

13.1 All data gathered by the MIS and the hospital statistics department is analyzed and used by the hospital to improve performance
13.1.1 The results of all data analysis are presented to the Physician-in-Chief for review within three days of completion
13.1.2 The results of all data collection and analysis are reported to the heads of all hospital departments within five days of completion

13.2 Each institution, regardless of its capacity, must collect the following types of information:
13.2.1 Clinical (medical statistics)
13.2.2 Financial and economic
13.2.3 Quality indices
13.2.4 Managerial (whole hospital and by departments)

13.3 Medical records and statistical documentation approved by the Republican Department of Statistics is a carrier of the clinical information.
All hospitals are responsible for completing the following records in a timely manner:
13.3.1 Card of discharged patient (F-066U)
13.3.2 Register of admission and movement of patients (F-7)
13.3.3 Coupon of out-patient client (F-025U)
13.3.4 Register of work of out-patient physician (F-39U)
13.3.5 Journal of registration of para-clinical departments (Physical therapy, laboratory, x-ray, etc…)
13.3.6 Journal of post-mortem examinations
13.3.7 Journal of out-patient services in hospital
13.3.8 Journal of registration of emergency notes (informational, analytical, etc…)  
13.3.9 Journal of registration of blood preparation and transfusion
13.3.10 Journal of registration of intra-hospital infections

13.4 Collection, registration, accumulation, statistical processing and release of information is made by the office of registration and medical statistics (by medical statistician) in the manner established by the Ministry of Health
13.5 The results of the analysis are discussed by the management staff of the facility and in the departments with the goal of developing proposals on improving performance and correcting identified problems

13.6 Financial & economic information (FEI) is collected, analyzed, and used by the hospital in the decision making process

13.7 FEI is gathered from: orders of departments, checks, time-sheets, inventory and write-off acts, input standards, legislative, administrative, normative documentation, register forms, reporting forms

13.8 FEI from the departments (clinical departments, drug-store, warehouses, etc.), in the form of copies of documents and register documents (time-sheets, inventory and write-off acts) is entered in the appropriate sections of the accountancy (material, accounting, economic, etc…)

13.9 FEI information sources include but are not limited to: daily - list of patient flow (F-007U), list of hospital days; monthly: occupancy of beds, number of visits to polyclinics; catering cost; total inflow of resources; total expenses; payrolls

13.10 FEI is analyzed by the economics department and submitted to the Physician-in-Chief. The information and the results of analysis is used for the following purposes among others: correction of funding volumes, expansion or decrease in the volume of services due to actual expenses, granting to departments of privileges or other opportunities, and expansion, reduction, organization of new or cutting of existing services.

Plant (Facility) Standards

The purpose of this section is to assure that the physical plant (buildings) of the hospital is operated, maintained, and repaired in a manner that is: safe for patients, staff, and visitors; conducive to the welfare of patients and the healing process; and, achieves the greatest possible operational efficiencies in terms of labor and funds while meeting safety and comfort goals.

15.1 The hospital shall meet all national requirements for the material and technical base (MTB) specified for the care of patients served by the facility

15.2 The hospital shall meet all applicable requirements of the SNIP codes adopted and accepted by the Ministry of Health, Kyrgyzstan

15.3 All issues related to the maintenance and repair of hospital buildings are controlled by the Deputy Chief Physician for Plant and Utility Operations Management, or, in a smaller facility, by a Deputy Chief Physician with additional responsibilities
15.4 Duties of the Deputy Chief Physician, Plant and Utility Operations include but are not limited to:

15.4.1 The selection and recommending of logistics specialists
15.4.2 Assuring the planning, prognosing and repair of existing material and technical resources of the facility
15.4.3 Developing, implementing, and monitoring a preventive inspection, maintenance and repair plan for all hospital buildings and mechanical systems
15.4.4 Assures the operation of all hospital departments and services by establishing a problem reporting system where all hospital staff may report building or logistical problems
15.4.5 The development, implementation and monitoring of all contracts related to logistical support of the hospital
15.4.6 Organizing and monitoring the work of each logistics service
15.4.7 Informing the Physician-in-Chief of any serious incidents or potential major problems with any issue of logistical support

15.5 Each operating department of the facility must have a minimal set of medical and other equipment, apparatus, instrumentation required by appropriate Kyrgyz national regulations

15.6 There is an organized Logistical Support Service for the hospital that supplies facility departments with soft and hard stock in compliance with minimal allowable norms established by the local SES

15.6.1 There is a written plan for the operations of the Logistical Support Service
15.6.2 The Logistical Support Service is responsible for providing and controlling transportation services sufficient to meet the priority needs of the hospital. These services may be provided by the hospital’s own motor pool, or may be contracted through independent vendors

15.7 If the Logistical Support Service is unable to provide a needed service, the head of the logistics service must: 1) inform the head of service who has applied for the service that the service or supply is not available; 2) Determine with the department head if an alternative service or supply will be sufficient; 3) If an alternative service or supply is not possible or appropriate, and the shortage will cause severe difficulties, the Physician-in-Chief must be informed; 4) The Head of Logistics, the department head, and the Physician-in-Chief must determine what course of action is appropriate, possible and most efficient. Alternatives might include, but are not limited to the following: rendering of other logistical service which meets demands; rendering of logistical support from another institution; execution of an order by contractual work during out-of-office hours (evening, night, time, weekends, and holidays)

15.8 All hospital buildings shall have lighting, heating, water supply, sewerage, and ventilation in compliance with local SES, except in the case
of new constructions, which shall not deviate from SNIP (Construction Norms and Regulations)

15.9 All emergency services (such as maternity house, newborn's room, surgery room, reanimation, ambulance, blood transfusion) must be provided with emergency lighting, heating and water supply

15.10 All essential medical services must be provided with operative internal and external communication

15.11 The hospital must satisfy the requirements of SES (location of green plants, intra-hospital sidewalks, containers for wastes, night lighting, etc.) and be comfortable for patients and work of personnel.

Hospital accreditation bodies and Interaction between accreditation and government regulations

Accreditation programs have repeatedly demonstrated that achieving a successful accreditation occurs when driven by independent (private) agencies, which are characterized by having on board health professionals who are genuinely concerned with resolving quality related issues directly connected with the delivery of health services and resulting outcomes. On one hand, an accreditation program must be objective and accurate in its evaluation of programs under inspection, on another hand, it must be educational assisting institutions and individuals in understanding and attaining agreed upon standards.

There are two types of accrediting bodies or systems, governmental (public) and non-governmental (private), and hospital accreditation might be either voluntary like in many countries around the world, or compulsory like in France, where it is a government sponsored initiative. According to some governments, national ownership of a hospital accreditation system is necessary, both to lay a founding ground for accreditation nationally and to make it sustainable. Also according to some governments, this would add a high level of integrity and amenability to the accreditation system. Moreover, it is believed that creating a national accreditation body, which is multi-representational (disciplinary) in nature is imperative. The accreditation body also must be multi-institutional and should comprise most active and prominent key players in the public and private health sectors.

This body is accountable for policy formulation and administration at the national level, setting the national standards for accreditation, identifying and training surveyors, directing and monitoring the on-site surveys. It is also responsible for making decisions attributed to awarding and maintaining accreditation. With a national accreditation body, representation from the Ministry of Health is elemental. A hospital is never a secluded facility; it is an integral constituent of the national health care system.
Therefore, the holistic functions of a hospital, whether public or private, in a national health system must be taken into consideration in a nation-based accreditation program.

On another hand, there exist accreditation bodies in different countries, which have local and international arms/branches. The oldest is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), established in the United States in 1951. Approximately 80% of the American hospitals are currently accredited by the Joint Commission. The Joint Commission International Accreditation (JCIA) is the international arm of the US-based JCAHO. JCIA has accredited international hospitals in South America, Europe and the Middle East. In addition to the Joint Commission there are other international accrediting bodies: The Canadian Council on Health Facilities Accreditation, the Australian Council on Health Care Standards, the Quality Health New Zealand, and others thoroughly discussed in the second chapter. These international accreditation bodies develop their own accreditation manuals, which are useful guides for hospitals.

Interplay exists between accreditation organizations regulations and those imposed by governments.

The Institute of Medicine (IOM) in the United States examined three models of interplay. In the first model, accreditation is considered to be a supplement to governmental regulations. Facilities that are regulated by government pursue private accreditation as a symbol of excellence.

In the second model, formal regulation of the government is literally absent and private accreditation replaces public regulation. Accreditation of higher educational institutions (e.g., universities) is an example of this model. Here private accreditation is the unique oversight system.

In the third model, accreditation represents a tool to ensure compliance with regulatory standards determined by the government or another entity. This kind of accreditation is seen as a procedure to enhance the implementation of current regulations. It attempts, and to a minimal level, to dictate compliance with current regulations and policies and regarded useful to the public interest.

**The importance of regular self assessment: getting prepared for the accreditation survey process**

Hospitals are generally divided into specialized departments, each led by a medical chief who practices full power on the departmental medical policies. Every department tends to seek its own interests with no genuine consideration for the hospital as one entity. Departments compete for their share of the hospital’s global budget. Moreover, the dominating
organizational culture is that of contesting interests rather than of productive solidarity. Another gap exists between managers and clinicians whose objectives, culture, and language are different. For these reasons, hospitals have frequently been described as a “mosaic” of decentralized decision centres. This concept can not hold nor survive in today’s healthcare industry. And opposing this selfish attitude, the accreditation manual, which is developed by accreditation bodies, adopts a radically dissimilar approach where quality is the result of everyone’s involvement and positive cooperation in different managerial processes. The accreditation manual is not divided by departments but by processes. It stresses on respecting patients’ rights, organizing patient care, managing patient records and health information systems, having a quality and risk prevention program actively functioning, following accepted guidelines in managing human resources.

Accreditation has been known to be a private and voluntary process, but as its goals are evolving towards public regulation, it is rapidly leaning to become compulsory. Hospital and other types of health care organizations must be on guard. Actually, health care consulting agencies are increasing in number for the simple reason of an increase in demand. A hospital’s management might want to contact them for assistance and guidance in case it lacks the expertise or the “know-how”. Such international accreditation and quality improvement teams usually are knowledgeable of the standards of the internationally recognized accrediting bodies, and have the right tools for their implementation. They usually assist international health care ministries, agencies, and organizations with the development of their own assessment process that can be used for accreditation. This individualized consultation and education service can assist the hospital’s management in: developing accreditation standards, survey processes, scoring criteria, data collection tools, and decision-making algorithms, developing selection criteria for surveyors, developing surveyor training courses, training surveyors, developing a quality improvement curriculum and training materials, and conducting education and training on quality improvement in health care. It is up to the hospital’s management to decide whether to purchase and use a companion survey or not. The decision might be affected by but not limited to the following factors:

- Lack of expertise or “know-how”
- Top management adoption of the process
- Availability of the right human resources
- Finance and budgeting
- Level of mental and physical preparation for the process

Accreditation starts with a self-assessment, and is followed by the survey visit leading to issuing the final report. Self-assessment is considered to be the most substantial part of the process. Self-assessment is the
preparation for the survey visit during which the hospital uncovers and discovers its compliance with the standards.

It is advisable that hospitals contact their accrediting body in order to discuss which programs and services it purposes to include in the accreditation process before initiating the self-study process or the petition for a survey. This step helps defining which standards will be applicable. If the hospital offers a program or service that is not catalogued in the manual, the hospital should also contact the accrediting agency to gather more information.

The intent statements in the standards manual provide additional information about particular standards and help the hospital in taking the right measures for a site survey. When such an intent statement exists, it is usually located right after the standards itself. Some intent statements accompanied by very helpful examples that cite potential ways a hospital may prove conformity to the standards.

Hospitals should ask for the latest copy of the standards manual for conducting a self-assessment and institutionalize compliance with standards into daily operations, both of which constitute essential steps in self assessment.

These manuals usually comprise a section titled the accreditation conditions presenting requirements that are mandatory before, during, and after the survey for a hospital to meet, gain, or uphold accreditation. A hospital should examine this section thoroughly both as part of the self-evaluation process and before setting a date for the on site survey.

Another section, titled accreditation policies and procedures, illustrates the steps of the accreditation process, the on site survey, and the policies and procedures that are essential for being awarded and maintaining accreditation. Policies and procedures may be altered between manual publication dates since all features of the accreditation process are revised on a regular basis for relevance. Notification of modifications, further information, and clarification can be acquired by contacting the accrediting body. Furthermore, changes and informational updates are posted on their corresponding websites.

The physical preparation for accreditation should go along with the mental preparation of the hospital’s staff. It is well known that the morale of the hospital’s personnel can sometimes be affected by the hectic efforts that should be implemented in such an endeavor. It is the top management’s responsibility to work on changing progressively the organizational culture, making clear the ultimate physical and non-physical rewards that the hospital as a whole will benefit from such recognition.
Accreditation fees

The Joint Commission, one of the largest accrediting bodies around the world, charges the following costs for accreditation, as retrieved from its website www.jcaho.org in 2005 (JCAHO, SV).

Beginning in 2005, the Joint Commission will institute a survey fee increase—only the second in the last decade—for all of its accreditation programs. The fee increase is attributed to inflation, improved customer support, and surveyor compensation and training. Hospital program fees are proportionately higher than some other accreditation programs because of the substantially greater overall complexity of these surveys. The cost of accreditation varies depending on the hospital size and the type of services it provides.

**Small hospitals:** This includes small hospitals with less than 25 beds; small psychiatric or rehabilitation hospitals with less than 60 beds; and critical access hospitals. In 2004, the cost of accreditation for these hospitals was $5,950; in 2005, it will be $6,250.

**Full service and large hospitals:** Cost is based on average daily census and the total number of outpatient visits. In 2004, full service hospitals had a base fee of $7,400 plus volume-based add-on fees, and large full service hospitals had an average cost of $23,000. In 2005, full service hospitals will have a base fee of $8,500 plus volume-based add-on fees, and large full service hospitals will have an average cost of $26,000.

Also, on January 1, 2005, the Joint Commission will begin adding a certified health care engineer to surveys of hospitals having 200 or more beds. This change will enhance the Joint Commission's ability to evaluate hospital compliance with Life Safety Code® and physical plant requirements. The additional survey fee for this survey team enhancement will be $3,500. In 2006, the Joint Commission plans to institute a subscription billing model that will allow accredited organizations to spread their survey fees over the three-year accreditation cycle. For more specific information about pricing, contact the Joint Commission's Pricing Unit at (630) 792-5115.

Accreditation decision making

The accreditation decisions as listed according to the Joint Commission (www.jcaho.org, JCAHO, AD) are categorized as follows:
Accreditation: is awarded to a health care organization that is in compliance with all standards at the time of the on-site survey or has successfully addressed requirements for improvement in an Evidence of Standards Compliance (ESC) within 90 days following the survey (45 days beginning January 1, 2006).

Provisional Accreditation: results when a health care organization that fails to successfully address all requirements for improvement in an ESC within 90 days following the survey (45 days beginning January 1, 2006), or fails to achieve an appropriate level of sustained compliance as determined by a Measure of Success result.

Conditional Accreditation: results when a health care organization that is not in substantial compliance with the standards, as usually evidenced by a count of the number of standards identified as not compliant at the time of survey. The threshold count is between two and three standard deviations above the mean number of non-compliant standards for organizations in that accreditation program. The organization must remedy identified problem areas through preparation and submission of an ESC and subsequently undergo an on-site follow-up survey.

Preliminary Denial of Accreditation: results when there is justification to deny accreditation to the organization as usually evidenced by a count of the number of non-compliant standards at the time of survey. The threshold count is at least three standard deviations above the mean number of standards identified as not compliant for organizations in that accreditation program. The decision is subject to appeal prior to the determination to deny accreditation; the appeal process may also result in a decision other than Denial of Accreditation.

Denial of Accreditation: results when a health care organization has been denied accreditation. All review and appeal opportunities have been exhausted.

Preliminary Accreditation: results when the health care organization demonstrates compliance with selected standards in the first of two surveys conducted under the Early Survey Policy Option 1. This decision remains in effect until one of the other official accreditation decision categories is assigned, based on a complete survey against all applicable standards approximately six months later.

Accreditation Watch: though the Joint Commission can publicly disclose not an official accreditation category. An organization is placed on
Accreditation Watch when a reviewable sentinel event (see definition below) has occurred and has come to the Joint Commission's attention, and a thorough and credible root cause analysis of the sentinel event and an action plan have not been completed within a specified time frame. Following determination by the Joint Commission that the organization has conducted an acceptable root cause analysis and developed an acceptable action plan, the Accreditation Watch designation is removed from the organization's accreditation status. During the period of Accreditation Watch, the organization retains its accreditation status in one of the above categories.

The Joint Commission’s definition of a sentinel event is: “(1) The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition, or (2) The event is one of the following (even if the outcome was not death or major permanent loss of function): Suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital residential treatment center, crisis stabilization center); Infant abduction or discharge to the wrong family; rape; Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities; or Surgery on the wrong patient or wrong body part”.

Additional information regarding accreditation decisions, policies and procedures can be found in all of the Joint Commission's accreditation manuals. For more information, visit the Joint Commission website: www.jcaho.org.

Hospital information available to the public: Information about the safety and quality of accredited hospitals is available to the public at Quality Check®, www.qualitycheck.org. This comprehensive listing includes each accredited hospital’s name, address, telephone number, accreditation decision, current accreditation status and effective date, and its Quality Report. Quality Reports include detailed information about a hospital’s performance and how it compares to similar hospitals (JCAHO, FHA).
The process of achieving accreditation: some advice and role of stakeholders

Accreditation of healthcare facilities constitutes an evaluation process of the adequacy of services through reliance on professional standards. The standards constitute signposts to reach the desired level of quality in patient care that should be accessible given the available resources.

The accreditation process consists of (1) setting agreed upon standards that define optimal performance with the existing resources; (2) the hospital survey which evaluates the hospital operations and leads to give recommendations for improvement; then (3) an accrediting body determines if a hospital is deemed to receive the accreditation honour.

In its simplest schematic fashion, the accreditation process can be represented as follows: voluntary request by hospital→ preparation and standards interpretation→ self-evaluation by hospital→ agreement on survey dates→ surveyors’ identification/appointment/consensus→ survey coordination→ pre-survey assessment→ survey→ summation conference→ survey report→ voting by counsellors→ accreditation award.

Successful accreditation programs begin with a steering committee of volunteers highly interested in the subject. Initial planning may be exhausting, complicated and costly. The main expense resides in developing the standards, an act that could be financed by stakeholders.

The traditional sequence in developing an a stakeholder-dependent accreditation program is first to “(1) develop and test standards in collaboration with stakeholders; (2) recruit and train accreditation teams; (3) finalize business plan; (4) commence accreditation process and design promotional materials; (5) implement governance; (6) educate stakeholders; finally (7) evaluate the accreditation process”.

In all instances however, standards should not be biased and distinguish against small-sized community hospitals. Peer review in setting valid and reliable standards is therefore a key issue.

A hospital engaging in accreditation for the first time, or even renewing its previously awarded accreditation could benefit from the following information. The preparation process for accreditation typically takes six months before an accreditation survey is conducted. Scheduling the survey before even starting the preparation for accreditation is essential. This is done with the hospital’s preferred accreditation agency, in the goal to guarantee the hospital’s time slot for a survey a year from the scheduling time. The accreditation process is not very easy; the road to successful accreditation is a laborious and time consuming process. It consists of implementing quality improvement plans, evaluating plant/facility safety
and maintenance processes, developing policies and procedures, standardizing patient and employee records, and a comprehensive data collection and record keeping.

A hospital would not appreciate being trapped waiting too long to undertake the accreditation process. This is why accreditation assistance is of value for hospitals that are newly embarking in this worthy endeavour. Assistance might help the hospitals’ owners with answering such questions: What is the best format for my policies and procedures? What kind of a quality improvement committee do I need? What kind of data do I need to collect?

**Features of accreditation**

Accreditation takes a *serious commitment* from the entire hospital to make through successfully. Most accreditation processes take, as previously mentioned, a minimum of six months to “put the icing on the cake”. Nine to twelve months is the average. The task of developing processes is only the beginning of this endeavour. Data collection is a must for proof of compliance. Having a comprehensive accreditation manual is helpful, especially when fully customized to the hospital’s practical operations and backed-up with support in order to reap maximum benefit from it.

Another important feature of the accreditation process is its *continuity*. Hospitals should understand that accreditation is not a one time procedure and it is not obtained once and for all. A cyclical process is therefore installed, establishing a systematic and prospective risk avoidance policy in hospital management, which initiates a fundamental departure from the retrospective crisis management of quality problems that has predominated up before. An important goal of a hospital’s policy is to refocus health care on its unsurpassed object- that is, the patient- instead of the process of care as such.

In 2002, the Joint Commission declared trenchant alterations to its accreditation process for health care organizations. The new process focuses on operational systems crucial to the quality and safety of patient care, and transfers the focus from survey preparation to *continuous improvement* of operational systems that influence the quality and safety of patient care. The Joint Commission launched a number of enhancements as part of its new accreditation process.

These consist of an electronic application for accreditation, an intensive review and coherence of the standards, an official certification for surveyors, and a completely new survey process. The characteristics of the new accreditation process are its ability to utilize data and information from different sources to pinpoint potential organization weaknesses, its adaptability to the specific characteristics of the health care organization
focusing on matters of concern to that organization, its patient-centeredness, its engagement of physicians, nurses and other clinicians, its gearing to enhancing system improvement, its capacity to be correlative with the organization’s daily operations, and finally, its engagement in continuous improvement process.

**Cost eligibility criteria for accreditation: trying to become a “Benchmarked” hospital? Should you apply?**

“Benchmark” hospitals are financially sound, have good patient outcomes and good patient satisfaction. The goal of any hospital applying for accreditation is to find out what are the characteristics that promote hospitals to this level of excellence. For cost eligibility reasons, any hospital that is embarking in the accreditation endeavor must have or adopt the right weapons, weapons that centers of excellence adopted before.

Benchmark hospitals are distinguished by their professionalism, positive culture, and commitment of staff, efforts to improve communication, and the dedication of management and staff to adopt financially sound methods in operating their premises.

Hospitals should have the right answers to all the questions that are expected to be asked during the on-site survey. Hospitals’ physicians should be licensed, mammography facilities should be FDA accredited, diagnostic and nuclear medicine facilities should be checked annually by physicists, the criteria adopted by the hospital to determine its health professionals’ qualifications should be clearly defined, patient charts/films must be allowed to be randomly selected, determining the means to ensure quality patient care is provided is a requirement, hospitals should also reveal the frequencies of various equipment checks, reporting deficiencies and the ways they were corrected is another item on the checklist, policy and procedures manuals for all the departments should be available, records for the receipt and disposal of radioactive materials should be safeguarded, hospitals are advised to have plans for replacing old equipment, technologists that run the equipment should be qualified, the way patient dose data are obtained should be demonstrated, minutes of the hospital’s quality assurance must be displayed upon request, etc... In summary, the hospital must be well prepared during the surveying process and this can be achieved by following the preparation manual’s guidelines.

In the same context, “Quality gap is a term that reflects the difference in performance between the top 10% of health plans, which are used as benchmarks, and the national average. It can be applied to any industry-in the airline industry, for example, the quality gap in terms of safety between the top 10% performers and the national average is miniscule: far less than
1%. In certain manufacturing, banking and other processes, we also see uniformly high degrees of accuracy. Not so in health care, where variation in the practice of medicine is the norm; the consequence of which is wildly varying quality. The quality gap on certain measures is 20% or more. But what are the drivers that are helping to close or at least tighten the gap?

The performance of the top 10% of health plans is considered as benchmark since it represents an achievable, realistic goal for an entire system. Failure to consistently administer principles of evidence-based medicine discloses most clearly in the extensive and well-documented variation in rates of care between the top performers among health plans that gather and report data and the national rate. In the new medical marketplace, better information on physician and hospital quality and performance data from managed care plans must become readily obtainable if consumers are expected to make informed decisions and ask for quality care. Thus, many hospitals are starting out to report such data at the urging of employers and governments. In parallel, recognizing and recompensing physicians and hospitals that bestow in quality improvement and show positive results for patients is vitally important. This contemporary performance improvement aids in the hospital accreditation process. However, there are some challenges that exist.

In order to hold accreditations, hospitals and their accredited programs must fit in with the accrediting body’s standards, satisfy its accreditation conditions, and comply with its policies and procedures as changes are published and applied from time to time. As part of the dedication to continuous performance excellence that all hospitals are assumed to demonstrate, each hospital that achieves a three-year accreditation must relinquish an annual conformance to quality report.

Mrs. Margaret O’Kane, president of the National Committee of Quality Assurance (NCQA) mentioned in the NCQA 2004 Annual Report, that “we’ve learned much over the past 15 years about how to make health care better”. She added that “we know more about the quality of our nation’s health plans, hospitals and medical groups than we ever have, and public reporting of performance data has had the impact we intended: it promotes continuous improvement.”

An aspect of Quality as recognized by the Institute of Medicine is building broad, participative partnerships intended to cherish even bigger improvements in efficiency, timeliness, patient-centeredness, safety, effectiveness, and equity. The importance of successful partnerships cannot be understated, especially as the center of quality measurement and coverage pushes down to the delivery system level.

NCQA’s newest program, Quality Plus, is designed to highlight innovations such as recognizing health plans that employ cutting-edge practices in areas such as information technology, chronic care management
and physician and hospital assessment and compensation. Importantly, Quality Plus considers quality not just from a technical point of view, but from the patient’s perspective as well, strengthening a hospital’s cost-eligibility for accreditation.

Challenges and benefits of hospital accreditation

Challenges

Hospital accreditation does meet challenges and obstacles along the way. Managing uncertainties, tackling concerns of health professionals related to their decreasing autonomy, finding the right conditions to make it a convenient process are just a part.

Hospitals can counteract against challenges by rewarding quality practices, developing standards that recognize cultural diversity, showing transparency, and loosening up the expertise control over the accreditation process.

In hospital accreditation multidisciplinary involvement is expected. This can sometimes be difficult, especially when doctors are involved. Indeed, doctors have frequently been the missing link in health care quality assurance systems, for their definition of quality in medicine is unrelated to the one approved by regulators and managers. For doctors, advancement in medical quality consists in the achievement of medical progression in medical research. The majority of doctors have not yet participated in the managerial culture of audit and accreditation.

Quality assurance as medical audit is seen by doctors as an overstepping and a waste of time. The fact that concepts gearing to quality assurance and management are not incorporated in the medical curriculum ministers to doctors’ interest. One reason why accreditation bodies’ structures include numerous professionals, apart from their indispensable contribution, is the priority of procuring professional legitimacy and credibility.

Gaining institutional involvement and dedication becomes even more complex when key stakeholders are not fully confident of the potential rewards or by-products of the accreditation initiative. Reaching consensus on the pattern of the model to be carried out, on the standards of accreditation, and on the procedures to be succeeded is another difficult and time-consuming task that might gobble up a considerable amount of time at the initiation of the process. This step can be largely eased if there is consensus along with clarity on the objectives of the accreditation endeavor early on. Moreover, identifying sustainable and meaningful incentives and the establishment of effects of performance are also crucial and complex aspects. It is not always simple to discover the right association of monetary and non-monetary incentives. Moreover, accreditation incentives that give
rise to quality of service ameliorations necessitate up front additional resource investment. The utter amount of superadded resources required for a large-scale and quality improvement initiative might be significant and at times unaffordable. It is therefore important to take into account the amount of the extrinsic resources that would be required and the possible sources of funding at the beginning of the design phase of the accreditation effort.

In addition, improving quality of care needs more than a technical approach. Failure to modify behaviours of people and organizations is the most frequent cause of unsuccessful quality initiatives. Sustained improvements frequently require an alteration in attitude and gathering a sense of possession with regard to the quality of services offered by the organization. The challenge in setting and measuring against standards are mainly technical while the challenges in making adequate change are managerial and social. Such challenges are: strengthening legal support, insuring use of minimum standards, ensuring use of standards to all hospital services, differentiating between licensing and accreditation, and basing accreditation on consensus rather than numerical scoring.

**Benefits**

Although obtaining accreditation can be a large endeavour, it is worth it. Accreditation assures consistency across hospital’s operations, which in turn originate gains in time and quality with considerable cost savings. Accreditation improves overall credibility with hospital’s patients and referral sources, which will generate a greater trust in the hospital’s management. Accreditation ensures a hospital has established systems to monitor ongoing process improvement. Accreditation allows a hospital to interact with experts in the field of accreditation, gaining from their knowledge. Accreditation provides an important marketing tool for a hospital that heightens its credibility. Accreditation boosts employee morale and job satisfaction through better training. Accreditation assists a hospital in maintaining an effective compliance program. Accreditation furnishes a hospital with an official apparatus from which it can continue to develop its daily operational activities and continually evaluate them. Accreditation contributes to inform and safeguard consumers, educate providers and maintain improvement in the quality of the overall health care system. According to the Joint Commission (www.jcaho.org, JCAHO, BA), the benefits of accreditation are:

- Improves care: Joint Commission standards focus on state-of-the-art performance improvement strategies that help health care organizations continuously improve the safety and quality of care provided to individuals
- Provides professional advice and enhances staff education: the survey process is designed to be educational, not punitive. Joint Commission
surveyors are experienced health care professionals trained to provide expert advice and education during the survey.

- Offers ongoing support: through its not-for-profit affiliate, Joint Commission Resources, each year the Joint Commission offers hundreds of educational seminars and publications about performance improvement and other standards-related topics. In addition, staff from each accreditation program and from the Standards Interpretation Group can provide immediate assistance and suggestions on survey process and standards compliance.

- Enhances staff recruitment: the Accreditation Council for Graduate Medical Education recommends that post-graduate medical residents be placed in accredited hospitals. Joint Commission accreditation can also help attract qualified personnel who prefer to serve in an accredited organization.

- Facilitates Medicare and Medicaid certification: accreditation can help lessen the burdens imposed by duplicative federal and state regulatory agency surveys. Some accredited health care organizations may qualify for Medicare and Medicaid certification without undergoing a separate government quality inspection.

- Meets insurer and other third party requirements: increasingly, accreditation is becoming a prerequisite to eligibility for insurance reimbursement, to participation in managed care plans and to bidding on contracts.

- Attracts professional referrals: case managers and other health care professionals frequently use accreditation as a benchmark of quality when placing individuals in health care organizations.

- Improves liability insurance coverage: by enhancing risk management efforts, accreditation may improve access to and reduce the cost of liability insurance coverage.

- Provides a competitive advantage: exposure of accreditation status may provide a marketing advantage in a competitive health care marketplace.

- Meets lender conditions: Joint Commission accreditation is often helpful to health care organizations in meeting lender conditions for securing financing.

Experiences in developing countries have proven that well-designed and executed accreditation processes result in enhanced quality of health services. In developing countries, this is especially true when the accreditation scheme is incorporated into a large-scale quality improvement and recognition program. Considerable increase in the utilization of healthcare facilities has been noticed. Application of accreditation processes
also ameliorate organizational efficiency though reduction of waste, improved staff time utilization, smoother management procedures.

Another favourable impact is on provider satisfaction and motivation, the reasons here are financial but also morale related. Likewise, patient satisfaction levels have improved with the provision of more effective, efficient, and better timed delivery of care.

Accreditation initiatives have helped to draw the attention of local leaders and decision-makers to this dominating health and quality related issue. This has been resulting in expanding investment in both human and financial resources to health-related efforts. As such, accreditation has led to decentralizing processes.

Accreditation and its influence on the staff

It is interesting to recognize the influence of accreditation on hospital staff. The goal of a survey done by Bedlick M., and Siwiec J (2003), was to investigate the influence of accreditation and external mechanism of quality assurance and the perception of this process by the hospital staff after the accreditation survey.

The questionnaire comprised questions referring to the following issues: (1) knowledge about the accreditation process; (2) involvement of individual personnel groups in the preparation to the accreditation process, the most difficult tasks during the preparation; (3) factors which contributed to granting the certificate; (4) influence of the accreditation on the hospital performance; (5) advantages resulting from obtaining the status of an accredited hospital.

The majority of respondents were very well acquainted with the accreditation process itself (89%) and indicated that the accreditation was the hospital assessment process based on external standards. 7.8% answered that accreditation was a process connected with ISO certificate granting.

They asked the respondents to express their opinion on the involvement of particular personnel groups in the preparation to the accreditation visit. The best assessment was given to nurses – average 4.21 (in a 10-point scale from –5 to 5), next to assistant personnel 3.2; administration personnel 2.69; maintenance personnel 2.63; with the lowest assessment for physicians 2.20.

The preparatory works for the visit were considered quite difficult and assessed by the respondents at 2.42 (a scale from 1: very difficult to 5: very easy). The most difficult tasks included gaining financial means for meeting the defined standards (2.4). Other tasks were assessed at a similar level and
comprised: the unification of medical documentation assessed at 3.03; the handling of current medical documentation assessed at 3.3; implementation of proceeding standards at 3.41; the monitoring of quality indices at 3.11. A slightly higher score (4.02) was recorded with respect to a direct co-operation with the superiors, and was regarded as less strenuous. According to the respondents’ opinion, the effort of the whole team was the factor that most contributed to granting the accreditation certificate (4.27).

In respondents’ assessment, the preparation to the accreditation process resulted in a significant improvement of hospital’s performance in its every single sector. With reference to the latter, there were differences in opinions between individual personnel groups. The most positive aspects of the accreditation process were noticed by members of management, followed by nurses, then maintenance as well as administration personnel with physicians closing the list.

The most significant improvement was noticed, and accordingly most highly assessed, with respect to hospital infections (3.28), medical documentation handling (3.40), patient satisfaction surveys (2.97) medicine handling (2.94) patient care (2.88) and hospital management (1.99).

Many respondents indicated that after the assessment, the hospital didn’t obtain the contract increase (45%) whilst the process of meeting the standards required additional tasks and duties (82%), yet, in spite of this, 70% of the respondents were proud of the success, and 80% expressed the view that the hospital should try to obtain the accreditation certificate in future.

The survey has proved that the accreditation is a tool supporting quality works, and hospital personnel accept contrary to many opinions.

Conclusions

Accreditation’s popularity is explained by the rising worries about the “quality” of medical services provided to the public, a model/concept borrowed from the Japanese who are leaders in Quality issues. Nowadays, several hospitals are integrating the “quality” approach in running and managing their services.

The rationale for pursuing accreditation resides in several facts. Accreditation reflects the high level of professionalism and training among health workers, expresses a hospital’s desire to provide continuous quality improvements, shows a consensus has been reached among multiple stakeholders to adopt the process and change the overall organizational culture to enhance the provision of health services.

However, arguments against accreditation do exist. Cost; dedicated time and efforts on behalf of staff; acquiring a show-off attitude by the accredited organization; and changing the nature of medical profession from
innovation, creation and discipline to compliance with agreed upon set standards. These have been written down to be taken into consideration by hospitals’ managements and to be dealt with them accordingly.

Without any doubt, accreditation will substantially improve proactive risk and quality management, and thus will hopefully decrease the hazards of hospitalizations.

Accreditation should be constructive, educational, and a customized process. Its main objective is the welfare of the patient. Always keep in mind that to achieve that it should be well designed and engineered. The road is long, quite stressful; it definitely requires everyone’s acceptance and willingness to be part of it. Details about the steps have been given, organize them into a working project, enjoy and share your success afterwards.

REFERENCES


8. Ambulatory Health Care Accreditation

M. Ammourah, MD, MPH

Accreditation of ambulatory healthcare organizations follows the same general guiding principles applied to any other type of a healthcare facility, however the standards used in measuring the organization’s performance and compliance will not be the same, since standards are services sensitive or related. Self assessment, types of survey, surveyors’ attributes, and different terms or nomenclatures used for accreditation that has been or not granted post external survey completion are among the presented issues that have already been came upon in earlier discussions.

Accreditation of ambulatory healthcare

Accreditation is a voluntary process through which an ambulatory health care organization is able to measure the quality of its services and performance against nationally recognized standards. The accreditation process involves self-assessment by the organization, as well as a thorough review by the Accreditation Association's expert surveyors, who themselves have extensive experience in the ambulatory health care environment. The certificate of accreditation has become a benchmark of quality not only to those involved in health care delivery and management, but to the general public. Ambulatory health care organizations value accreditation as a measure of professional achievement and quality of care. Many third-party payers such as commercial insurance carriers and governmental agencies recognize and accept accredited health care organizations as meeting their requirements for reimbursement. Professional liability insurance carriers acknowledge that accreditation is a valuable indicator of quality and frequently consider it in evaluating an organization applying for coverage. Before accreditation is awarded, an organization participates in a thorough multi-step evaluation process. The basic elements of the process are a self-assessment completed by the organization itself and an on-site survey conducted by a team of physicians, health care managers, and other health professionals who actively participate in accreditation organizations. All surveyors are volunteers, serving without pay because they believe in promoting high quality ambulatory health care. Accreditation may be awarded for either one or three years, depending on the level of compliance with the standards.
Survey eligibility criteria

An organization is eligible for an accreditation survey if it:

- has been providing health care services for at least six months before the on-site survey.
- is either a formally organized and legally constituted entity that primarily provides health care services, or a sub-unit that primarily provides such services within a formally organized and legally constituted entity that may be, but need not be, health related
- is in compliance with applicable local laws and regulations
- is licensed by the government in which it is located
- provides health care services under the direction of one of the following health care professionals:
  a. doctor of medicine or osteopathy (MD/DO)
  b. doctor of dental surgery or dental medicine (DDS/DMD)
  c. doctor of podiatric medicine (DPM)
  d. doctor of optometry (OD)
  e. doctor of chiropractic (DC)
  (These individuals or groups of professionals must accept responsibility for the health care provided by the organization and are licensed in accordance with applicable government law.)
- shares the facilities, equipment, business management, and records involved in patient care among the members of the organization
- provides the signed Application for Survey and other documents in advance of the survey
- pays the appropriate fees
- acts in good faith in providing complete and accurate information to the Accreditation organization during the accreditation or reaccreditation process.

Health Organizations are considered for survey on an individual basis. The Accreditation organization determines whether the standards can be applied to any given applicant. If the Accreditation organization decides that the standards cannot be applied, a survey will not be conducted. The health organization will be informed regarding the reason for such a decision and will be refunded their application fee. If a survey is conducted and the Accreditation organization decides that the standards cannot be applied appropriately in order to reach an accreditation decision, the survey will be deemed to be a consultation and no accreditation decision will be made. Fees for such a consultation shall not be refunded.
Accreditation associated terms

Terms of accreditation are determined by assessing the organization's compliance with the Accreditation Association Standards. The longest term of accreditation an organization can be awarded following a survey is three years. Organizations may also receive an accreditation term lasting one-year or six-months.

Three years

The Accreditation Committee awards an organization accreditation for three years when it concludes that the organization is in substantial compliance with the standards, and the committee has no reservations about the accuracy of the survey findings or the organization's commitment to continue providing high-quality care and services as reflected in the standards.

One year

The Accreditation Committee awards an organization accreditation for one year when a portion of the organization’s operations are acceptable but other areas need to be addressed and the organization requires sufficient time to achieve compliance. The organization must have a special on-site review within 10 months from the previous survey date to avoid a lapse in accreditation. Such a special on-site review may be conducted by one or more surveyors in a visit to the organization at the prevailing fee. The on-site review will not necessarily be limited to the recommendations in the previous survey report. An additional application fee will not be required.

Six months

The Accreditation Committee awards an organization a six-month term of accreditation when it concludes that the organization is in substantial compliance with the standards but it is not eligible for a three-year term of accreditation because the organization does not meet certain requirements, e.g., the organization has not been operational for six months. The Accreditation Committee also awards a six-month term of accreditation to organizations that are in compliance with the standards but the organization's demonstration of continued compliance with the standards is not sufficiently well established to grant a longer term of accreditation. The organization must have a special on-site review within six months from the previous survey date to avoid a lapse in accreditation. One or more surveyors may conduct such a special on-site review in a visit to the
organization at the prevailing rate. The on-site review will not necessarily be limited to the recommendations of the previous survey report. An additional application fee will not be required.

**Deferred accreditation decision**

The Accreditation Committee may defer an accreditation decision when the organization’s operations do not meet the standards, but the organization demonstrates the commitment and capability to correct identified deficiencies within six months. In such cases, the organization must request another on-site survey. This survey will be conducted at the prevailing rate. However, no additional application fee will be assessed. The request must be made within three months of the notification of the deferral accreditation decision, and the re-survey must occur within six months of the date of the previous survey. If an organization was not accredited prior to the deferred decision, the organization will remain not accredited. If an organization was accredited prior to the deferred decision and requests a re-survey within three months of the notification of the deferral accreditation decision, the organization remains accredited pending the decision on the findings of the re-survey.

**Denial or revocation of accreditation**

The Accreditation Committee denies accreditation to an organization when it concludes that the organization is not in substantial compliance with the standards. An Accreditation Organization reserves the right to revoke the accreditation of any organization at any time without prior notice if it determines that an organization (1) no longer satisfies its Survey Eligibility Criteria; (2) is no longer in compliance with its policies, procedures or standards; (3) has significantly compromised or jeopardized patient care; (4) fails to act in good faith in providing data and other information to the Accreditation Organization; (5) fails to notify the Accreditation Organization (AO) within 30 days of any significant organizational, operational or financial change, or any change in ownership or control; or (6) fails to notify the AO within 30 days of any imposition of sanctions, changes in license or qualification status or any violation of governmental law with respect to the organization, its owners, or its health care professionals. In addition, the AO may revoke the accreditation of an organization when it determines that there is a material change in the organizational structure, financial viability, operations, ownership or control of the organization or its ability to perform services which requires a new survey by AO to determine the organization's compliance with its Survey Eligibility Criteria or its standards. Revocation may be retroactive to the
date of the material change, the imposition of sanctions or the violation of law. An organization that is not granted accreditation or that has its accreditation revoked may apply for another survey at any time following the decision, as long as it has not exercised its right to appeal or right of reconsideration. Organizations receiving a denial of accreditation or has its accreditation revoked must submit an Application for Survey and application fee when applying again for another survey.

**Accreditation Association for Ambulatory Health Care (AAAHC)**

Following the receipt of a completed application from an organization, the Accreditation Association starts the scheduling process for the survey. The size and range of services being offered by the organization seeking accreditation is what determines the length of the on-site visit, the number of surveyors needed, and the survey fee. The Accreditation Association Scheduling Office, in cooperation with the organization being surveyed, determines survey dates. The expertise of the survey team members is matched as closely as possible to the practice specialty of the organization being surveyed. The on-site survey includes a comprehensive assessment of compliance of the entire organization with the Accreditation Association Standards, including any separate entities that have a close interrelationship with the organization seeking accreditation. At the conclusion of the on-site survey, surveyors hold a summation conference at which they present their findings to the organizations' representatives. The organization will have the opportunity to comment on the findings, as well as the entire survey process.

**Accreditation survey process**

The accreditation decision is based on a careful and reasonable assessment of an organization's compliance with applicable standards and adherence to the policies and procedures of the Accreditation Association. The Accreditation Association expects substantial compliance with all applicable standards. Compliance is assessed through at least one of the following means: documented evidence, answers to detailed questions concerning implementation, and on-site observations and interviews by surveyors.

Although the accreditation survey process is of necessity evaluative, the Accreditation Association emphasizes the educational and consultative benefits of accreditation. Consequently, the Accreditation Association surveyors are physicians, dentists, nurses, and administrators who are
actively involved in ambulatory health care. Specific survey team members are selected, to the extent possible, on the basis of their knowledge of and experience with the range of services provided by the organization seeking an accreditation survey, as well as with its type, size, and location.

To initiate the survey process, interested organizations must submit a completed Application for Survey along with the supporting documentation listed in the Application. The Application is designed to provide the Accreditation Association with a profile of the organization that has requested an accreditation survey. The answers to the questions do not weigh toward achieving or not achieving accreditation. They provide descriptive information that is helpful to the surveyors, staff and Accreditation Committee in understanding the organization and its practices. Surveyors will review the application and supporting documents prior to conducting the on-site survey and may seek verification and clarification of certain items during the survey. Each accreditation survey is tailored to the type, size, and range of services offered by the organization seeking accreditation. The length of the on-site visit and the number of surveyors used by the Accreditation Association, referred to as the Scope of Survey, are based on a careful review of the information provided in the Application for Survey and supporting documents submitted by the organization.

For organizations with multiple service locations, Accreditation Association staff will determine which service sites will be visited on any survey. When an organization has service sites in more than one state, at least one site in each state will be visited. If the organization indicates that a service location should not be reviewed, this site will not be eligible for accreditation and will not be listed on the “Certificate of Accreditation.”

The survey is conducted in accordance with the procedures discussed with the organization before the on-site survey. These procedures enable the surveyors to gather information with minimal disruption of the daily activities of the organization being surveyed. Organizations will be asked in advance to have specified documents and other information available to the surveyors during the on-site visit. They will also be asked to submit other documents directly to the Accreditation Association in advance of the survey. Surveyors may, however, ask to see additional documents or may request additional information during the on-site survey. If applicable, it will be necessary for the surveyor(s) to observe a surgery or procedure.

At the conclusion of the on-site survey, the surveyors hold a summation conference at which they present their findings to representatives of the organization for discussion and clarification. As the surveyors are “fact finders” for the Accreditation Association and do not render the final accreditation decision, no information regarding the organization’s accreditation decision will be provided during this conference. Members of the organization’s governing body, medical staff, and administration are
encouraged to take this opportunity to comment on or rebut the findings as well as express their perceptions of the survey.

After the on-site survey is completed, Accreditation Association staff members review the survey report, surveyor recommendations, including the survey team’s overall recommendation regarding accreditation, and any other relevant information, and make an independent recommendation regarding accreditation to the Accreditation Committee of the AAAHC. The committee carefully reviews each survey report, surveyor and staff recommendations, and any other relevant information before making a decision. Accreditation is awarded to organizations that demonstrate substantial compliance with the standards and are in adherence to the AAAHC accreditation policies. The degree and number of variations in compliance, as well as the importance of a particular deficiency in a specific organization, determine the length of the accreditation term. For further details regarding the specific terms, refer to “terms of accreditation.”

Types of surveys

The Accreditation Association offers several different types of surveys; Early Option Surveys for organizations that want to be accredited, but that have been in business less than six months; and consultative surveys, for organizations that would like to better understand the Accreditation Association standards and get help preparing for accreditation.

- Initial Accreditation Survey
- Re-Accreditation Survey
- Resurvey
- Early Option Survey
- Consultative
- Random and Discretionary.

Initial Accreditation survey
The initial accreditation survey is for an organization that is seeking AAAHC accreditation for the first time. An application must be filled out depending on the type of survey you are seeking. The Accreditation Association's office-based surgery, managed care, and lithotripsy centers have their own applications, different from the general application used for all other types of ambulatory health care organizations.

Re-Accreditation survey
A survey of an organization that is currently AAAHC accredited and is seeking re-accreditation following a three-year term. The Accreditation Association notifies organizations a minimum of six months prior to the expiration of their current term of accreditation. Organizations must again
fill out an Application for Survey for their subsequent re-accreditation survey. To prevent a lapse in accreditation, re-accreditation surveys must occur within two months of the expiration date. Therefore, it is required that all documentation be submitted to the Accreditation Association at least five months prior to the expiration date. In the United States where accreditation is mandated by law, organizations should submit the required documentation a minimum of six months prior to their expiration date.

**Resurvey**
A resurvey is survey of an organization following a prior Accreditation Association survey that resulted in one of the following accreditation decisions: one-year term, six-month term or a deferral. An organization applying for a resurvey will be expected to complete a new application and supply supporting documentation to the Accreditation Association.

**Early Option survey**
The Accreditation Association's Early Option Survey (EOS) Program is a survey program developed for organizations (1) that require accreditation for the purposes of state regulations that demand some form of accreditation before the facility can legally begin operations, or (2) that are newly constructed and operational and require accreditation for health insurance, managed care, or other third party reimbursement, and a six-month wait for a survey would entail financial hardship. The eligibility for an organization to participate in the Accreditation Association Early Option Survey Program is the same as the regular Accreditation Association eligibility criteria, except for the requirement that an organization has been providing health care services for at least six months before the on-site survey can be conducted is waived when the factors described above are present and the organization has requested such a waiver.

Any organization requesting a survey through the Accreditation Association Early Option Survey Program must submit an Application for Survey, application fee and supporting documentation. In addition, the organization needs to submit evidence to the Accreditation Association of the following:
- Licensure or provisional licensure has been obtained from their state. (If the organization is not subject to facility licensure law in its state, then it should provide a statement from the state agency attesting to this fact. If an organization's state requires a licensure survey just prior to opening for preliminary licensure, verification of the preliminary license or survey may be obtained by the survey team at the time of the EOS)
The building in which patient care services will be delivered is built and ready to support patient care service delivery

All policies and procedures, bylaws, governance and administrative structures are in place

Key executive and medical staff has been employed by the organization

All necessary equipment is in place and has been appropriately tested and/or calibrated with up to date maintenance logs in place

The date to begin operations has been identified.

Consultative
The Accreditation Association provides a consultative survey for any organization desiring additional help in understanding the standards, preparing for accreditation, or achieving compliance with a particular standard. Consultation allows the participating organization to seek assistance in meeting specific needs. This includes specifying areas to be reviewed, as well as the number of surveyors. By definition, on-site consultation does not result in an accreditation decision. Problems are identified and recommendations for improvement are made, but all reports of findings are strictly for the use of the requesting organization. The consultation may be one or two days in length with one or more surveyors. Organizations may request specific surveyors (pending availability). Consultative surveys may be held any time the organization requests, provided the organization is open and operating. Consultation from the Accreditation Association cannot be part of preconstruction or pre-opening planning. As with all Accreditation Association surveys, to initiate a consultative survey, the organization must submit the Application for Survey and the supporting documentation

Random and Discretionary
To support the Accreditation Association's ongoing quality assurance initiatives, an accredited organization may be selected for a random survey from 9 to 30 months after the completion of their original survey. Organizations are selected on a proportionate basis across practice settings, geographic areas and accreditation decision categories. These surveys, which are conducted by one surveyor and may last one full day, are a means by which the Accreditation Association can evaluate the consistency and quality of its program, while also demonstrating to the public and regulators that accredited organizations remain committed to the standards throughout the accreditation cycle. They also provide the Accreditation Association and its surveyors with the opportunity to further consult with accredited organizations in the interval between regular surveys. No fee shall be charged to the organization when a random survey is initiated. The random
unannounced surveys are not to be confused with those that might be conducted “for cause,” which have traditionally been conducted as discretionary surveys when concerns have been raised over an organization's continued compliance with standards. An accredited organization may be scheduled for a discretionary survey, with or without advance notice, at any time, and at the discretion of the Accreditation Association. No fee shall be charged to the organization when a discretionary survey is initiated. If an accredited organization is surveyed by the Accreditation Association for a random or a discretionary survey and is judged not to be in substantial compliance with the standards, its accreditation will be revoked or reduced.

**Fees, schedules and cancellation policies**

Each accreditation survey is tailored to the type, size and range of services offered by the organization seeking accreditation. The length of the on-site visit and the number of surveyors (scope of survey) used by the Accreditation Association are based on a careful review of the information provided in the *Application for Survey* along with the supporting documents submitted by the organization. Factors considered in determining the scope include the size, type and range of services provided by the organization as well as other issues such as the number of service locations and whether it is an initial or re-accreditation survey. Following the determination of the scope of the survey by the Accreditation Association staff, the organization is notified of the decision to ensure the appropriate scope has been established. The Scope of Survey is then used to establish the survey fee.

The Accreditation Association in cooperation determines survey dates with the organization being surveyed. Every attempt is made to schedule the survey at a convenient time for the requesting organization. Once a survey has been scheduled, the Accreditation Association sends a confirmation of the date(s) of the survey, the name(s) of the surveyors who will conduct the survey, the survey schedule, and an invoice to the organization to be surveyed.

If an organization cancels or postpones its survey in writing 30 days or more before the survey, the entire fee is refundable. If the organization cancels or postpones its survey in writing between 29 and 15 days before the survey, the Accreditation Association will assess the organization a $500 administration fee and in addition, the organization will be responsible for all direct and indirect nonrefundable costs associated with the survey, including any airline tickets. If the organization cancels or postpones its survey in writing less than 15 days before the survey, no refunds will be given and the organization will be expected to pay the complete survey fee as a penalty. If an organization cancels or postpones a scheduled survey more than one time, additional fee will be assessed at the discretion of the Accreditation Association.
Accreditation Association, and the fee must be paid prior to scheduling the next survey.

**Including related entity or service**

The accreditation site survey includes a comprehensive review of all aspects of the organizational legal entity, or sub-unit of a legal entity, seeking accreditation. When the organization seeking accreditation has a close interrelationship with a separate related patient care entity or service, the survey will include a review of the components outside the boundaries of the legal entity or entity sub-unit seeking accreditation if: 1) there are Accreditation Association standards applicable to the related entity or service, and 2) the related entity or service is organizationally and functionally integrated with the applicant organization, and/or 3) the related entity or service is represented or reasonably appears to the public as being part of the applicant organization. In cases where items 1 and 2 or 1 and 3 above are not met, but there is sufficient relatedness between the services and the applicant organization to suggest that the service or related entity functions as part of the applicant organization or reasonably appears to, both the applicant organization and the service or related entity will be included in the survey process. For example, a surgery centre organized as a distinct legal entity is surveyed to assess compliance with the Accreditation Association standards. The survey will normally include a review of components of a separate, but related, medical practice (e.g., corresponding clinical records, shared space or resources, etc.) to provide relevant information to determine compliance with the standards. However, any accreditation decision conferred will be solely on the legal entity seeking accreditation even though (an) other related entity (ies) was included in the survey review process.

Although in general the Accreditation Association surveys accredit a single legal entity, it will review a sub-unit of a survey-eligible legal entity when the sub-unit exhibits autonomous characteristics and demonstrates a capability of meeting the Accreditation Association standards on its own. Organizational integration exists when the applicant organization's governing body, either directly or ultimately, controls the budgetary and resource allocation decisions for the related entity or service. Where separate corporate entities are involved, organizational integration also exists when there is greater than 50% of the same governing body membership on the board of the applicant organization and the board of the other entity.

Functional integration exists when the entity meets four of the following eight criteria, including either the first or the second:
there is a common organized medical or professional staff for the
applicant organization and the related entity
the applicant organization's human resources function is responsible
for all staffing of the related entity or service (or vice versa) and
development and implementation of the established personnel activities
the applicant organization's policies and procedures are applicable to
the related entity or service, with few or no exceptions
the applicant organization manages all operations of the related
entity or service, i.e. the related entity has little or no management authority
or autonomy independent of the applicant organization
the service or related entity's patient records are integrated into the
applicant organization's record system (or vice versa)
the applicant organization applies its quality improvement program
to the related entity or service and has authority to implement actions
intended to improve the performance at the related entity or service
the applicant organization bills for services provided by the related
entity or service under the name of the applicant organization
the applicant organization occupies physically connected floor space
and/or a geographic location with the related entity or service such that the
related entity or service is represented or reasonably appears to the public as
being part of the applicant organization.

Maintaining accreditation

Accredited organizations are required to maintain their operations in
compliance with current Accreditation Association standards. The
Accreditation Association reserves the right to amend its standards, provided
that it provides all accredited organizations with notice of such amendments,
or includes such amendments in the most recent edition of the Accreditation

In order to avoid a lapse in accreditation status, organizations must
undergo full, regular surveys at least once every three years. The
Accreditation Association notifies organizations a minimum of six months
prior to the expiration of their current term of accreditation. Organizations
must again fill out an Application for Survey for their subsequent full
accreditation survey (also referred to as "re-accreditation" surveys). Upon
receipt of the application, the Accreditation Association will contact
organizations to establish survey dates. To prevent a lapse in accreditation,
re-accreditation surveys must occur within two months of the expiration
date. Therefore it is required that all documentation be submitted to the
Accreditation Association at least five months prior to expiration dates. In
states where accreditation is mandated by law, organizations should submit
the required documentation a minimum of six months prior to their expiration date.

Accredited organizations must notify the Accreditation Association in writing within 30 days of any significant organizational, operational, or financial changes including but not limited to mergers, change in majority interest, consolidation, name change, additional services or locations, death or incapacitation of the physician or dentist in solo physician or dentist organizations, changes in state license or federal certification or qualifying status, significant changes in managed care enrolment, significant changes in a managed care organization or staff membership, bankruptcy, or other significant change in the financial viability of the organization, or any governmental investigation, criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) involving directly or indirectly the organization or any of its officers, administrators, physicians/practitioners or staff. An organization's duty to provide this information continues during the entire accreditation process. Failure to notify the Accreditation Association may result in an immediate revocation of accreditation, or reduction in the term if accreditation. Depending on the circumstances, any significant, organizational, operational or financial change may result in revocation of accreditation or reduction in the term of accreditation.

**Transfer of accreditation**

Accreditation is not automatically transferable when an accredited organization changes ownership or control, such as a merger or consolidation. The accredited organization must advise the Accreditation Association within 30 days of any such change, as required by Standard 2-I-C-3, and the Accreditation Committee will determine whether the accreditation term is transferable and the conditions of transfer. Failure to comply with these provisions will result in the loss of accreditation.

**Annual standard revision**

Each year the Accreditation Association Standards and Survey Procedures Committee review and revise Accreditation Association standards to ensure that they remain relevant to the ambulatory care community. These revisions are released for a 30-day comment period to allow interested parties an opportunity to comment on the proposed standards. The revisions are then sent to the Accreditation Association Board of Directors for final approval.
REFERENCES


9. ILAC Guidelines on Qualifications and Competence of Assessors and Technical Experts

The International Laboratory Accreditation Cooperation (ILAC) Technical Accreditation Issues Committee has released in 2006 the ILAC guidelines on qualifications and competence of assessors and technical experts, a document which is much informative about the accreditation assessors, where the latter are themselves being subject to assessment according to the standards set by ILAC in this regard. It is highly recommended that any internal and/or external surveyor refers to this document for its objectivity and ethical considerations regarding the surveyors’ attributes. As surveyors are held responsible for assessing specific standards, there should also be standards to dictate the selection process of surveyors.

Sections of this document will be subsequently presented, and it can be read in its fullness at: http://www.ilac.org/documents/WhatsNew.G11_2006_Final_Version_050706.pdf

Demonstration of assessor competence

3.1 General

Assessors need to be competent in order to effectively plan and conduct assessments and report assessment results. An assessor's competence is based on the foundation provided by education, training and experience. Assessor competence is measured by the demonstration of the application of specific assessor knowledge, skills and personal attributes, as described in Section 2.

3.2 Methods of demonstration and evaluation of assessor competence

Accreditation bodies to evaluate the competence of assessors may use various methods. These methods should be used in an appropriate combination to give the required level of confidence in assessor competence. Demonstration and evaluation of assessor competence include, but are not limited to the following methods:

3.2.1 Examination/testing/training evaluation. Written or oral examination may be used to determine an assessor's knowledge and skills (Section 2.2) as appropriate to the needs of the accreditation body.

3.2.2 Demonstration. The planned and formal witnessing of specific assessor skill performance, such as in role play situations.
3.2.3 Formal evaluation. The formal, planned and structured witnessing and evaluation of assessor performance during an actual assessment.

3.2.4 Casual observation. The unplanned or informal witnessing of limited assessor performance. This observation could take place in actual assessment or other situations in which assessment skills or personal attributes can be observed.

3.2.5 Documentation. Recorded information, such as resumes, assessment logs, training certificates, transcripts, certifications, and professional licenses.

3.2.6 Attestation. Oral or written statement; a testimonial. An attestation may give different levels of confidence depending on the credibility and independence of the provider.

3.2.7 Verification. An independent check or provision of additional objective evidence obtained to support other methods of evaluating competency, such as attestation and documentation.

3.2.8 Review of previous work. The review of assessor reports, completed checklists, assessment plans or other writing samples.

3.2.9 Interview. Interviews may involve one or more interviewers and the use of selection boards or evaluation panels. Interviews may also be used to verify evidence from other sources.

3.3 Competence with accreditation criteria and reference documents

Assessors and technical experts should demonstrate an awareness and understanding of accreditation criteria and appropriate reference documents, and the application of these requirements to assessment situations relevant to their assigned assessment functions. Assessors and technical experts should be able to:

3.3.1 Identify compliance to requirements;

3.3.2 Evaluate the adequacy and effectiveness of fulfilling these requirements, when appropriate; and

3.3.3 Relate any non-conformities found to the corresponding accreditation requirements.

Note 6 – Examination, formal observation and demonstration are useful for determining competence in this area.
3.4 Competence with assessment principles, practices and techniques
Assessors should demonstrate knowledge and skills in using assessment principles, practices and techniques.

*Note 7* – Examination, formal observation and demonstration are useful for determining competence in this area.

### Selection and initial qualification

#### 4.1 General

For each type of person involved in assessment, accreditation bodies should have documented procedures and criteria for selection and use of persons having suitable or sufficient skill, knowledge, and experience for their assigned assessment function(s). This section, together with Section 5, “Training and Professional Development”, Section 6, “Evaluation of Performance”, and Section 7, “Conflict of Interest, Confidentiality and Integrity”, provides detailed guidance and recommends minimum criteria for the acceptance of lead assessors, technical assessors and technical experts.

#### 4.2 Selection Criteria

The criteria used by accreditation bodies for selection of assessor candidates should be performance oriented and flexible enough so that assessor suitability is judged on a case-by-case basis taking into account factors such as education and demonstrated working knowledge, working experience, training, and assessment experience, communication/interpersonal skills and auditing skills. Accrediting bodies should use a combination of these factors in either ranking and/or establishing minimum qualification requirements for potential assessor candidates. The following sections present recommendations for minimum criteria.

**4.2.1 Education.** Accreditation bodies should require at least post-secondary qualification in a scientific/technological discipline. In some cases, extensive experience in the relevant fields of expertise may be substituted for formal qualification. Degree of technical knowledge and testing, calibration and/or inspection expertise should be established, if possible, through actual examination, demonstration and/or documentation. (See Section 3.2) If this is not possible, then attestation from technical peers to confirm the relevance of their educational and "knowledge" credentials should be obtained.

**4.2.2 Working Experience.** For lead assessors, accreditation bodies should require at least four years of experience in a technical field, two of which should be in quality management, quality assurance or quality system auditing related to laboratory and/or inspection activities. For technical
assessors and technical experts, accreditation bodies should require at least four years of experience in laboratory testing or calibration and/or inspection, two of which should be in the assigned field of assessment. Depending upon the complexity and sophistication of the field, these minimum numbers of years may need to be increased.

4.2.3 Training. For lead assessors, accreditation bodies should require successful completion of a training course or a combination of training courses which covers the topics as specified in ILAC-G3: 1994, “Guidelines for Training Courses for Assessors Used by Laboratory Accreditation Schemes”. For technical assessors, accreditation bodies should require successful completion of a training course or a combination of training courses which covers the topics as specified in Appendix I, Training Course Outline for Technical Assessors”.

4.2.3.1 The framework of the requirements for training of inspection body assessors should be the same as in Section 4.2.3 but the content should cover the corresponding issues of inspection body accreditation.

4.2.4 Assessment Experience. For lead assessors, accreditation bodies should require sufficient assessment experience using relevant accreditation criteria such as ISO/IEC 17025, ISO 15189 or ISO 17020 in the capacity of an assessor or have understudied five assessments using ISO/IEC 17025, ISO 15189 or ISO/IEC 17020 or equivalent criteria accompanied by a lead assessor. For technical assessors, accreditation bodies should require the equivalent of attendance at one or more assessments as observers.

4.2.5 Language Proficiency. Assessors and technical experts should be proficient in both the spoken and written language of the accreditation body. Where an assessment takes place in which part or all of the assessment is conducted in a language other than that spoken and written by the assessor, an interpreter (provided independently from the body being assessed) should be used.

Note 8 - Scoring Systems: Accreditation bodies may find it useful to establish formal scoring systems which define minimum credits for a combination of education, experience and training in order to be considered as an assessor. After attaining the minimum credits, candidates are evaluated for suitability to conduct assessments using additional competency-based criteria.

Training and professional development

5.1 General

Accreditation bodies should have documented procedures for both initial training as well as ongoing training of its assessors.

5.2 Initial Training
Accreditation bodies should have processes for initially training people to ensure a high level of confidence that they can competently perform on their first assessment.

5.2.1 If actual performance during the first one or more assessments is not satisfactory, the assessor candidate should either not be used further or, if not of a technical nature, additional training and/or counseling should be provided.

5.2.2 Accreditation bodies should establish formal apprenticeship (also called assessor development or grandfathering) programs in which assessors progress through a series of levels, typically from an assessor-in-training level to technical and/or lead assessor level based upon successful completion of a certain number of assessments at each level coupled with acceptable performance.

5.2.3 Activities of an assessor in training may range from observing a qualified assessor, usually on the first one or two assessments, to carrying out the assessment, partially or in full, under the supervision of a qualified assessor.

5.3 Ongoing Training

Accreditation bodies should provide for their qualified assessors 'refresher' training sessions and periodic short courses to help keep them updated on evolving procedures and requirements and to give them an opportunity to share experiences and to learn from each other.

5.3.1 Accreditation bodies should organize special meetings, as appropriate, for assessors, and, where relevant technical experts, in specific fields to discuss specific problem areas. This promotes consistency of assessment and overall improvement in the accreditation process.

5.3.2 These training activities should be held regularly. Accreditation bodies should consider requiring assessors to attend a minimum percentage of these periodic training activities over a multi-year period in order to maintain their status as an approved assessor.

5.4 Professional Development

Accreditation bodies should encourage and, as necessary, require their assessors and technical experts to undertake various activities of ongoing professional development including:

5.4.1 Continuing education. Assessors and technical experts should continually update their knowledge and skills through attendance at relevant courses, seminars, workshops and assessor training sessions.

5.4.2 Development activities. In addition to continuing education, other helpful professional development activities include participating in professional societies, conferences, and standards writing bodies.
5.4.3 Tutoring. Participation as a tutor or instructor in a formal course related to assessment practice helps to develop further knowledge.

5.4.4 Mentoring. Overseeing and evaluating others perform assessments often provides useful insights for improving assessment practice.

Evaluation of performance

6.1 General
Ensuring competent performance of assessment is essential. Accordingly, accreditation bodies need to have a formal program and procedures for both the initial evaluation and the ongoing evaluation of the performance of their assessors.

6.2 Initial Evaluation
Accreditation bodies need to monitor and evaluate on-site the initial assessment(s) of new assessors usually with experienced staff, lead or technical assessors and/or case officers performing the on-site evaluation. The criteria used should be consistent with Section 2, but should be tailored to reflect the accreditation body's specific policies and procedures for the proper conduct of assessments. Accreditation bodies should also consider using feedback from the laboratories regarding their assessments and feedback from reviewers of assessor reports as part of their evaluation of assessor performance.

6.3 Ongoing Evaluation
Accreditation bodies need to monitor ongoing performance of their assessors using a planned combination of the following ways.

6.3.1 Formal Observation. Qualified personnel of the accreditation body conduct on-site audits and report on the performance of assessors and recommended appropriate follow-up to improve performance. All assessors should be audited periodically at least once every three years or more frequently if there are no other ways of establishing an assessor's continued mental acuity and physical stamina to perform assessments.

6.3.2 Reviewing Assessor Reports. Qualified personnel of the accreditation body check the assessor's report of findings and completed documentation such as checklists to ensure appropriate interpretation of requirements, adequate documentation of evidence, and clarity of writing. These checks should be done systematically and documented for suitable feedback to the assessors.

6.3.3 Collecting Feedback from Laboratories and Inspection Bodies. Soliciting oral and written feedback from accredited bodies can be a very
useful tool to supplement the assessor performance evaluation program. Careful consideration must be given to the timing and veracity of this feedback since the accredited body may think honest criticism will have a negative impact on the accreditation decision. The collection of laboratory and inspection body feedback should be done systematically and documented for suitable feedback to the assessors.

6.3.4 Collecting Feedback from Team Members. Oral and written feedback from peer assessors (solicited or unsolicited) can also serve as a useful tool towards evaluating the particular assessor and adding to the uniformity of the assessment process because of the differing points of view that may be discerned.

6.3.5 Casual Observation. The unplanned or informal witnessing of limited assessor performance can be useful. This observation could take place in actual assessment or other situations, such as group meetings and refresher training, in which assessment skills or personal attributes can be observed.

Conflict of interest, confidentiality, and integrity

7.1 Conflict of Interest
Accreditation bodies should establish policies and procedures to help ensure that before accepting a specific assignment, an assessor or technical expert discloses to the body any professional, financial and work-related interest that could be construed as a conflict of interest.

7.2 Confidentiality
Assessors and technical experts should sign an agreement of confidentiality guaranteeing that all information received from and about each assessed body is held in strict confidence and no confidential information should be disclosed without the written permission of the accredited body, unless the law requires such information to be disclosed without such consent.

7.3 Integrity
Accreditation bodies should have arrangements to ensure that assessors and technical experts are not subjected to undue influence or pressures that might affect their integrity.

7.4 Impartiality
Assessors and technical experts should act objectively and should be free from any undue commercial, financial or other pressures which could compromise impartiality.
7.5 Consultancy

Accreditation Bodies should not allow their assessors to consult with accredited bodies that they have assessed; at least until such time as the responsibility for the issues of that particular accredited body have been fully discharged (e.g. a new assessment team has been assigned).

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10. The Mission and Philosophy of Hospital Accreditation Programs: An International Perspective

Nour Chachaty, MD, MSc

The mission and philosophy of an accreditation program are the principal determinants of its success. An evaluative framework designed by Donahue and O’Leary (1997) identified the mission and philosophy of these programs as the first element in any healthcare accreditation program\(^1\). There are significant differences in accreditation philosophies among hospital accreditation programs around the world. Accreditation programs differ in their approach to quality improvement and risk reduction, and may often serve diverse objectives. Such differences may also be revealed through the standards embraced by the accrediting programs and the emphasis that these standards reflect. Understanding these differences will enable emerging hospital accreditation programs to refine their respective mission and philosophy so that they can be assured of success, and will assist clients of these programs in selecting an accrediting program that is attuned to their needs and expectations.

It is out of the scope of this chapter to discuss the concept of accreditation of healthcare organizations. However, accreditation can be defined in general terms as the process in which excellence is evaluated based on a set of defined standards. An accrediting body is an entity which provides the evaluation process and determines the outcome of the evaluation.

Referring to the set of International Standards for Healthcare Accreditation Bodies endorsed by ISQua (International Society of Quality in Health Care) in 2000, and where applicable, drawing on the experience of several countries, this chapter provides an analysis of the mission and philosophy of hospital accreditation programs by examining three aspects of these programs:

1. The purpose which the program intends to serve
2. The strategic directions implied by the analysis of the internal and external environments of the program
3. Governance and authority of the program

\(^1\) According to Donahue and O’Leary (1997), the key elements of an accreditation program are: 1) Mission and philosophy; 2) Infrastructure and authority; 3) Published performance standards; 4) Management of field operations; 5) Framework of accreditation decision making; 6) Accreditation database; and 7) Accreditation program sustainability
Purpose

According to ISQua,

“The mission defines the accreditation body’s purpose and its relationship to its clients. The mission:
provides the basis for planning and direction;
is communicated to professional, purchaser, consumer and client groups;
is regularly reviewed” (Standard 1.1.1)[2:9].

Walshe argues that only in the most general terms can it be said that a consensus about the purpose of accreditation exists, in that most systems are intended to maintain and improve standards of care. Accreditation may be used to serve different objectives. While these objectives can be complementary, they might also conflict.

The standards against which performance is assessed are central to any accreditation program. And different purposes are likely to result in quite different sets of standards for accreditation. If an accreditation system is intended to serve conflicting purposes (or if the purpose is unstated and open to different interpretations), then the resulting standards will reflect that conflict and confusion.

If the purpose of the process is quality improvement, then standards should be challenging, able to identify opportunities for improvement in even the best practices so that every accreditation visit brings about change and improvement. If regulation was the purpose of accreditation, the concern is likely to be focused on defining a minimum standard below which no practice should fall. The standards are therefore likely to be set at a level with which most practices can comply with ease, and only a few practices will have difficulty in demonstrating that they meet all the standards.

The strict focus on compliance with minimum standards is a key characteristic of licensing activities. Hence the possibility of confusion between licensing and accreditation, especially when, according to Scrivens, state regulation begins to use accreditation to supplement its functions. As such, the role of accreditation changes from the professional model of education and consultation to one of control. Standards become minimal hurdles to be crossed rather than guidelines for good practice. Surveyors change their role from educators and professional reviewers to that of inspectors. Regulations may be formulated that require an organization to achieve a certain accreditation level as a condition of license to practice or to receive public funding. Surely, sharing of “best practices” from other health care organizations or innovative ways to meet standards and improve
organizational processes is a central feature in the pursuit of accreditation for quality improvement purposes, but is typically not encouraged in the course of a licensing inspection.

According to the WHO, such confusion between licensing and accreditation might exist in countries where a national hospital licensing system has not been instituted. Such licensing functions almost always deal only with observable structural features, and when a country tries to use accreditation as a tool for licensing, complexity is created as to render accreditation impractical.

Bukonda et al. suggest a ‘phased model’ to introduce a hospital accreditation program in countries where not all hospitals are licensed. Such model involves a separation of the licensing and accreditation functions. All hospitals first seek licensing to stay open and then apply for accreditation subsequently. The government administers licensing. A government or private accrediting body conducts accreditation.

An application of this model can be found in India, whereby, in 1997, the Central Council of Health and Family Welfare passed a resolution urging states to enact laws to provide for licensing (registration) of only those private hospitals that have minimum facilities for different forms of treatment. Monitoring mechanisms would be developed by each Indian state to ensure that the facilities and services established continue to be available. Later, a voluntary system of accreditation can be established in each state.

As Scrivens states, accreditation is often used to describe the process of licensing training posts, facilities or practitioners as qualified to train professional staff, particularly doctors. However, it should not be confused with accreditation as the process of evaluating the functioning of health care organizations.

In many countries around the world, programs aimed primarily at the recognition of specialized medical training (e.g., certification practiced by the Royal Colleges in the UK) are separate from those in charge of accrediting health care organizations. They differ in that the primary purpose of the former programs is to ensure that a young doctor is reasonably prepared and equipped to practice in a certain specialty. Another equally important purpose of such programs is to ensure resident safety. These fundamental differences are reflected in the set of standards these programs focus on. An illustrative example is given below.

The Accreditation Council for Graduate Medical Education (ACGME) is a private professional organization responsible for the accreditation of residency programs in the United States. Its role is distinct from the ABMS (American Board of Medical Specialties) which certifies individuals, the “products” of such programs. It is also distinct from that of the Joint Commission on Accreditation on Healthcare Organizations (JCAHO) which is to improve the safety and quality of care provided to the
public through the accreditation of American health care organizations. The role of the ACGME is to give the assurance that a given residency program meets an accepted set of educational standards. These standards treat duty hours, supervision, support for non-educational tasks and the educational environment a program provides as related matters.

It is true that accreditation systems were designed originally to ensure a suitable environment for training and practice. However, stretching the function of an accreditation program to breaking point by drawing it into the sphere of licensing or certification may create role confusion.

The purpose of any accreditation program needs to be explicit. Otherwise, without clearly stated objectives, it is difficult to make meaningful decisions about many other important issues (such as the design of standards, the methods of assessment, the use and dissemination of results, and so on). Objectives must also be formulated to support the communication with and education of potential users. Last but not least, for the evaluation of an accreditation program to be possible, it is necessary to identify objectives against which its performance should be measured.

**Strategic Directions**

According to ISQua,

“The accreditation body determines its services, programs and activities based on analyses of its external and internal environments and the needs of existing and potential clients” (Standard 1.2.1) [2:9].

**Congruence with Context**

As Schyve states, the long term success of accreditation programs in health care depends on responding to all those who will want to depend on it. It makes sense to pay attention to the demand side at the planning stage, and selecting the right system or combination of systems requires careful analysis of user needs and expectations. Low compliance rates have been observed where standards were set without the involvement of relevant staff. Without this involvement, stakeholders are unlikely to find the mechanisms credible in addressing their needs. In addition, unrealistic expectations expressed by hospitals could threaten the program’s sustainability. Therefore, it is essential to identify the full range of expectations hospitals have and correct any misconceptions as quickly as possible. A built-in mechanism for periodic evaluation will be crucial to help the new accreditation program reflect the state-of-the-art standards and remain responsive to the needs of stakeholders.
Performing according to standards requires the target group of health providers to have the competence and motivation needed to comply with standards, as well as the resources required to do so. Hence, it is essential to assess what capabilities already exist and what needs to be created, expanded or upgraded, instead of assuming that hospitals would be able to marshal the knowledge, skills and resources necessary to meet the standards, as shown by the Zambian experience with building a national hospital accreditation program. Moreover, standards should be based on what is deemed acceptable practice by those who will ultimately use them. Standards should address indicators which public hospital managers’ control, and should recognize the pressures upon private hospitals to be efficient. Many hospitals in the developing world frequently suffer from basic limitations such as lack of trained personnel, precarious physical infrastructure, and only rudimentary technological support. They may be constrained in both their ability to prepare adequately for accreditation, and their capacity to manage the resulting change agenda. Although preparation costs diminish after the first accreditation visit, hospitals should weigh resource considerations as they will probably need resources earmarked for the new activities. It should be noted, however, that budgetary constraints held constant, capacity to deliver good services may still be unequally distributed between hospitals.

According to the WHO, the need to implement basic accreditation standards still exists in the early phases of development of national hospital accreditation programs in developing countries. Given the prevalence of small size hospitals in the developing world, this seems to be the most rational approach since optimal standards may have prohibitive resource implications.

**Incentives**

The uptake and success of external quality systems in individual countries are closely connected to the social, political and economic climate that determines incentives and disincentives for participation. Providers need incentives to change behavior. Furthermore, organizations have their own language and cultures, and a customized structure of incentives may be required to change organizational routines and promote co-operation.

Incentives might be in the form of a process to link accreditation status to financing by third party payers. One example can be found in Egypt, where according to the Primary Health Care facility accreditation program, accreditation is the basis for contracting with the Family Health Fund, a national health insurer. The United States offer another example, whereby those hospitals who wish to be paid for the care of Medicare and Medicaid patients (US government programs for the elderly and poor) must
be accredited. The use of standards to justify expansions or changes in a hospital’s functions or facilities can represent another type of incentives. Finally, direct financial incentives may also be used to stimulate participation in accreditation programs. In Canada, for example, a small incentive is offered to nursing homes who are accredited. However, when reimbursement or payment is linked to accreditation status there is always the risk that meeting standards will be done for financial reasons rather than for a concern with the delivery of quality care. The threat of punitive consequences may often overshadow the positive commitment and attitude of the organization to continually achieve and improve quality, Heidemann warns.

**External Relations**

MOH-based hospital accreditation programs rarely engage in partnerships with other concerned authorities within the country. Such partnerships and ties may need to be set up if MOH-based programs are to gain more popularity and be responsive to the demands of existing and potential users. It is equally important to co-ordinate and conciliate any fragmented efforts aimed at quality improvement of hospital care if these efforts are conducted by multiple parties other than the MOH, and are using accreditation as a tool for improvement.

Joint collaboration efforts for accreditation purposes at the regional level may, if they materialize, provide countries with technical assistance, and help create entities that would serve as external evaluators of the local/national accreditation system. Regional conferences can provide an opportunity to strengthen ties and discuss regionally specific quality improvement issues.

Countries around the world are looking beyond their borders for tools, techniques, and methods that are working for other countries. International organizations such as ISQua enable individuals and organizations with a common interest in quality in health care to share expertise and experience via an international multi-disciplinary forum. ISQua’s Agenda for Leadership in Programs for Healthcare Accreditation (ALPHA) mentioned above offers various services to new and emerging health care accreditation programs, and there is considerable value in mutual learning at meetings and activities of the sort organized by these international organizations.

**Governance**

With regard to effective governance, the set of International Standards for Healthcare Accreditation Bodies reads:
“The accreditation body is a legal entity and is governed by a governing body which acts in accordance with a deed, constitution or articles of association defining its powers and responsibilities” (Standard 1.5.1) [2:9], and

“The structure of the governing body safeguards impartiality and ensures that members are chosen to provide a balance of interests, with no single interest predominating” (Standard 1.5.2) [2:9].

An important question that must be considered while embarking on a national accreditation program is whether the accrediting body should be a governmental or non-governmental organization. Shaw argues that the world’s oldest and most successful programs were independent of the state and provincial authorities that had statutory responsibility for managing health care services. Meanwhile, the WHO advises that governments have a role to play at least in the establishment of broadly-based, minimal accreditation standards. This is particularly true in developing countries where the public sector is a major if not dominant provider of care, and no disinterested institution exists which could play the role of an external evaluator. Below are examples of some national accreditation programs currently in existence, with varying degrees of governmental involvement.

Accreditation in the United States is the product of an initiative taken by the medical profession in 1917. Early accreditation efforts were very much physician initiated and physician dominated and this was to remain the case for some time into the future. While still fully controlled by health care professionals, accreditation in the United States had a new user in 1965: the government, and accordingly, any hospital accredited by the Joint Commission would be deemed to be eligible for Medicare. Today, the JCAHO is the largest of several private non-profit organizations which set standards and conduct surveys in health care institutions, and its accreditation programs are the main instruments used by the US government for the distribution of financial resources to health institutions. Furthermore, the board of JCAHO now has consumer representatives.

The responsibility for most accreditation programs currently in existence (e.g., Forum for Healthcare Standards (FHS) in India, Zambian Health Accreditation Council (ZHAC) in Zambia, Council for Health Service Accreditation of South Africa (COHSASA) in South Africa, JCAHO in the United States, Canadian Council on Health Facilities Accreditation (CCHFA) in Canada, and Australian Council on Healthcare Standards (ACHS) in Australia) generally rests with autonomous organizations, as opposed to governmental or individual professional associations. Since accreditation represents an amalgam of interests, the accrediting organization usually involves representatives of multiple players. A representative governing body must demonstrate a fair representation of stakeholders. Governing bodies may be formed by representatives of
professional organizations representing health professionals and health institutions, public members who bring professional experience other than health care, but also representatives of the health ministries. Such an approach facilitates the inclusion of a wide range of stakeholders in determining the strategic directions of the accrediting organization.

Another interesting example is the Primary Health Care Facility Accreditation Program in Egypt, which is designed as a “quasi-public” model. That is, the Ministry of Health and Population (MOHP) has direct responsibility of the program but works closely with other public and non-public entities on program development and implementation. The Quality Improvement (QI) Directorate at the MOHP is in charge of the day-to-day operation of the program. Appointed and chaired by the Minister of Health and Population, the National Accreditation Board has the authority to award the accreditation status based on the recommendation of the QI Directorate.

One example on the authority that a governmental body may have can be found in China, where according to a national hospital accreditation program, the MOH has the possibility of closing hospitals which do not meet standards after a certain period of time. Another example is the role of ANAES (Agence Nationale d’Accréditation et d’Evaluation en Santé), which operates the French national accreditation program and is in charge of developing practice guidelines, and has the capacity to enforce organizational compliance with clinical standards.

As Scrivens notes, accreditation is increasingly becoming of interest to governments in regulating and promoting quality. The role of the Ministries of Health is becoming more focused on steering the health system using promising tools and methods such as hospital accreditation. Nandraj argues that administering an accreditation system is not an alternative to the government’s role in regulating health care, but is rather an additional, more collaborative role for governments, given the present scenario of changing health care systems. However, recent evidence from Africa shows that governments tend to focus more on regulation and quality control than on “partnerships”, especially when it comes to private practice. As Lopez-Acuna put it, the challenge is to preserve government responsibility and accountability, while at the same time delegating authority to non-governmental entities and fostering participatory schemes of governance. Heidemann argues that, ideally, the government would wish to support and facilitate participatory standard setting and a positive process to measure compliance with standards, and reserve unto itself its real power which is to reassure itself and the public it serves that there are adequate ways to monitor quality of care and that these methods are being used with positive results.

To conclude, it should be emphasized that, in addition to providing high quality basic service, the accreditation body must be considered...
accountable and credible. The ultimate success of an accrediting body depends on others’ reliance on accreditation. Accordingly, there is a need to balance independence and accountability for an accrediting body to maintain its credibility and distance itself from governments and their political masters. However, independence from government involves a price to pay: although such an independent accrediting entity may be powerful at periphery, its recommendations may not enjoy enough authority to be followed up.

Conclusions

This chapter has discussed the impact that an accrediting program’s mission and philosophy can have on the success of the program. By examining the determinants of an accrediting program’s mission and philosophy, a number of factors have been shown to facilitate or hamper the acceptability, uptake and credibility of the accrediting program’s services and products.

One of the most prominent goals of hospital accreditation programs is to promote patient safety and improvements in hospital care. Hospital accreditation programs may also aim to provide support systems for hospitals by offering them a better understanding of the areas that pose the greatest challenge for their performance. However, accreditation programs may be used to serve different objectives, whether explicit or implied, such as regulation and financing. Using accreditation as a regulation tool, although proven as an effective strategy to enforce the uptake of accreditation, may lead to shifting the focus of hospitals being surveyed from continuous improvement endeavors to efforts merely aimed at satisfying a set of minimal standards, and thus loosing much of the potential of the philosophy of accreditation as a catalyst to excellence.

Since the success of an accrediting program will largely depend on its acceptability on the part of its client organizations as well as the community, an emerging accreditation program needs to consider the internal and external environments in which it will operate. The philosophy and mission of an accrediting program should be attuned to those of the entities it intends to serve in order to satisfy their aspirations. The strategies of the program have to reflect a high degree of sensitivity to customers’ needs and expectations, as well as to their capabilities and constraints in meeting the standards. The accrediting program might choose to adopt a philosophy of consultation to grant clients the opportunity to receive constructive suggestions on how to achieve accreditation, and an incentive structure may need to be sought out in order to encourage individual hospitals to change their cultures and behaviors. Building strategic ties with other concerned parties at the national, regional and international levels should offer
excellent opportunities for growth and mutual learning for accrediting programs.

One of the most significant challenges of accrediting programs is to foster participatory schemes of governance. Administering an accreditation system should not be regarded as an alternative to the government’s role in regulating health care, but as an additional, more collaborative role for governments. Governments should avoid focusing more on regulation and quality control than on “partnerships” and should encourage accreditation programs to adopt a participative approach in the design and development of these programs.
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11. Healthcare Quality: Systems and Alternative Methods

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The main challenge of healthcare quality resides in the fundamental principle of reducing the number of errors and continually improving performance. For the last two decades, the quality of healthcare services has been constantly changing for the better. Moreover, in today’s highly competitive and changing world, an organization’s survival and success does depend on vigilant planning and preparation for the future. As such, most of healthcare organizations worldwide are organizing their systems as to be more competitive and more cost effective based on the constituents of quality systems.

The general ideology of quality management

There are basic principles pertaining to quality management. Important tenets are discussed below.

Write what you do

The documentation of activities (services and products) is necessary for several reasons:

• To inform clients (patients and purchasers) about what you do
• To make sure staff is notified and educated about planned activities ensuring their work is being carried according to plan
• To carry evidence based practice, which is actually the objective of clinical guidelines and protocols written by health care experts.

Do as you write

In any quality system documentation is essential to make sure that work is being carried out according the quality manual which has been specifically developed for this purpose. An interesting challenge arises: will these guidelines and protocols be accurately implemented in everyday practice, i.e., in real life situations? As a matter of fact, many of the developed guidelines have been criticized as being too scientific and thus inapplicable and inappropriate for implementation. This is an issue to be seriously considered when writing down policies, protocols, and procedures to make them doable.
Measure your performance

Delineating quality in health care is clearly explaining the means to measure it that is to make it quantitative. This is not an easy task but also not impossible. As such, performance indicators need to be chosen accurately to represent a valid (true) and reliable (repetitive) situation. A performance indicator is a quantitative measurement that can be used to examine and improve functions within management, clinics, and support services that affect patient outcome assessing and comparing past, present, and future organizational performance.

Historically, the quality of health care has largely been determined through the professional judgment of individual clinicians. However, with rising health care costs and limited funds, hospitals and governments are seeking objective evidence that health care services are being provided effectively and efficiently, and that quality of patient care is being enhanced or at least maintained.

Performance indicators are powerful tools that allow us to assess, monitor, and improve the quality of health care. They provide quantitative information that enables consumers to make informed choices about treatment options. They also inform providers about their performance level. Further, they help purchasers and administrators make appropriate purchasing and policy decisions.

Evaluation of hospital system performance can be summarized in the following stages:

1. Identifying and building teams
2. Recognizing and complying with the organizational culture
3. Identifying priorities
4. Defining patient demands and needs
5. Selecting performance indicators
6. Measuring current status and evaluating status and outputs of the system
7. Interpreting the results
8. Thriving to achieve optimal clinical outcomes for patients
9. Constantly identifying new aims and objectives

Defining the methods and gathering the correct data is very important. As pinpointed in item (6) above, the key element of a good evaluation is identifying an indicator that directly relates to the output being investigated. Moreover, when choosing indicators that have been used by other organizations, it is advisable to compare the features of both institutions being investigated to make sure we are comparing apples with apples. To be taken into consideration are services provided, size of the
organization, population served, demographics and so on. The indicator’s applicability to the organization in question should be a controlling factor in the decision-making process.

**Improve your performance**

An organization cannot improve its performance if it doesn’t measure it. Deming’s PDCA cycle (Plan-Do-Check-Act) is well known and frequently used in health care. The PDCA cycle has been used in numerous quality projects where principles of continuous quality improvement have been successfully implemented. The challenge in health care is to ensure that everyday activities are an integral part of the quality system and quality improvement projects.

**WHAT does the health care organization perform? - TASKS AND DUTIES**

A health care organization’s mission constitutes the basis for the tasks being performed. Tasks are considered as bigger entities, which include more detailed activities. These tasks can be defined for instance as hospital care, ambulatory medical care, home care, rehabilitation etc.

Health care organizations have the core task of health promotion and disease prevention. These population-targeted tasks are carried out according to national or local strategies and often require co-ordination of the health care facility with other public and private organizations.

**Quality management systems**

**The ISO and EFQM models**

The use of ISO (International Organization for Standardization) quality systems and EFQM (European Foundation for Quality Management) model is rapidly spreading in the health care industry. Theses represent general management models that aim to ensure application of a fact-based management at all levels in the organization. The idea is to acquire evidence based thinking during each and every day of clinical practice. This is basically done by obtaining feedback from customers (internal and external) through the use of process development techniques, by first, second and third party audits, and by measuring clinical quality and efficiency of care with different indicators ISO quality systems and the EFQM models represent *general schemes*. The organization must define in details the
activities to taken care of, in other words, what and how the management
system is going to be used for. ISO and EFQM strongly focus on processes
and the means to appropriately manage them as well as on the outcomes.

In the last twenty years, the ISO standards and the Quality Award
criteria have developed into dynamic quality management methods, which
make continuous quality improvement possible at all levels of an
organization. They emphasize the significance of self-assessment which is
carried out at the different levels of the organization, as a tool for
development. The ISO standards and the Quality Award criteria are general
quality management criteria which are applicable to any field of activity.

ISO 9000 standards and Quality Award criteria are applicable for
quality management of health care organizations.

ISO 9001; 2000

The ISO 9000 standards are the most widely known standards. ISO
9000 has become an international reference for quality management
requirements in business dealings. The ISO 9000 family is primarily
concerned with "quality management". This comprises:

- What the organization does to fulfill the customer's requirements
  about quality and the applicable regulatory requirements. It does this by
  aiming to enhance customer's satisfaction, and achieve continual
  performance improvement in its pursuit of complying with the customers' and
  regulatory requirements.

- The quality manual is a formal statement from the management about
  its adopted values; practically, it is closely linked to its business and
  marketing plan and to its customers' needs. The quality manual is
  understood and applied at all levels and by all employees. Each employee
  needs to work according to specific measurable objectives.

- Decisions pertaining to the quality system should be based on the
  information derived from collected data and the quality system should be
  regularly audited and evaluated for conformance and effectiveness.

- A documented procedure is needed to control quality documents in
  the healthcare facility. Staff must have access to up-to-date documents and
  be familiar with their utilization mode.

- To maintain the quality system and produce conforming
  products/services, the following is needed: providing suitable infrastructure,
  resources, information technology, equipments, measuring and monitoring
devices, as well as suitable environmental conditions.

- HCOs ought to map out all key processes and control them by
  monitoring, measurement and analysis; and ensure that quality objectives
  are met. If a process can not be monitored by measurement, then make sure
the process is well defined to be able to make adjustments when the product/service does not meet users’ needs.

- For each product/service offered by the facility, you need to establish its quality objectives; plan processes; document and measure results to use as a tool for improvement. For each process, determine what kind of procedural documentation is required. (Note: a “product” can be hardware, software, services, processed materials, or a combination of these.)
- You need to determine key points in the process requiring monitoring and measurement, and ensure that monitoring and measuring devices are properly maintained and calibrated.
- You need to have clear requirements for any purchased/outsourced product or service. Select your suppliers appropriately and check that these products meet your set of requirements.
- You need to determine the skills required for each job in your healthcare organization, suitably train your employees and evaluate the effectiveness of the training.
- You need to determine customers’ requirements and create systems for communicating with them information regarding your products and services, receive their inquiries; inform them about your contracts, and respond to their feedback and complaints.
- You need to regularly review performance through internal audits and meetings. Determine whether the quality system is working and what improvements can be made. Deal with past problems and potential problems. Keep records of these activities and the resulting decisions, and monitor their effectiveness.

ISO 9000:2000 combines the three standards 9001, 9002, and 9003 into one standard, now called 9001. Designing and developing procedures are required when a company engages in the creation of new products. The 2000 version sought to make a radical change in managerial thinking by actually placing the concept of process management upfront and centered. ("Process management" consists of monitoring and optimizing the company's tasks and activities, instead of just inspecting the final product.)

ISO 9000 standards form the basis for a documented quality system. According to ISO, the new ISO 9000: 2000 standards are based on eight quality management principles. ISO chose these principles because they can be used to improve organizational performance and achieve the desired success.

ISO 9001:2000, the requirement standard, includes the following main sections:
1. Quality Management System
2. Management Responsibility
3. Resource Management
4. Product Realization
5. Measurement Analysis and Improvement

The standard is based around the principles of customer satisfaction, continual improvement and the development of a process-based quality management system. Although not referenced in the standard itself the ISO 9001:2000 document is underpinned by eight key quality management principles:

- Customer focused organization
- Leadership
- People involvement
- Establishing a process approach
- A systematic approach to management
- A factual approach to decision making
- Mutually beneficial customer-supplier relationship
- Continuous improvement

ISO 9001:2000 has been written to ensure that its guiding principles are equally relevant to all sectors of industry and to all types of organizations. Although comprising requirements to control the key processes within an organization, it only requires six documented procedures. The standard emphasizes the need for an organization to continually monitor its own processes and systems, with many clauses/sections making reference to self-monitoring or measurement or both. This emphasis aims for an integrated approach to business processes. Instead of operating to a business plan on one hand and a quality management system on the other, the standard aims to integrate both of these functions into one system.

The Quality Award criteria place a strong emphasis on the use of quality techniques in the development of processes, competitiveness and focus on customers.

**EFQM Model**

The European Quality Award Criteria are published by the European Foundation for Quality management (EFQM) (http://www.efqm.org). EFQM was founded in 1988 by the Presidents of 14 major European companies, with the endorsement of the European Commission. The model was launched to the public and voluntary sector in 1999. There has been a pilot group for educating and health care testing the model. It has lead to the formation of a health care network that has actively shared their experiences of the implementation of the EFQM model and since then, there has not been any effort of starting a new project concerning indicators for health
care quality. Apparently, the EFQM model is performing its job to perfection.

Regardless of sector, size, structure or maturity, to be successful, organizations need to establish an appropriate management framework.

The EFQM Excellence Model was introduced at the beginning of 1992 as the framework for assessing organizations for the European Quality Award. It is now the most widely used organizational framework in Europe and it has become the basis for the majority of national and regional Quality Awards.

The EFQM Excellence Model is a practical tool that can be used in a number of different ways:

- As a tool for Self-Assessment
- As a way to Benchmark with other organizations
- As a guide to identify areas for Improvement
- As the basis for a common Vocabulary and a way of thinking
- As a Structure for the organization’s management system

The EFQM Excellence Model is a non-prescriptive framework based on 9 criteria. Five of these are 'Enablers' and four are 'Results'. The 'Enablers' criteria cover what an organization does. The 'Results' criteria cover what an organization achieves. 'Results' are caused by 'Enablers' and 'Enablers' are improved using feedback from 'Results'.

![EFQM Excellence Model Criteria](image)

**Concepts of the EFQM model**

- **Results Orientation**: to achieve results which delight all the organization's stakeholders.

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Customer Focus: to create sustainable customer value.

Leadership & Constancy of Purpose: to apply visionary and inspirational leadership, coupled with constancy of purpose.

Management by Processes & Facts: to manage the organization through a set of interdependent and interrelated systems, processes and facts.

People Development & Involvement: to maximize the contribution of employees through their development and involvement.

Continuous Learning, Innovation & Improvement: to challenge the status quo and achieve change by using learning to create innovation and improvement opportunities.

Partnership Development: to develop and maintain value-adding partnerships.

Corporate Social Responsibility: to exceed the minimum regulatory framework in which the organization operates and to strive to understand and respond to the expectations of their stakeholders in society.

The European Commission supports the use of the EFOM model. The Commission has published the European Quality Policy. The Quality policy is meant to lead to an increase in competitiveness accompanied by an improvement in society's conditions.

MALCOLM BALDRIGE NATIONAL QUALITY AWARD- PROGRAM HEALTH CARE CRITERIA FOR PERFORMANCE EXCELLENCE

Since 1995, healthcare organizations have used the Baldrige Health Care Criteria to help them address challenges such as focusing on core competencies, introducing new technologies, reducing costs, communicating and sharing information electronically, establishing new alliances with health care providers, or just maintaining market advantage. Whether the organization is small or large, is involved in ambulance service or health maintenance organization, or has one facility or multiple sites across the country, the Baldrige Criteria provide a valuable framework that can help the organization plan in an uncertain environment. This is accomplished by using the Baldrige Criteria to assess performance on a wide range of key indicators, health care outcomes, patient satisfaction, operational, staff, and financial indicators.

The Baldrige Health Care Criteria have three important roles in strengthening competitiveness:

1. They help improve organizational performance practices, capabilities, and results;
2. They facilitate communication and sharing of best practices information among health care organizations and among U.S. organizations of all types; and

3. They serve as working tool for understanding and managing performance and for guiding organizational planning and opportunities for learning.

The Baldrige Health Care Criteria are designed to help organizations use an integrated approach to organizational performance management that results in:

- The delivery of ever-improving value to patients and other customers, contributing to improved health care quality;
- Improvement of overall organizational effectiveness and capabilities as a health care provider; and
- Organizational and personal learning.

The Baldrige Health Care Criteria are built upon the following set of inter-related Core Values and Concepts:
- Visionary leadership
- Patient-focused excellence
- Organizational and personal learning
- Valuing staff and partners
- Agility
- Focus on the future
- Managing for innovation
- Management by fact
- Social responsibility and community health
- Focus on results and creating value
- Systems perspective

These values and concepts are embedded beliefs and behaviors found in high-performing organizations. They are the foundation for integrating key organizational requirements within a results-oriented framework that creates a basis for action and feedback.

The Core Values and Concepts are embodied in seven Baldrige Categories, as follows:

1. Leadership
2. Strategic Planning
3. Focus on Patients, Other Customers, and Markets
4. Measurement, Analysis, and Knowledge Management
5. Staff Focus
6. Process Management
7. Organizational Performance Results
It has been interesting to notice that many hospitals and health care organizations have built their management systems without coverage of the clinical processes (care and prevention). This is quite puzzling considering that good patient care (cure and prevention) leads to the key added value of the hospital function. Actually, there are many reasons for the difficulty in grasping the clinical process. The clinical care processes are often very complex and it is difficult to attribute them to detailed descriptions. Moreover, the autonomy of professional experts, like physicians, doesn't promote transparency of the activities which are an essential part of the system. On another hand a management system that doesn't grab the core activity of the experts - the clinical process - doesn't interest the clinicians. As such, the clinicians will never feel committed to this kind of management system.

Some other related quality management systems

ISO 14001 Environmental Management System

This standard (ISO 14001) specifies requirements for an environmental management system enabling an organization to develop and implement a policy with objectives which take into account legal and other requirements that the organization donates itself to, and information about significant environmental aspects. It applies to environmental aspects that the organization identifies as those over which it has control, and those, which it can influence. There is not any specification of environmental performance criteria.

This International Standard is applicable to any organization that wishes to

a) Establish, implement, maintain and improve an environmental management system,

b) Ensure conformity with its stated environmental policy,

c) Demonstrate conformity with this International Standard by
    i) Making a self-determination and self-declaration, or
    ii) Seeking confirmation of its compliance by parties having an interest in the organization, such as customers, or
    iii) Seeking confirmation of its self-declaration by a party external to the organization, or
    iv) Seeking certification/registration of its environmental management system by an external organization.

All the requirements in this International Standard are intended to be incorporated into any environmental management system. The extent of the application depends on factors such as the environmental policy of the
organization, the nature of its activities, products and services and the location where and the conditions in which it functions.

### ISO 22000 food safety management systems

Food safety is related to the presence of food-borne hazards at the point of consumption (intake by the consumer). As food safety hazards can occur at any stage of the food chain, adequate control throughout the food chain is essential. Thus, food safety can be ensured through the combined efforts of all the parties participating in the food chain.

This International Standard specifies the requirements for a food safety management system that combines the following generally recognized key elements to ensure food safety along the food chain, up to the point of final consumption:

- Interactive communication;
- System management;
- Prerequisite programs;
- Hazard Analysis and Critical Control Point (HACCP) principles.

Communication along the food chain is essential to ensure that all relevant food safety hazards are identified and adequately controlled at each step within the food chain. This implies communication between organizations both upstream and downstream in the food chain. Communication with customers and suppliers about identified hazards and control measures which will assist in clarifying customer and supplier requirements. Recognition of the organization's role and position within the food chain is essential to ensure effective interactive communication throughout the chain in order to deliver safe food products to the final consumer.

The most effective food safety systems are established, operated and updated within the framework of a structured management system and incorporated into the overall management activities of the organization. This provides maximum benefit for the organization and interested parties. This International Standard can be applied independently of other management system standards. Its implementation can be aligned or integrated with existing related management system requirements, while organizations may utilize existing management system(s) to establish a food safety management system that complies with the requirements of this International Standard.

This International Standard integrates the principles of the Hazard Analysis and Critical Control Point (HACCP) system and application steps developed by the Codex Alimentarius Commission. By means of audited
requirements, it combines the HACCP plan with prerequisite programs (PRPs). Hazard analysis is the key to an effective food safety management system, since conducting a hazard analysis assists in organizing the knowledge required to establish an effective combination of control measures. This International Standard requires that all hazards that may be reasonably expected to occur in the food chain are identified and assessed, including those that may be associated with the type of process and nature of facilities used. By doing this, it provides the means to determine and document why certain identified hazards need to be controlled by a particular organization and why others need not.

During hazard analysis, the organization determines the strategy to be used to ensure hazard control by combining the PRP(s), operational PRP(s) and the HACCP plan.

This International Standard specifies requirements for a food safety management system where an organization in the food chain needs to demonstrate its ability to control food safety hazards in order to ensure that food is safe at the time of human consumption.

It is applicable to all organizations, regardless of size, which are involved in any aspect of the food chain and want to implement systems that consistently provide safe products. The means of meeting any requirements of this International Standard can be accomplished through the use of internal and/or external resources.

This International Standard specifies requirements to enable an organization

a) To plan, implement, operate, maintain and update a food safety management system aimed at providing products that, according to their intended use, are safe for the consumer,

b) To demonstrate compliance with applicable statutory and regulatory food safety requirements,

c) To evaluate and assess customer requirements and demonstrate conformity with those mutually agreed customer requirements that relate to food safety, in order to enhance customer satisfaction,

d) To effectively communicate food safety issues to their suppliers, customers and relevant interested parties in the food chain,

e) To ensure that the organization conforms to its stated food safety policy,

f) To demonstrate such conformity to relevant interested parties, and

g) To seek certification or registration of its food safety management system by an external organization, or make a self-assessment or self-declaration of conformity to this International Standard.

OHSAS 18001: Occupational Health and Safety Assessment Series
OHSAS 18000 is an international occupational health and safety management system specification. OHSAS 18001 is an *Occupation Health and Safety Assessment Series* for health and safety management systems. It is intended to help an organization to control occupational health and safety risks. It was developed in response to widespread demand for a recognized standard against which to be certified and assessed. ([http://www.ohsas-18001-occupational-health-and-safety.com/what.htm](http://www.ohsas-18001-occupational-health-and-safety.com/what.htm))

The OHSAS specification is applicable to any organization that wishes to:

- Establish an OH&S management system to eliminate or minimize risk to employees and other interested parties who may be exposed to OH&S risks associated with its activities
- Assure it is conforming with its stated OH&S policy
- Demonstrate such conformance to others
- Implement, maintain and continually improve an OH&S management system
- Make a self-determination and declaration of conformance with this OHSAS specification.
- Seek certification/registration of its OH&S management system by an external organization

Essentially, OHSAS helps in a variety of respects. It helps: minimize risk to employees/etc, improve an existing OH&S management system; demonstrate diligence; gain assurance; etc.

**ISO 15189:2003 Medical laboratories - Particular requirements for quality and competence**

It specifies the quality management system requirements particular to medical laboratories. The International Organization developed the standard for Standardization’s Technical Committee 212 (ISO/TC 212). ISO/TC 212 assigned ISO 15189 to a working group to prepare the standard based on the details of ISO/IEC 17025:1999 General requirements for the competence of testing and calibration laboratories. This working group included provision of advice to users of the laboratory service, the collection of patient samples, the interpretation of test results, acceptable turnaround times, how testing is to be provided in a medical emergency and the lab's role in the education and training of health care staff.

While the standard is based on ISO/IEC 17025 and ISO 9001, it is a unique document that takes into consideration the specific requirements of
the medical environment and the importance of the medical laboratory to patient care.(http://en.wikipedia.org/wiki/ISO_15189)

**ISO 17025 Competence of laboratories**

The ISO 17025 Quality Management System Model provides structure using the industry standard ISO 9001 approach. It embraces trusted methods and frameworks to help provide a stable quality environment. "Management system" refers to the organization's structure for managing its processes - or activities - that transform inputs of resources into a product or service which meet the organization's objectives, such as satisfying the customer's quality requirements, complying with regulations, or meeting environmental objectives.

ISO 9001 is a generic management standard that can be applied to any business enterprise, public administration, or government department.

Growth in the use of management systems generally has increased the need to ensure that laboratories can operate to a quality management system that is seen as compliant with ISO 9001 as well as demonstrate technical competency. Therefore, ISO 17025 was written to incorporate all the ISO 9001 requirements that are relevant to the scope of testing and calibration services as well as specifying the technical requirements for technical competence.

Testing and calibration laboratories that comply with ISO 17025 will also operate in accordance with ISO 9001.

**The health care accreditation and related methods**

The International Society of Quality in Health Care defines accreditation as...“a self assessment and external peer review process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system. Quality standards and the external peer review process are directed by nationally recognized autonomous, independent accrediting agencies with a commitment to improve the quality of health care for the public.”

The term accreditation (applied to organizations rather than to specialty clinical training) reflects the origins of systematic assessment of hospitals against explicit standards. Accreditation is applied primarily to organizations rather than individuals, departments or units. Accreditation is a comprehensive evaluation process through which an accrediting body assesses the quality of the key systems and processes that make up health care organizations.
It developed in the USA in 1917 as a mechanism for the recognition of training posts in surgery. That model was the beginning of the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) (http://www.jcaho.org/), exported via Canada to Australia in the 1970s and arriving in Europe in the 1980s.

Many of the quality systems in Europe have also used the JCAHO, EFQM and ISO 9000 standards in combination to produce more useful and applicable model for each country. The use of the model varies depending on the sector (private, public...) that is administering it in the various countries. In some countries the organizations are non-profit (UK), in others they are government-initiated (France) and they can also be for profit consultancy organizations. Accordingly, the support and commitment to the programs might vary.

JCAHO has also founded the Joint Commission International Accreditation in 1998. They use criteria published in 1999 that were developed by an international task force.

The differences between ISO 9001, EFQM and JCI accreditation system are analysed according to JCI chapters and for each measurable element in Table 1.

Table 1: The differences between ISO 9001, EFQM and JCI accreditation system

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A typical example of health care accreditation is the program of ANAES (http://www.anaes.fr) in France. The accreditation process was introduced into the French Health care system under law no. 96-346 in April 24th, 1996. The “Agence Nationale d’Accreditation et d’Evaluation en Sante” was commissioned to develop the criteria and program to be used. Accreditation is a compulsory procedure for public and private French hospitals of all types.

The accreditation process was inspired by models from English-speaking countries, which have been developed over many years following the initiative of health professionals aiming to improve the quality of services delivered to patients. At the same time, care has been taken that
these models were adapted to suit the specific culture and characteristics of the French health care system.

The independent nature of the process conducted by ANAES is similar to that of accreditation bodies in other countries. The objectives of the accreditation are:

- To assess quality and safety of care
- To assess a health care organization’s ability to ensure continuous improvement in quality of overall patient care
- To formulate explicit recommendations
- To involve professionals at all stages of the quality initiative
- To provide external recognition of the quality of care in health care organizations
- To improve public confidence.

The focus in the accreditation process is first and foremost concerned with the patient’s progress through the health care organization and system, and with the coordination of patient cares assuring its continuum. It focuses on patient safety, continuous quality improvement, and involvement of professionals working in the health care organization as well as long term commitment on quality improvement. The accreditation process was launched in 1999. The gradual development of the accreditation initiative has been planned to take about 5 years. The aim has been to have 300 organizations in the program in 1999 and 500-800 organizations a year later. Each hospital has to initiate the process by April 2001. The organization is expected to join the program and provide with the application form detailed information including an organization chart, a document describing the health care organization and its activities, the development plan, a social audit for the last three years, patient information booklets and building plans.

The health care organization will carry out a self-assessment against the standards and send the results to ANAES. Later the program will involve an accreditation survey. A multidisciplinary team of at least three members including a doctor, a paramedical professional and an administrator carries out the survey. A dialogue between the team of visitors and the health care organization is encouraged by ensuring that the team has at least one professional who works in the same type of health care organization as the one being surveyed.

In order to ensure consistency in applying the accreditation process across all health care organizations and to ensure that its fundamental principles are complied with, an «accreditation surveyors’ charter» has been produced. The surveyors are required to conduct a minimum of six surveys over a two-year period, although they may not spend more than one third of
their working time on accreditation.

**ISQua and the Alpha Agenda**

The accreditation/certification and their credibility have also been tackled by ISQua (The International Society for Quality in Health Care) (http://isqua.org.au). ISQua was founded in 1985 by a group of health care quality professionals. Avedis Donabedian had deeply influenced many of the original groups. Now incorporated in Australia, ISQua has members in over sixty countries. The society is a non-profit organization, managed by an Executive Board which is elected every two years. ISQua organizes annual quality conferences and publishes the International Journal for Quality in Health Care.

One of the activities of ISQua is the Alpha program, which aims to harmonize the principles of the health care accreditation schemes. The Alpha Agenda and The Health Care Accreditation issues are discussed annually in a seminar usually held in conjunction with the annual ISQua meeting. ISQua has funded the International Accreditation Federation to manage the accreditation issues. It has two programs aligning along with the health care accreditation activities namely the International Principles Program and the Accradiator Support and Assessment Program.

The objectives of the Alpha Agenda are:

- To demonstrate internationally that accreditation is a credible evaluation process
- To demonstrate that external and objective evaluation of a national accrediting organization is possible and desirable and there is a means to do this
- To respond to an ongoing need for a forum and organization structure through which knowledge and experience about accreditation could be shared.

**The clinical audits or surveying**

The quality of clinical care is often difficult to measure. Many of the activities carried out by health care experts cannot be defined as standardized procedures. Good patient care is based upon the assessment of the specific situation of the patient and the opinion of the health care experts. This opinion is based on the basic specialist’s training and his or her experience. In the best conditions, the patient would feel that her/his needs are taken into account and that the carried out care process is the best for the specific situation.

The quality attributed to clinical expertise needs a different approach
for assessment. The peer reviews done by other experts working in the same field act as an assessment of the complex and multi-sided patient care. Many countries are actively developing their clinical audit systems.

An example of these clinical audit schemes is the Visitatie in the Netherlands. It has originally been developed for the selection and monitoring of special medical training. It has since been developed into a quality assessment tool. It focuses on clinical practice, professional development and service quality. Visiting teams are mostly clinical and often uni-disciplinary.

The clinical governance

Health care experts often feel threatened when asked for showing more transparency, which in their opinion leads to less autonomy. There is a need for a constructive way to engage both hospital managers and clinicians in higher commitment. One good example of this is Clinical Governance used in United Kingdom.

Clinical governance relates to activities carried out in UK with the support of the NHS Executive. The consultation document on quality in the new NHS: “A first Class Service” suggests clinical governance can be defined by a framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. In the North Thames region this definition was felt to be too broad and they defined clinical governance to be the means by which organizations ensure the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards.

Clinical governance has a broader approach compared to clinical audit. The expert is asked to audit his performance, but also demonstrate how to improve the performance and maintain it. It also emphasized the responsibilities of both clinicians and managers in the delivery of care. The responsibilities can be described:

- A clinician is responsible for providing individual patient care of high quality and for being able to demonstrate this by setting standards and monitoring acceptable standards.
- A health institution is responsible for providing services of high quality and for being able to demonstrate this by setting the system’s standards to provide the services and by ensuring that clinicians deployed by the institution are fulfilling their individual responsibilities.
Quality Improvement

Performance improvement should be based on collected data. The medical and health care sciences have produced a lot of information in relation to evidence based care methods. According to experts, evidence based health care covers only health care professionals carry out about one fifth of the overall activities at the moment.

The measurement systems

ISO quality system and EFQM model aim to be "fact-based" management systems. This means that all the improvement and management of activities should be based on data and information gathered from the activities of the organization. This is comparable to the concept of evidence-based medicine. The quality systems idea is to reach the evidence based thinking at the level of every day practice of health care. There are numerous studies about process of care methods, but there is very little attention or means to ensure that these research based process of care methods are carried out in the practice of health care.

The objectives

The attainment of objectives is evaluated in several ways, for example by obtaining feedback from customers and by measuring the clinical quality and efficiency of care. The development of activities requires many kinds of measurements and the utilization of information, which is continuously gathered from routine statistics.

Patient documents and other sources in the assessment and development of activities is a major challenge in the health care sector. Routine statistics provide quantitative information on the blend of resources. However, to assess how efficiently the resources are used, their benefit to patient health must be evaluated. Health care specialists evaluate patient’s health as part of the normal patient care process. These assessments can be used in quality management, for example, when they are classified numerically. Different indicators and classifications have also been developed to measure the benefit to the patient’s health; these make it possible to systematically monitor and assess the usefulness of care.

There are many international projects that develop indicator systems for health care. One of the most developed systems is the ORYX initiative by the Joint Commission on Health Care Accreditation in USA. (http://www.jcaho.org). Within the ORYX initiative a set of indicators and measures has been evaluated. The validity, reliability and other
characteristics of different measures have been evaluated as well as the way they can be used by the health care organization. The focus is on the outcome measures. The Joint Commission is requiring the health care organizations to select a set of measures to be used and these measures are used as part of the external audits. Similar systems are also developed in many European countries.

The Agency for Healthcare Research and Quality

The value of information in health care quality has never been so widely recognized; yet many organizations lack the resources and/or expertise to build a quality information program from the ground up. Recognizing this, the Agency for Healthcare Research and Quality (AHRQ) Quality Indicators were developed specifically to meet the short-term needs for information on health care quality using standardized, user-friendly methods and existing sources of data.

The Agency for Healthcare Research and Quality's (AHRQ) mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Information from AHRQ's research helps people make more informed decisions and improve the quality of health care services. AHRQ was formerly known as the Agency for Health Care Policy and Research. AHRQ's focuses on:

- Safety and quality: Reduce the risk of harm by promoting delivery of the best possible health care.
- Effectiveness: Improve health care outcomes by encouraging the use of evidence to make informed health care decisions.
- Efficiency: Transform research into practice to facilitate wider access to effective health care services and reduce unnecessary costs.
- Organizational excellence: Use efficient and responsive business processes to maximize the Agency's resources and the effectiveness of its programs.

AHRQ's strategic goals reflect the needs of its customers. These goals are to:

- Support improvements in health outcomes. The field of health outcomes research examines the end results of the structure and processes of health care on the health and well being of patients and populations. A unique characteristic of this research is the incorporation of the patient's perspective in the assessment of effectiveness. Public and private sector policymakers are also concerned with the end results of their investments in health care, whether at the individual, community, or population level.
- Strengthen quality measurement and improvement. Achieving this goal requires developing and testing quality measures and investigating the
best ways to collect, compare, and communicate these data so they are useful to decision makers. AHRQ's research will also emphasize studies of the most effective ways to implement these measures and strategies in order to improve patient safety and health care quality.

- **Identify strategies that improve access, foster appropriate use, and reduce unnecessary expenditures.** The Agency support studies of access, health care utilization, and expenditures to identify whether particular approaches to health care delivery and payment alter behaviors in ways that promote access and/or economize on health care resource use.

  In addition the 1999 reauthorizing legislation directs AHRQ to:

- **Improve the quality of health care.** AHRQ coordinates, conducts, and supports research, demonstrations, and evaluations related to the measurement and improvement of health care quality. AHRQ also disseminates scientific findings about what works best and facilitates public access to information on the quality of, and consumer satisfaction with, health care.

- **Promote patient safety and reduce medical errors.** AHRQ develops research and building partnerships with health care practitioners and health care systems and establishes a permanent program of Centers for Education and Research on Therapeutics. These initiatives will help address concerns raised in a 1999 report by the Institute of Medicine (IOM) that estimates as many as 98,000 patients die as a result of medical errors in hospitals each year.

- **Advance the use of information technology for coordinating patient care and conducting quality and outcomes research.** AHRQ:
  - Promotes the use of information systems to develop and disseminate performance measures.
  - Creates effective linkages between health information sources to enhance health care delivery and coordination of evidence-based health care services.
  - Safeguards identifiable patient information used in health services research and health care quality improvement.

### Impact of AHRQ's User-Driven Research

AHRQ's research, data, clinical improvement tools, and quality measurement and improvement tools are used by its customers to enhance the quality of care they provide and purchase, and to make better informed health care decisions. Research grants are subject to the same scientific peer review and ranking used by the National Institutes of Health. Examples of intramural and extramural research at work within the Nation's health care system include the following:
1. Outcomes Research
Supporting improvements in health outcomes remains one of the Agency's underlying research priorities. AHRQ's outcomes research initiatives, including its Patient Outcomes Research Teams (PORTs), pharmaceutical outcomes projects, and medical effectiveness research, have helped build the scientific base underlying day-to-day clinical practice and health policy.

2. Diabetes Treatment
Diabetes Quality Improvement Project (DQIP) comprises a set of national diabetes performance measures that will allow for comparisons of quality and stimulate efforts to improve the care for people with diabetes.

3. Reducing Medical Errors and Promoting Patient Safety
According to studies done by investigators, AHRQ has shown that system-level failures led to three-fourths of adverse drug events in the hospital systems. According to another Agency-sponsored study, preventable adverse drug events in a 700-bed teaching hospital accounted for half of the total cost of $5.6 million attributable to such events in 1 year, even when they constituted less than one third of the total number of events. As the operating chair of the Quality Interagency Coordination Task Force—the Government-wide collaboration on health care quality issues—AHRQ has coordinated the Federal response to the Institute of Medicine's

**AHRQ Projects and Quality Improvement Efforts**

In fiscal year 2001, AHRQ's focus on improving patient safety included a broad $50 million research initiative that was deployed to:
- Achieve further understanding of when and how errors occur.
- Identify causes of errors.
- Develop the research capacity needed to foster a national strategy to improve patient safety.
- Work with public- and private-sector partners to apply evidence-based approaches to the improvement of patient safety.

In addition to these projects, AHRQ's major ongoing quality improvement efforts include the following.

**Centers for Education and Research on Therapeutics (CERTs)**

**Consumer Assessment of Health Plans (CAHPS®)**
CAHPS® is an easy-to-use kit of survey and report tools that provides reliable and valid information to help consumers and purchasers assess and choose among health plans.
Quality Measures

The most current evidence-based quality measures and measure sets to evaluate and improve the quality of health care are available from the National Quality Measures Clearinghouse™.

Healthcare Cost and Utilization Project (HCUP)

AHRQ sponsors the Healthcare Cost and Utilization Project, a Federal-State-industry partnership to build a multi-State health care data system for conducting research, policy analysis, and quality measurement and improvement. HCUP comprises a family of databases, Web products, and software tools that can be used with HCUP data as well as with other administrative databases to identify, track, analyze, and compare trends in hospital care.

National Guideline Clearinghouse™ (NGC)

Developed in partnership with the American Medical Association and the American Association of Health Plans, the NGC is a Web-based resource for information on evidence-based clinical practice guidelines.

Evidence-based Practice Centers (EPCs)

AHRQ's 12 Evidence-based Practice Centers conduct systematic, comprehensive analyses and syntheses of the scientific literature to develop evidence reports and technology assessments on clinical topics that are common, expensive, and present challenges to decision makers. Since December 1998, over 60 evidence reports have been released.

The accuracy of the measurements in diagnosis and treatment processes

The accuracy of measurement is dependent on the measurement methods and equipment used. Health should be measured by using validated (international) methods, the precision of which has already been verified. There are numerous internationally recognized measures for functional capability, quality of life, severity of disease etc. These should be used as part of evaluating the every day performance and outcome of the health care organization.

There is a lot of high technology used in diagnosis and treatment. The accuracy of the technology should be verified to ensure patient safety and the accuracy of the measures used. The accuracy and calibration of the equipment used in health care must be based on the clinical need. The clinicians must specify the accuracy of equipment required for the assessment of the patients' condition. For example, the accuracy of the equipment used in clinical and physiological laboratories must, whenever possible, be based on calibration methods and procedures that are traceable. Calibration is carried out by comparing the equipments performance with standard equipment, the accuracy of which has been verified. Usually the accuracy is verified in a traceable way by using national or international
measurement standards.

A case study:

A University hospital was certified according to ISO 9001 in 1997. One of the most interesting findings was the fact that the accuracy of medical technology is poorly managed. The hospital identified 4072 pieces of technological equipment in the hospital and identified the clinically based need for 3259 (80% of the total) pieces to be calibrated. Only 436 pieces were under continuous maintenance and calibration. For 783 devices, new procedures had to be created for maintenance and calibration. For the remaining, the calibration and maintenance procedures existed, but were not performed in a systematic way.

The unit also has to specify what level of accuracy must be used in practice. To specify the reliability of measurements, the unit carries out a series of measurements. On the basis of these measurements, it is able to assess the inaccuracy of measurement caused by the patient, employees, and local circumstances. This information is needed for clinical decision-making. In another health centre, a study was conducted where the blood pressure manometers used every day were calibrated and the measurement uncertainty evaluated. The calibration was done against a manometer calibrated by a notified body (VTT-automation). 32 devices where studied, out of which only six had so serious malfunctioning and did not need calibration. For the rest, calibration was done at the level of 250, 200, 150, 100 and 50 mmHg. The health centre manometers pointed at the average 153 mmHg at the level of 150 mmHg for the test device (minimum 148 and maximum 158) and of the average error of the manometers and 106 mmHg at the level of 101 (minimum 96 and maximum 104). The measurement uncertainty was evaluated so that the manometer and the patient stayed in one room and eight health centre experts (doctors and nurses) came into the room to measure the blood pressure. In these stable conditions the measurement uncertainty was still larger than +/-15 mmHg, even for a series of three to four measures. This demonstrated how important it is to manage the maintenance of health care technology and that the basic principles of measurement systems and their accuracy are not understood in health care well enough.

The responsibilities for measuring

The standards of the ISO quality system and the quality award (EFQM) criteria require systematic assessment procedures and their documentation at all levels in the organization. The organization itself has to specify the objects to be assessed and measured, and the indicators that are
applied. The principles of systematic quality management demands that the attainment of the objectives specified in the organization’s quality policy be verified by assessing the efficiency of the processes.

**The quality techniques**

Competitive companies routinely analyze the properties of the product. In health care there has been customer satisfaction surveys carried out by many of the quality focused organizations. Customer expectations can never be fully met by health care organizations due to resources limitation. Industrialized countries have means of regulating the health care market in an attempt to use the available resources in the best way possible. This attempt is increasingly challenged by the citizens (patients) who consume health care products subjectively perceiving the outcome. The properties of these products can and should be analyzed both from the consumer and the provider perspective. There are numerous quality techniques available for these analyses that would help increase the transparency of health care products and resolve the debate between patients and health care experts.

*Process development techniques* are often based on problem solving. When the problem is being specified, the aim should be to generate factual information with the heir/use of appropriate indicators and measurements. Problems can be analyzed with different techniques, such as the scatter diagram, the Pareto chart, the histogram, the fishbone technique and the check sheet. Useful ways of trying out alternative solutions to problems include piloting, simulation, and looking for good practices. The results must be assessed to make sure that the solution works. The new action plan can then be introduced as part of a continuous quality management system.

**Process management**

**The challenge for better process management**

Donald Berwick and Lucian Leap published an overview of recent studies of medical errors and harm in the *British Medical Journal (BMJ)* in July of year 1999. The rising complexity of modern medicine have generated new risk modes and levels of patients’ harm. A recent study in two of the most reputable hospitals in the world discovered serious or potentially serious medication errors in the patient care process of 6.7%. The Harvard Medical Practice Study (which reviewed over 30 000 hospital records in State of New York) found care-related injuries (adverse effects) occurring in 3.7% of hospital admissions, over half of which were preventable and
13.6% of which were mortal. If these figures are generalized to the American health care system, then it would be found that over 100,000 Americans die each year as a result of preventable errors during hospitalization. The costs of medical errors are high in financial terms as well; they are estimated to equal $4700 per preventable adverse drug event in one American hospital. There are studies on this subject going on in Europe suggesting that the same problem is occurring in European hospitals.

Berwick’s article in July 1999 was an invitation to scientists and professionals involved in quality to seriously tackle this issue. In March 2000 the *BMJ* published a special issue focusing on medical harm and ways to prevent it. It was revealed that the annual toll exceeds the combined number of deaths and injuries from motor and air crashes, suicides, falls, poisonings and drowning.

There are examples of how the number of errors can be brought down and the level of quality brought up. Lower error rates in reading radiographs can be achieved and maintained by redesigning the system. Information technology offers us tools for better management. Portable computerized prescribing may reduce errors. Interesting findings from a study by Sexton et al demonstrates that health care experts are more likely to deny their fatigue, stress and errors compared to aviation personnel. The rationale would suggest that health care is seen as a system instead of focusing on individuals and their errors. All the studies clearly demonstrate the need to change the way of thinking among health care experts and managers.

**The description of the processes**

For the patient/customer, any given process is a chain of therapeutic modalities plus other measures taken consecutively. A description drawn up in this way is usually enough to outline the entity. The general description of the care process represents the general frame; moreover, healthcare personnel responsible for the process can continue to describe the clinical content of the various phases of the process in more details, when they consider it appropriately. It may be reasonable to describe part of the clinical process and add description of those phases that are perceived by the patient. To keep the process description as clear as possible and to make sure that it doesn't become too large, it may be justified to describe most of the process’s phases in details under the instructions that help implement the process. As a result, a documented entity is formed, in which the division of labor and co-operation between the various phases of care is clearly specified.

The first element, understanding the production process, refers to the every day work of a healthcare organization; that is, understanding patient’s needs, offering services that respond to those needs, developing products for
our costumers, and delivering outcomes that bring satisfaction through health improvement. To do so, we are investing in exploring, examining, and analyzing every process involved in the production of patient satisfaction.

The general frame of the process can be seen as the phases seen through the patients ‘eyes. The patient sees the process as entities like a nurse interview, a doctor encounter, a laboratory test, a surgical procedure etc. She/he cannot often evaluate the content of these phases that can include numerous details that require high expertise. For the patient the process is a journey where different experts and organizations form a network producing the care process based on her/his individual needs.

Figure 6: – Schematic representation of a Process

The patient (customer, subject of care) comes with a health issue (health problem, disease, illness, requested procedure), which is often given a label, possibly a diagnosis. The care is a period of service (for instance a hospital stay) during which one health care provider delivers healthcare
services to a subject of care, with regard to one or more health issues. All the contacts with health care providers that are related to the same health issue form an episode of care. The episode of care can consist of activities of one health care provider or many.

A care plan refers to the service package offered to a patient/customer in a given operational organization. The care plans can address one or more health issues. From the point of view of the health organization these plans can be used as the basis of the quality system, aggregating individual processes into manageable entities. The clinical guidelines and other «good practice» descriptions can be attached to the care plans, thus increasing the requirements for discipline in clinical practice. According to the concept of quality systems, service providers and the organizations must follow and abide by the description of processes and the instructions.

The quality system of individual service providers includes the processes of the organization. The provider alone produces some of the processes, while other processes are part of a care chain from various providers. For the care plan to function effectively, an important point is to identify the nodes between these partial processes and the instructions that these nodes require. When the quality system is being documented, it is important to make sure that the responsibilities and obligations of the various processes, the instructions of operations and other characteristics of the quality system are not in contradiction with each other.

Many factors affect people's well being and health. A strategy to promote the wellbeing of local inhabitants should be drawn up after reviewing and analyzing the current need for social and healthcare services.

The service network available to people is described in a local service/health care plan. These plans define for example the division of labor between the various organizations and care plans which require co-operative procedures. The plan can also include the principles by which purchased services are arranged, their quality criteria and the patients' freedom of choice within the local service system.

The local service plan can be seen as the basis for local care programs, which define the treatment and prevention of specific diseases and local health problems. In these programs the nodes in the care chain are defined (transfers of patients, for example, from one hospital to another) and the instructions which ensure efficient operation of these nodes. The local experts define the recommendations concerning treatment and treatment practices to be used.

The local care program should be based on a care recommendation. A clinical guideline, which according to PT-II-030:

'Is a set of systematically developed statements to assist health care providers and subjects of care decisions about health care services to be provided with regard to a health issue in specified clinical circumstances.'
Clinical guidelines are generic. They concern no actual subject of care in particular. They reflect a broad statement of good practice, with little operational detail. Clinical guidelines should be structured and should comprise standards, criteria and indicators for measurement.’

Clinical guidelines are expected to be based on scientific research and its critical assessment. Many care processes include a care chain in which the different phases of care are implemented by public and private providers of social and health care services (the service package offered to a patient/customer). The efficiency of the patient care plan requires that the activities of health care experts in relation to clinical guidelines are defined organizational or local work instructions. This will promote the use of the best clinical knowledge in everyday clinical practice.

Quality systems are usually chosen for each individual service organization. In practice a large hospital or large social services department and health care organization can include more than one quality system. Large operational entities can have completely separate service systems, the interfaces between which are based on the customer groups using these entities. They can also form part of a single comprehensive quality system. In this case, the documentation for the entire system describes only general principles while the quality management of operations is realized as part of the unitary process management.

The assessment of the implementation and results of the processes

The most important aspects of the health care process are patient care and measures taken to promote health. The customer in these processes is usually one patient (subject of care). The population-targeted activities as a whole are processes, in which the customer is the entire population. The population can be defined geographically or based on epidemiological data etc. The key processes in health care are the diagnostic procedures, patient care, rehabilitation, prevention and the promotion of health.

The description of processes is important so that the processes can be managed, assessed, and developed. It is important to describe the processes from the point of view of the patient/customer and the employer/work group. Processes often include medical treatment and prevention measures and other procedures. However, the objectives should mainly be based on patient/customer needs.

A useful basic description is the flowchart technique, which can be complemented with a written description. The specialists who are responsible for the process and those who participate in it should join forces to develop the most appropriate description method. Flowcharts, organization charts and other procedures integrate the care process with the activities of the unit and the organization.
How detailed the description should be and what form it should take depend on the process and on the objective of the description (whether the description, for example, promotes the flexible implementation of the process or co-operation during the process).

The aim of the description is not to document self-evident facts related to clinical work but to make sure that the processes are implemented as required. Those responsible for the process and those who participate in the process decide upon the details of process implementation, and write down the instructions, which ensure the correct implementation of the process. Using protocols for procedures, action plans and work instructions, which provide the most important instructions for clinical activities, and ensure the correct implementation of the processes.

In the instructions, reference is made to manuals, recommendations concerning care, and other corresponding documents that include descriptions of patient care and activities that the organization has decided to implement or the implementation of which is required. The aim of directions for procedures and actions is usually to specify and direct large entities, which, for example, require co-operation between different specialists. The directions for procedures and actions can be specified in more detail in work directions; these are used to guide and specify individual tasks or parts of processes that have been defined in more detail. Only part of the knowledge based on health care expertise is included in the description of the process content and in the instructions.

A case study: Process elements

Let’s examine the process of service delivery at the outpatient clinic. The process of service delivery starts before the patients arrives in the clinic. It starts when the patient is discharged from the hospital or in her/his previous visit to the hospital clinic and an appointment for follow up is given. For those first time patients the process starts when they hear about the hospital clinic and its services and decide, among many other clinics and hospitals, to make use of it for their particular health condition. The first question is how is that appointments are made and kept?

Once the patient is in the clinic, issues of patient flow are to be considered. What is the disposition of the patient waiting area, relation to the admission and nursing station, number of seats relative to number of patients, reading and educational materials, waiting area for relatives, snack service, etc. Some of the questions are: who opens the clinic, orders the records, checks for completion, when does the first patient comes relative to clinic opening, who sees the patient first, how long does it take to process admission, record retrieval and check? What is the policy for patient no show?
The patient is processed by admission and her/his record is retrieved. How long does it take to see the physician? Are nurses and physicians on time? What happens when the physician is delayed? What happens when nurses and physicians take breaks? Is there a standard for how long a first time visit and a follow up visit should take? Who takes vital signs?

What about physician and patient interaction? Who places the patient’s record in the physician’s office? Are vital records recorded and laboratories in place? Does the patient see the same physician every time? Who writes the prescription and explains its content making sure patients understand? When laboratories are ordered, who takes the order and process it? Can physician and patient get the results in the same clinic visit? Is the patient escorted to the waiting area after examination ends?

Finally, patients pay for the services provided. Is payment done at the clinic? How long does it take for the claim to be processed? What if insurance is not current or has changed? Can the patient be billed at home?

As we can see, one process is composed of many processes and mapping each one of them is a complex task. Also, we have to realize that mapping and a step-to-step analysis is not enough. Have we been able to detect key areas for service improvement? Have we done queue analysis to understand patient service times, key services interactions and see where delays and queues in the system happen? How do we measure patient’s satisfaction? Do we think this is enough? What about measuring or understanding what patient’s values and designing services to respond to these values?

For these reasons, a systematic approach has to be instituted. Systematic approach means the understanding of the process, identification of key areas of improvement, development of indicators to measure and evaluate process delivery, and definition of outcomes.

To glue this entire process together we need an integrated information system where patient encounter data and operational costs and patient revenues are accessible. In other words, moving one step forward from process based service delivery to evidence and outcome based creating employee satisfaction, patient satisfaction, reduction of medical errors, and cost efficient health care service delivery. Therefore examining and taking care of patients often requires co-operation between several health care units. Quality management in the various units is based on the expertise in each individual field. The instructions needed and the indicators suitable for the assessment of quality are therefore based on this expertise. For example, laboratories often form separate quality systems that have their own quality manuals. It is particularly important for the entire organization to recognize the nodes between the different processes in the patient care system when transferring the patients from one unit to another. In these nodes, it is necessary to specify the instructions, the internal customers and other factors
that will ensure smooth operation in this interface, as well as functions that are directly related to care. As such, there are different support functions in the organization, which are parts of the entire organization’s quality system.

The external quality assurance procedures

The concepts and types of external audits

Internationally accepted methods that have been proved to be effective are mainly used for external quality assurance. Information about the efficiency of the quality system is obtained by means of assessments, or audits. Audits are classified into first-party, second-party and third party audits. First-party audits are called internal audits in the ISO quality system, but, in a broader sense, all systematic self-assessments carried out by the organization are first-party audits. The Quality award schemes (EFQM, Malcolm Baldrige and national Quality Award) emphasize the use of the criteria for self-assessment. Many of the health care accreditation schemes include a self-assessment and improvement based on the assessment, a requirement before the external audit. Self-assessment is a good means of identifying improvement potential and of creating a basis for a systematic improvement of quality.

Second-party assessments refer to audits performed by the customer for the producer of the service or product. In health care the purchasers who often audit the health care organizations they purchase from usually do the second party audits.

Audits performed by a third party, i.e. an independent party, include assessments carried out by certification bodies. Quality Award contests are external quality assessment methods, which have been recognized internationally. Among the competitions in which companies in EU countries have participated are the Malcolm Baldrige, the European Quality Award, and the national Quality Award competitions. A third party does not verify the accuracy and repeatability of the Quality Award criteria and of the points awarded; neither are these quality assessment methods accredited. Therefore, they are not suitable for comparisons between organizations. They focus on the excellence of the organization and can be used to identify top performing organizations as benchmarks for others. Client/producer models place emphasis on the status of the municipality as the purchaser of services and as the party that organizes competitive bidding among providers. Competitive bidding for services is not very common in municipal health care services yet. Quality assurance is an important point in competitive bidding. Methods whose reliability has been verified should be used for quality assessment.
Other health care related activities

There are also other health care specific audits and marks developed mainly by the representatives of the expert groups. Some of these audits have been formalized as clinical audit programs that are used as quality measurement schemes. These activities add useful and important information on the broader overall quality management perspectives.
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ISO International Standard, 14001 Environmental Management System,

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**Quality systems and alternative methods related websites:**

http://www.praxiom.com/iso-9001.htm
http://www.tc176.org/Interpre.asp
http://emea.bsiglobal.com/Environment/Overview/WhatisISO14001.xalter
http://www.iso-14001.org.uk/
http://www.iso9000plus.com/iso-15189.html
http://www.fasor.com/iso25/
http://www.quality.co.uk/custpage.htm
http://emea.bsiglobal.com/OHS/Overview/WhatareOHSAS18001and18002.xalter
http://www.xlp.com/iso-14001-training-consulting
Quality Improvement is now a mature business development strategy, which is being actively pursued throughout every sector of the global economy. The common theme is to build profitable enterprises by satisfying the customer, with each seeking to do so in a unique way and thus to be different from and beat the competition. In planning their specific journey to their distinct Quality destination, many start by articulating what the destination will look like through stating the Mission (alternatively called ‘the Vision’).

**What is a Mission Statement?**

It encapsulates what the organization seeks to be, to achieve. It may take some time to get there: a Mission statement acts as a constant reminder, over what may be a lengthy period, of the direction set for the journey. This is particularly important when Quality Improvement has been selected as a business strategy, as a means of communication to all customers.

**What constitutes a good Mission Statement?**

There are many views on this. An approach often taken is: one which passes the ‘MARCH’ test:

- **M**emorable—thus needs to be short.
- **A**chievable—otherwise it will not be motivational.
- **R**elates to commercial realities—not abstract concepts.
- **C**ommands consensus—all need to be able to ‘buy in’ to it.
- **H**as personality—to be different and compelling.

**When should it be used?**

The Mission should be a driving force for everyone, everyday. Whatever is being planned to be done or is currently being done, these should be tested against the aspirations set by the Mission.

**How does it work?**

The Mission gives a framework within which to make decisions and to plan. Are plans and actions aligned with the Mission? Are they contrary to
it? Are standards being met, and if not is corrective action being taken? Are groups and individuals being challenged to aim higher?

THE SEVEN FUNDAMENTALS OF QUALITY IMPROVEMENT

What are they?

The Seven Fundamentals of Quality Improvement are based on the 'Baldrige Criteria', used widely particularly in America.

1. **Leadership** - Quality Improvement cannot begin unless the environment exists for changes to happen. Leadership from the top carried throughout the organization, can create the environment or culture for improvement within an organization.

2. **Act on Facts** - Quality Improvement involves the collection and analysis of data to bring about change: to act on facts, not on hunch, opinion, or guesswork.

3. **Planning** - Planning is a key aspect of Quality Improvement, because Quality Improvement will not happen unless it is planned at corporate level.

4. **Teamwork and Empowerment of People** - Quality organizations recognize that the people who are actually doing the job are best placed to know what is happening and how best to achieve the desired performance improvements. This understanding leads directly to the conclusion that all staff must have the confidence, knowledge and skills necessary to translate this potential into action. Empowerment is based on devolving authority based on knowledge, skill and training to the person best placed to deliver Quality to the customer.

5. **Quality Assurance** - We can plan for Quality Improvement but we need a system of procedures and controls so that everyone knows what to do and how their work relates to that of other people. These systems of procedures and controls are assessed by standards such as ISO 9000.

6. **Quality Results** - We need to make sure that our Quality Improvement efforts deliver the results we want, so that we get a pay-off for the investment of time and money that we have made in Quality Improvement.

7. **Customer Focus** - The ability to provide products and services, which meet the expectations of customers, is based on our understanding and anticipation of their requirements. Only when everyone in the business understands what the customer wants and how they, as individuals, contribute to achieving customer satisfaction can the organization expect to attain the overall level of Quality performance demanded. The idea of internal customers and suppliers
is used to emphasize that to satisfy the final customer everyone inside the business has customers they must satisfy.

STANDARD SETTING

What is it?
A standard for a product or service sets a target or goal that we must consistently meet.

When should it be used?
We should set explicit standards in order to:
- Tell our customers what they can expect to receive from us.
- Tell our people what we need to achieve.
- Focus attention on the key result areas.
- Aid measuring and monitoring of performance.
- Compare with others and help us to learn from the best.

How does it work?
Standards are an essential part of the improvement process.

Review/
develop

Measure
achievements

Take
action to

Identify opportunities
to improve
Performance standards should be:

- **Customer related:**
  The standard must meet or exceed their expectations.

- **Business related:**
  The mission statement and business plans set us specific targets. We must reflect these in our standards.

- **Competitor related:**
  If we are in a competitive market, we cannot ignore our competitors’ standards, whether or not they are explicitly stated. We must at least match and preferably exceed them or we will lose customers.

- **Specific:**
  Clear and unambiguous.

- **Quantified and measurable:**
  They must contain a number, ratio or percentage, or it must be clear when they have been achieved.

- **Realistic and attainable:**
  Not too easy, not too hard.

- **Time bound:**
  Indicating when achievement is to be attained.

- **Prioritized:**
  To show the relative importance of each objective.

- **Limited in number:**
  To focus on key result areas.

- **Simple and memorable:**
  People need to be able to remember the standard.

- **Output based:**
  We need measures of results as well as measures of activities.
QUALITY IMPROVEMENT: TOOLS AND TECHNIQUES

Historically, the quality of health care has largely been determined through the professional judgment of individual clinicians. However, with rising health care costs and limited funds, hospitals and even governments worldwide are seeking objective evidence that health care services are being provided effectively and efficiently, and that quality of patient care is being enhanced or at least maintained. Performance indicators are powerful tools that allow us to monitor, assess, and improve the quality of health care. They provide quantitative information that enables consumers to make informed choices about treatment options. They also inform providers about the level at which they are practicing. Further, they help purchasers and administrators make appropriate purchasing and policy decisions.

Evaluation of hospital system performance can be summarized in key stages, as follows:
- Identifying and building teams
- Recognizing and working within the organizational culture
- Identifying priorities
- Defining patient demands and needs
- Selecting indicators
- Measuring current status and evaluating status and outputs of the system
- Interpreting the results
- Achieving optimal clinical outcomes for patients
- Identifying new aims and objectives

WHAT IS PERFORMANCE IMPROVEMENT?
It is a philosophy that encourages every member of the organization to find new and better ways of doing things with the end goal of improving the quality of patient care.

Performance Improvement is a process for achieving desired institutional and individual results. The goal of Performance Improvement is the provision of high quality and sustainable health services. Performance indicator systems are used
- To document the quality of care
- To make comparisons
  - Over time
  - Between places (e.g. hospitals)
- To support accountability, regulation, and accreditation
- To support quality improvement
- Transparency for society and patients
INDICATOR-BASED SYSTEM

According to ISQua, Melbourne 1999,

Indicators provide a ‘quantitative’ basis for clinicians, providers, organizations and planners aiming to achieve improvement in care and the processes by which patient care is provided.

For (Joint Commission, 1990)

Indicators are ‘quantitative’ measures that can be used to monitor and evaluate the quality of important governance, management, clinical, and support functions that affect patient outcomes.

Why We Need To Develop Indicators? Because the Indicators answer following questions

- Are we doing the right things?
- Are we doing them in the right way?
- Are we staying within cost?
- The functions of the indicators are summarized as;
- Indicators helps to understand the variation that exist in process
- Monitor a process over a time frame
- Show the effect of a change in process
- Provide a common reference point

Therefore, performance indicators are powerful tools by which the quality and effectiveness of health care can be monitored, assessed and improved. They provide quantitative information to enable consumers to make informed choices about treatment options; for providers to know the level at which they are practicing, and for purchasers and founders to make appropriate policy and purchasing decisions.

MEASUREMENT TECHNIQUES

The unit and the organization use information that is systematically collected to evaluate the quality of their own activities and to identify potential areas of improvement. Collecting data helps the organization assess outcomes or determine the performance of a function or process. Before collecting data, the organization develops specific questions to be answered by the data collected. The organization collects only useful and necessary data. When data collection is systematic, the data can be used to:

- Establish a baseline when a process is implemented or redesigned;
- Describe process performance or stability;
- Describe the dimensions of performance relevant to functions, processes and outcomes;
- Identify areas for improvement; and
Determine whether changes in a process have met objectives.

The monitoring and assessment of practical activities are not the same as the scientific study of efficiency; they main systematic evaluation and development of the respective activities of the unit.

The detail and frequency of all data collection have been determined and are appropriate to the activity or process being measured. The organization collects data about patients' and families’ needs. The organization collects data also about staff views on current performance and opportunities for improvement. Patients, families, and staff members can provide information to give the organization insight about process design and functioning. Other sources of information are surrogate decision makers and payers.

One of the main principles of quality improvement is statistical thinking.

Using statistical methods in data collection and analysis increases the credibility and accuracy of information obtained. Therefore, the analysis of the results requires the application of statistical methods. Statistical tools and methods are helpful in both assessing variation and studying a process to determine where the improvement needs to occur. By understanding the type and cause of variation and using statistical tools and methods, the organization can focus its attention and resources on the processes and outcomes that would benefit from more intensive assessment.

THE QUALITY IMPROVEMENT CYCLE

What is it?

To succeed in the long term, Quality Improvement must be more than just problem solving for customers. It must become a habit, a ‘way of life’ for everyone in the organization, simply ‘the way we do it here’. The Quality Improvement Cycle provides a structure for implementing Quality Improvement initiatives which build on the habits of a systematic approach based on the Seven Fundamentals of Quality Improvement. The methodology of the Quality Improvement Cycle and how it links into the various Quality Improvement tools and techniques is explained below, to secure real steps forward in achieving customer satisfaction, employee satisfaction and economic operation.
THE FIVE STAGE QUALITY IMPROVEMENT CYCLE

1. Identify opportunities to improve
2. Collect and analyse data
3. Identify improvements
4. Plan and implement
5. Measure and review

The Quality Improvement Cycle provides a framework within which to plan and monitor the progress of individual projects. It can also be used as a 'road map' at critical stages in the project to help you decide what to do next. When you are working with the Quality Improvement Cycle, use it as a guide which can prompt and focus discussion but do not try to stick to it rigidly or dogmatically. There may well be occasions when it makes sense to do things in a different order, include extra steps or simply not do specific stages. By using the Quality Improvement cycle as a starting point for your discussions on project planning, you will ensure that the whole team can enter into the decision making process on the basis of a common understanding with the opportunity to contribute their views.
The following chart breaks the Quality Improvement Cycle down into its specific stages and describes examples of the tools and techniques that can be used at each stage.

<table>
<thead>
<tr>
<th>STEP</th>
<th>TOOLS AND TECHNIQUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Identify opportunities to improve</td>
<td>Customer Supplier Chain Analysis, Cost of Quality, Mission, Suggestions, Quality Comparisons—Best Practice, Brainstorming, Graphs, Pareto Analysis, Prioritization</td>
</tr>
<tr>
<td>2 Collect and analyze data</td>
<td>Interviewing, Check Sheets, Pareto Analysis, Graphs, Control Charts, Cause and Effect, Flow Charting, Six word Analysis</td>
</tr>
<tr>
<td>3 Identify improvements</td>
<td>Brainstorming, Nominal Group Technique, Customer Supplier Chain Analysis, Cause and Effect, Six Word Analysis, Decision Making</td>
</tr>
<tr>
<td>4 Plan and implement</td>
<td>Forcefield Analysis, Contingency Planning, Check Lists, Flow Charting</td>
</tr>
<tr>
<td>5 Measure and review</td>
<td>Check Sheets, Graphs, Customer Supplier Chain Analysis, Costs of Quality</td>
</tr>
</tbody>
</table>
A TEN-STEP MODEL FOR MONITORING AND EVALUATION

Step 1: Assign Responsibility

The organization leaders are responsible for

(a) overseeing the design of a quality improvement system;
(b) fostering an organization wide commitment to quality improvement;
(c) establishing quality-improvement responsibilities;
(d) setting strategic priorities for quality assessment and improvement.

According to the 1999 “Quality Assessment and Improvement” standards, the organization’s leaders include at least the following:

The leaders of the governing body; the chief executive officer and other senior managers; the elected and/or appointed leaders of the medical staff and clinical departments, and other medical staff members in hospital administrative positions; and the nursing executive and other senior nursing leaders.

Leadership involvement is key to achieving an organization wide commitment to improving quality, to ensuring that quality improvement is given high priority among the organization's activities, and to ensuring that it includes those important process and cross department/service lines.

Step 2: Delineate Scope of Care and Service

To make sure all care and service the organization provides for patients is considered when setting priorities for ongoing monitoring, organizations delineate their scope of care and service.

The tools used in this step are Brainstorming, selection grids, affinity diagrams,

Step 3. Identify Important Aspects of Care and Service

In this step, the organization chooses the subjects for ongoing monitoring and determines their priorities. Using the scope of care and service as a basis, the organization selects those aspects of care and service
important enough to warrant ongoing monitoring. These aspects of care may be important functions, procedures, treatments, processes, or other activities that affect patient care. Once the aspects are chosen, they should be ranked by priority. Brainstorming, selection grids, affinity diagrams, and multivoting can be used to carry out this sets.

**Step 4. Identify Indicators**

This step involves selecting the performance measures for the important aspects of care and service. As we discussed earlier, an indicator is a quantitative measure that can be used to assess and improve the performance of important governance, management, clinical, and support functions that affect patient outcomes. An indicator is not a direct measure of quality. Rather, it is a tool can be used to assess performance and that can direct attention to potential performance issues that may require more intense review within an organization.

Those identifying indicators can use brainstorming, affinity diagrams, multivoting, selection grids, and flowcharts in developing and choosing indicators; check sheets and run charts can help in testing indicators.

**Step 5. Establish a Means to Trigger Evaluation**

In this step, the organization establishes, for each indicator, a mechanism to determine when further evaluation must be triggered. In other words, the means to trigger evaluation should answer the question, “Based on these data, must we launch an intensive evaluation of this aspect of care?” (Action to improve care and service may of course be taken even when not triggered by a specified means).

By definition, a sentinel-event indicator identifies an event that triggers intensive evaluation each time the event occurs. Triggers for rate-based indicators determine expected rates for the monitored activity or objectives for performance relating to a given indicator. Another approach involves using a derived range around a statistical mean (calculated from data collected and adjusted, when necessary, for case mix). Patterns, including trends, in the data also may be used to trigger evaluation, as may feedback from staff, patients or other sources. Feedback from other sources (for example, patient or family complaints or reports, clinicians’ reports, accreditation reports, comparison with the performance of other organizations through a reference database) may also trigger evaluation; or further revaluation may be triggered by organization’s strategic plans.
Run charts and control charts are useful tools to determine when performance reaches or crosses a threshold and requires evaluation.

**Step 6. Collect and Organize Data**

For each indicator, data are collected and organized so that those responsible can determine when further evaluation is required. This step involved answering several relations questions:

What are the data sources?
- Who will collect data?
- Will collection be concurrent, retrospective, or both?
- Will sampling be appropriate?
- Is data collection amenable to computer support?
- How often will data be organized and assessed to note when evaluation is necessary?
- Who will organize data?
- How will data be displayed?
- Who will initiate evaluation?

Check sheets are an important data-collection tool. Data can be displayed in many ways, including run charts, control charts, histograms, Pareto diagrams, and scatter diagrams.

**Step 7. Initiate Evaluation**

A decision must be made as to whether the data, both from ongoing monitoring and other quality-related feedback, warrant further evaluation of the aspect of care and service (see discussion of step 5). At regular, specified times the responsible individual(s) should assess the data to determine whether they indicate the need for further evaluation based on the established trends, patterns, limits or levels.

Evaluation, including peer review when appropriate, should be used to determine whether there is an opportunity, to improve care or service. In general, staff evaluating care should be attentive to opportunities for improvement involving systems, knowledge, and behavior.
One difficulty in evaluating care and service is detraining exactly how performance can be improved. It is important to make such decisions as objectively as possible.

Many tools can facilitate objectivity and help teams understand the causes of observed performance. These include measures of processes and outcomes; cause-and-effect diagrams, Pareto charts, flowcharts, run charts, control charts, histograms, and scatter diagrams; department standards, guidelines, protocols, and parameters of care or practice; team members’ expertise; professional society and nationally developed clinical practice guidelines or parameters; pertinent health care literature; and comparative data from reference data bases.

### Step 8. Take Actions to Improve Care and Service

If evaluation identifies an opportunity for improvement, actions should be recommended and taken. Actions should be directed toward the root causes and toward overall improvement in the quality of care and service.

The tools used in evaluating care (cause-and-effect diagrams and so forth) should already have illuminated possible actions. Brainstorming, multivoting, and selection grids can help create and choose the best actions. Flowcharts can help in designing new processes or redesigning existing ones.

### Step 9. Assess the Effectiveness of Actions and Ensure That Improvement Is Maintained

Monitoring and evaluation does not end when actions are taken. Whether the actions actually improve care or service should be determined. If performance does not improve, further assessment and action should be carried out. If performance does improve, the organization should take any actions necessary to maintain the gain, and it should continue regular monitoring.

To test whether an action is effective, run charts, control charts, Pareto charts, and histograms can be used.
Step 10. Communicate Results to Relevant Individuals and Groups

To close the loop of monitoring and evaluation, the conclusion, recommendations, actions, and follow-up must be reported to the appropriate individuals and groups. The involved team, as well as the organization leaders, should disseminate necessary information throughout the organization. In addition, the leaders and others will receive formal and informal comments, reactions, and information from involved individuals and groups on the effectiveness of monitoring and evaluation. These should also be made known to affected individual and groups.

QUALITY IMPROVEMENT: TOOLS AND TECHNIQUES

- Brainstorming
- Cause and Effect Diagram
- Check Lists
- Check Sheets
- Flow Charting and Process Analysis
- Force field Analysis
- Graphs
- Histograms
- Pie Charts
- Mind Mapping
- Prioritisation
- Prioritisation Assessment
- Prioritisation Grid
- Nominal Group Technique
- Pareto Analysis
- Six Word Analysis
- Types of Issue
- Problem Solving
- Decision Making
- Planning
BRAINSTORMING

What is it?
Brainstorming is a way of finding new ideas and solutions to problems. It is a group activity, where people can put forward any idea, no matter how wild. One person’s idea will spark off suggestions and ideas from the others in the group.

When should it be used?
When new ideas are needed to overcome problems, to identify causes and possible solutions and also as an aid to planning.

How does it work?
- Write down the problem or objective on a flipchart.
- Agree a team facilitator to keep you to these rules.
- Set a time limit for each session, say 10 minutes.
- Write every idea down.
- Do not criticize or discuss ideas during the brainstorm.
- Work through the first silence—more ideas will come.
- Congratulate the team.
- Consider and evaluate the ideas but do not dismiss any idea too quickly. Often the most unlikely ideas can lead into original, creative and useful solutions if discussed further.
- Collect data, discuss, evaluate and plan to implement the best ideas.

Brainstorming is a good tool for:
- To establish a common method for a team to creatively and efficiently generate a high volume of ideas on any topic by creating a process that is free of criticism and judgment.
- This technique is usually group-oriented, whereby a group of individuals meet to generate an exhaustive list of ideas regarding an area or topic at hand. Brainstorming:
  - Encourages open thinking when a team is stuck in the same old way of thinking
  - Gets all team members involved and enthusiastic so that a few people don’t dominate the whole group
  - Allow team members to build on each other’s creativity while staying focused on their joint mission.
FOCUS GROUP
The focus group is a powerful information-gathering technique that uses small-group discussions to identify the views of people in the group about a certain subject. A facilitator leads the discussion using a question guide. Focus groups work best when questions are open-ended and the facilitator encourages substantial discussion of each question.

CAUSE AND EFFECT DIAGRAM
(FISHBONE OR ISHIKAWA)
What is it?
A simple visual way of structuring an analysis of the root causes of a problem or the resource requirements of an objective.

When should it be used?
β To analyse brainstorming ideas.
β To build-up an analysis over a period of time.
β To break down a problem or objective into manageable sub-sections.

How does it work?
β Draw the spine first with the effect in the lead box. The effect is a description of the problem or objective.
β Draw and label the main legs of the spine. These can be the six categories shown as the example but any categories can be used.
β Brainstorm each category, applying the rules of Brainstorming.
β When complete, investigate the possible causes or ideas.
β Consider using Pareto Analysis to prioritise

The Cause & Effect diagram was developed to represent the relationship between some « effect » and all possible « causes » influencing it.

η The effect or problem is stated on the right side of the chart and major influences or “causes” are listed to the left.
η Cause & Effect diagrams are drawn to clearly illustrate the various causes affecting a process by sorting out and relating causes.
η For every effect there are likely to have several major categories: People, Machine, Methods, and materials.

SURVEYS
Surveys are written questionnaires used to collect quantitative data. Surveys are quantitative devices for collecting feedback to enlighten decision-making. They are useful for soliciting perceptions of customers
when you want to identify reliable trends and patterns for large number of people.

**SURVEYS** can be used:
- To identify customer or staff expectations and needs (with customer and staff)
- To monitor customer satisfaction with the attributes of your service that is important to them.
- To identify the gap or discrepancy between real and desired performance in order to target problems or improvement opportunities.
- To measure the effects of an improvement to see whether customer and staff perceptions improved as a result.
- To illicit reactions to hypothetical improvement alternatives.
- To tune your staff in to their customers, firsthand if you have staff serve as data collectors and analyst.
- To show your customers or staff that you care what they think

**CHECK LISTS**

What are they?
Check lists are lists for example of steps that need to be taken, or of resources that are needed, for implementing planned action.

**When should they be used?**
Check lists can be used at all stages of the Quality Improvement Cycle to ensure that:
- Plans are complete.
- All necessary data is collected.
- All resources are identified to implement the plan.
- All actions have been taken.

Check lists are often used to ensure that nothing is forgotten when an action or sequence of actions is taken periodically. They save “re-inventing the wheel”. They are particularly useful when a group of people are involved in any part of the Improvement Cycle. They help to ensure that everyone does the same thing in the same sequence, to aid monitoring, summarizing and analysis.

**How do they work?**
The steps in developing a checklist are:
1. Make a list of all possible actions/resources, perhaps by brainstorming;
2. Arrange them into a logical order, by time or by category;
3. Assign responsibility and target dates, if appropriate;
4. Allow space for ticking or signing off items as they are completed;
5. Distribute the check list to everyone involved;
6. Check off actions as they are completed;
7. The format of a check list can vary considerably. Here is a simple example for assessing presentation skills.

**Example: Check Lists:**

**Presentations**

Rate Performance on a scale from 1 (inadequate) to 5 (very good)

<table>
<thead>
<tr>
<th>Welcoming courtesies</th>
<th>Eye contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self identification</td>
<td>Smiles</td>
</tr>
<tr>
<td>Intention clearly stated</td>
<td>Voice level</td>
</tr>
<tr>
<td>Timing stated</td>
<td>Voice clarity</td>
</tr>
<tr>
<td>Questions during or afterwards</td>
<td>Flow of delivery</td>
</tr>
<tr>
<td>Sensitivity to audience</td>
<td>Use of hands</td>
</tr>
<tr>
<td>Coping with interruptions</td>
<td>Body language</td>
</tr>
<tr>
<td>Use of Visual Aids</td>
<td>Mannerisms</td>
</tr>
<tr>
<td>Ability to stay with text</td>
<td>Use of notes</td>
</tr>
<tr>
<td>Speed of delivery</td>
<td>Props</td>
</tr>
<tr>
<td>Dress and appearance</td>
<td>Timing</td>
</tr>
<tr>
<td>Clichés, catch phrases</td>
<td>Jargon</td>
</tr>
<tr>
<td>Appropriateness of examples</td>
<td>Foggy words</td>
</tr>
<tr>
<td>Courteous questions answered</td>
<td></td>
</tr>
</tbody>
</table>

**CHECK SHEETS**

We use check sheets because they allow a team to systematically record and compile data from historical sources, or observations as they happen, so that patterns and trends can be clearly detected and shown. Check sheets are also useful tool for data collection in order to answer questions regarding resources allocation, analyze a current problem or identify potential problem areas.

What are they?

Check sheets are a simple way of gathering data about what is happening in a process.
When should they be used?
Check sheets should be used to gather data to allow a problem to be analysed. Having analysed a problem and developed and implemented a solution, a check list can be used to monitor results to ensure that the planned outcome has been achieved.

How do they work?
There are six main steps to organizing a check sheet and reporting data:

1. Decide how to organize data
   By office?
   By department?

2. Decide the time period
   Frequency?
   Hours, days, weeks, months?
   Note: When doing this, identify whether there is like to be a seasonal effect and account for it.

3. Determine the objective measurements
   Look for ease of recording. Be objective.

4. Design the check sheet
   Look for ease of analysis. Allow comments to report on unexpected factors.

5. Brief those who are to record data.
   Brief areas/personnel subject to the study.

6. Collect data, analyse and report on the analysis
Example: Check Sheet:

**Reasons for Social Conflict**

<table>
<thead>
<tr>
<th>Reason</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>T</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politics</td>
<td>III</td>
<td>II</td>
<td>/</td>
<td>III</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>III</td>
<td>II</td>
<td>I</td>
<td>I</td>
<td>III</td>
<td>II</td>
</tr>
<tr>
<td>Money</td>
<td>/</td>
<td>III</td>
<td>II</td>
<td>I</td>
<td>/</td>
<td>III</td>
</tr>
<tr>
<td>Race</td>
<td>II</td>
<td>II</td>
<td>II</td>
<td>II</td>
<td>III</td>
<td>II</td>
</tr>
<tr>
<td>Other</td>
<td>/</td>
<td>III</td>
<td>II</td>
<td>/</td>
<td>III</td>
<td>II</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>10</td>
<td>19</td>
<td>9</td>
<td>14</td>
<td>6</td>
</tr>
</tbody>
</table>

**FLOW CHARTING AND PROCESS ANALYSIS**

**What is it?**

Flow charting is a simple visual way of representing the stages of a work process to help in the understanding and analysis of each process. Flowcharts are a step-by-step sequence of processes and sub-processes that pictorially includes events, reactions or decisions. It provides a common language to be used by teams when discussing the different elements of a process. It allows a team to identify the actual flow or sequence of events in a process. It shows unexpected complexity, problem areas, unnecessary loops, and areas where simplification and standardization might be possible. It also compares the actual versus the ideal flow of a process to identify opportunities.

**When should it be used?**

Every process should be recorded so that everyone involved in it knows where their work fits into the overall process chains. Flow charting a new process chain can ensure that a task has not been left out. It can provide the basis to allow each stage of an existing process chain to be examined systematically in order to identify improvement opportunities and also to
anticipate potential problems.

**How does it work?**

When developing a flow chart, we would normally start with what we believe should be the first operation and work through towards the final output.

The basic symbols connected by input/output lines are:

**RECTANGLE** □ A specific process operation which achieves something. A process which adds value or a checking process. This could be—painting, machining, typing, writing, delivering, communicating, etc.

**LOZENGE** □ Start or finish of a process.

**DIAMOND** □ A decision process. This would be applied to an either/or situation, e.g. good or bad; yes or no; repair or do not repair.
FORCEFIELD ANALYSIS

What is it?

Forcefield Analysis is a technique which helps us to achieve improvement by considering those factors or forces that encourage change or those which work against change. Improvement will happen only if the encouraging factors are strengthened or the inhibiting factors weakened.

When should it be used?

Whenever a change or improvement is needed. It is useful to write down the factors working for and against change, but even if you don’t have time for this, stop and think about it. We all want Quality Improvement. What is stopping us from achieving it?

How does it work?

☐ Draw the improvement or change needed in a box at the head of a page and draw a line down from it.

☐ List the encouraging factors on the left and the inhibiting factors on the right.

☐ Are there more on one side than the other?
§ What are the relative strengths of the factors?
§ Can the encouraging factors be strengthened or the inhibiting factors reduced or eliminated? Unless one of those happens, there will be no improvement.

Example: Forcefield Analysis

<table>
<thead>
<tr>
<th>Career Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driving Forces</td>
</tr>
<tr>
<td>New challenge</td>
</tr>
<tr>
<td>More money</td>
</tr>
<tr>
<td>Better job prospects</td>
</tr>
<tr>
<td>More training</td>
</tr>
<tr>
<td>Better working conditions</td>
</tr>
<tr>
<td>Fringe benefits</td>
</tr>
<tr>
<td>Nearer home</td>
</tr>
</tbody>
</table>
GRAPHS

What are they?
A graph is a visual presentation of data comparing two or more factors in relation to each other.

When should they be used?
Graphs should be used to present data, as they make it come alive, by showing relationships, variations and trends. People see information in graphs far more easily than they do in tables of figures and data.

How do they work?
There are two types of graph that are commonly used in Quality Improvement.

As in this example, graphs can make clear where patterns and trends are occurring. Often the performance target and a lower limit are plotted to make the graph a control chart to trigger action when the limits are exceeded.

Line graphs, which can show how performance changes over time, e.g. £'s revenue against time.
Scatter diagrams, which can help to bring order to a mass of seemingly random data. This helps us to see if one factor (a cause) has any link with another (the effect). For example, if we plotted the lateness of deliveries arriving at a warehouse against the time of day, we might find that there was a relationship between the time of day that they were scheduled to arrive and the delay, perhaps due to the build up of traffic at the rush hour, or to cumulative delays from earlier journeys.

There is no direct link, but there is some link or correlation between the two factors, and we could draw a “line of best fit” which would allow us to make predictions and plan for future improvements.
HISTOGRAMS

What are they?
A histogram is a visual presentation of a single type of data on a chart. For example, you can chart people’s weight or their height on a histogram, but to relate height to weight you would use a scatter diagram or graph.

When should they be used?
Histograms are normally used to show the frequency or distribution of the items being measured.

How do they work?
Take the data to be analyzed and categorized it. For example, if we consider the length of telephone calls made, we might classify them as below 1 minute, 1 to 2 minutes, 2 to 3 minutes, 3 to 4 minutes, 4 to 5 minutes and over 5 minutes. If we recorded the number of calls, we might arrive at a histogram like this:

This histogram can help us to understand the data, to focus on the major items, or on the extremes if we want to take corrective action.

![Histogram Example](image-url)
PIE CHARTS

What are they?
A pie chart is another simple way of displaying data.

When should they be used?
A pie chart is normally used to show how resources are allocated, or to break down a total into its component parts.

How do they work?
First draw the “pie”. This is a circle to represent the whole group. The size of the circle or pie can be related to the size of the total.

Slice up the pie in proportion to the make-up of the total.
Using the same example as for Histograms, where we categorized a total of telephone calls and plotted them on a histogram, we could also construct a pie chart using the same data:
PARETO CHART

What is it?

Pareto was an Italian economist who observed that 80% of wealth was owned by 20% of people. This breakdown of 80-20 has since been observed to apply to many situations: 80% of stock issues are for 20% of stock items, 20% of your colleagues will make 80% of internal calls to you, etc.

When should it be used?

Pareto is most useful when you are deciding which of several options to take. It helps you to judge how to get the best value for money.

How does it work?

- Identify the subject you wish to investigate.
- Identify the main factors through brainstorming or other methods.
- Collect data and analyze the results.
- Construct a Pareto Chart.
- Analyze the data and decide which factor should be tackled first. For example, complaints about late deliveries could be about machine breakdowns, lack of product, wrong address, or poor product.
- When data has been collected and collated, it can then be plotted for example as a histogram.

- Can be used to focus attention on the “vital few” instead of the “trivial many” problems or processes needing attention
- Can be used to decide which problem to pursue
- Can be used to identify the more influential causes of your problem
- Can be used to show changes in performance over time
- Progress is measured in a highly visible format that provides incentive to push on for more improvement
Pareto Chart Used to Determine Which Problems to Target for Improvement

Patient ratings of nursing quality: survey results by item

1: Timeliness of response to call button
2: Communicating about what patient can expect
3: Timeliness of medication delivery
4: Response to complaints
5: Courtesy
6: Friendliness
7: Attitudes toward family and other visitors
8: Concern shown for patient's comfort
9: Attention to patient's cleanliness
10: Communication about patient's condition

Percentage of Fair/Poor Ratings
MIND MAPPING

What is it?

Mind mapping is a way of generating or recording ideas in a creative yet structured way.

When should it be used?

Mind mapping is often used as a form of individual brainstorming. Each idea is built on and developed in a structured way until a complete analysis is developed. It is sometimes used by small groups of people during a meeting to prepare for presentations, or as a way of making notes.

How does it work?

- The problem or issue is defined in a circle in the middle of a sheet of paper. This is important as it allows ideas to be developed outwards, unrestricted by space. Each idea stimulates related ideas.

- Initial ideas about the issues are drawn as a branch out from the centre, and related ideas are linked to them, as in this example. Each branch is developed until ideas run out, then another is pursued.

- Use a large sheet of paper, a flipchart perhaps, and leave it pinned up for a week or two. Encourage others to add to the chart before gathering data and prioritizing areas for action.

- Brainstorming rules apply with regard to no discussion or criticism.
Example: Mind Mapping

Improve Job Satisfaction

- Social Events
  - Christmas Party
  - Lunch with staff
- Canteen
- Offices
- Better facilities

- Communications

- Vehicles
- Bulletins and newsletters

- Equipment
- Welfare
- Training
- Visual
- Computers

- Aids
  - Safety clothing
  - Private health scheme

- QI
  - First Aid
  - Product
  - Knowledge
    - Technical skills
PRIORITIZATION

What is it?

Prioritisation is important at all stages in the Quality Improvement Cycle. It helps to decide what to improve in the first place – where to direct your time and effort; what possible solutions are the best to focus on, or to shortlist by going through a formal decision making process. Most importantly, it helps you to distinguish between what’s important, what is urgent and what will become both important and urgent when it is not dealt with.

Which techniques can we use?

There is a variety of prioritisation techniques. No single method will be appropriate every time, and all reflect different and complementary aspects of prioritisation:

Prioritisation Assessment is an analytical technique, which will lead you to the highest priorities from a business or quality viewpoint. Pareto may tell you which error occurs most often, but it may be that this is causing fewer problems to your customers than a less frequent but more serious errors. Prioritization Assessment will guide you in your consideration of these issues.

The Prioritisation Grid is most useful when you have a large number of options to consider, say after a brainstorming session. There is a tendency, reinforced by Pareto and Prioritisation Assessment, to focus on serious, complex and long term issues. It is obviously essential to do this, but it is easy to overlook the short term gains that are possible achieve at the same time which will yield immediate short term benefits and help to develop a momentum for Quality improvement.

Nominal Group Technique prioritises through voting by team members and so is useful where there is no clear priority from the other techniques, either because data is unclear or not available or because of strongly held and strongly argued advocacy of individual courses of action. NGT will take the heat out of a situation and allow all views on the subject to be taken into account.

Pareto Analysis should be used when you have the time and are able to gather data about a situation. This is not always possible if the situations you are analysing have already happened and are not likely to recur, or if you need a quick decision on which item is the priority and data collection would be time consuming. However, when possible, always use Pareto.
PRIORITIZATION ASSESSMENT

What is it?
In some instances, the priority among a number of issues may be in question and a method of setting priorities objectively can be of value. The objective of setting priorities is that of identifying the most important among a number of competing issues.

Since we all have a finite amount of time available, it is important that effort is devoted to those issues from which the organization would derive the most benefit.

Another instance where setting priority can be of value is where two or more people have a disagreement over which of the competing issues should take priority.

How is it done?
List the options available through discussion or Brainstorming.

The first step in the Prioritisation Assessment process is that of gathering information with respect to each specific issue. This is done by asking a series of process questions:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Process Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact Potential</td>
<td>How serious is the issue in terms of its impact on people, money, morale, the organization?</td>
</tr>
<tr>
<td>Timing</td>
<td>How critical is the effect of the passage of time?</td>
</tr>
<tr>
<td>Growth Potential</td>
<td>What is the probability of the issue expanding if it is not addressed?</td>
</tr>
<tr>
<td>Priority Number</td>
<td>What does the overall picture tell us regarding the order in which the issues should be addressed?</td>
</tr>
</tbody>
</table>

Guidelines
Deal with fact rather than opinion as far as possible. Ensure that the specific information is listed under the appropriate column.
PRIORITIZATION GRID

What is it?

Prioritisation Grid is a simple way of deciding which of a number of improvement opportunities to tackle first. It helps to prevent smaller, simpler improvements from being overlooked.

When should it be used?

Use regularly to take stock of what needs to be done and in what order to keep on top of changing priorities.

How does it work?

Write the improvement opportunities in the grid in the appropriate box on the long term/short term, easy/difficult scales.

Always do some of the short term/easy opportunities first to generate a momentum if improvement. Publicize your success.

Put in hand long term/easy projects, and plan carefully for short term difficult.

Draw the grid on a flipchart, and write the opportunities on ‘Post it’ notes. This helps you to adjust relative positions as the grid develops.

Example: Prioritisation Grid:

<table>
<thead>
<tr>
<th>Hard to do</th>
<th>Easy to do</th>
<th>Short term</th>
<th>Long term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit good new staff</td>
<td>Acquisitions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attract new customers</td>
<td>New market sectors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New territories</td>
<td>Service improvements</td>
<td></td>
<td>New products/services</td>
</tr>
<tr>
<td></td>
<td>Management development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop existing customers</td>
<td>Increase sales activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase sales activity</td>
<td>New territories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discounts</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOMINAL GROUP TECHNIQUE

What is it?

Nominal group technique is a method for prioritising or ranking a number of ideas or suggestions.

When should it be used?

Nominal group technique can be used whenever a group decision needs to be taken on the relative priority or importance of alternatives. It
helps to achieve a consensus decision and so is particularly helpful to ‘take the heat’ out of decision-making when participants in the group have strongly held views or entrenched positions.

**How does it work?**

- Identify the issue to be addressed.
- Members of the group write down alternatives/options, in silence, without discussion.
- Each member of the group presents one idea in turn. These ideas are recorded. Participants take turns until all ideas are listed.
- The ideas are discussed, without evaluation, to clarify their meaning only.
- The group votes on each suggestion, either by ranking the items or by having a limited number of votes to assign.
- The options are ranked by the voting scores.

**SIX WORD ANALYSIS**

**What is it?**

A simple check list for e.g. exploring a problem, most famously originally described by Rudyard Kipling:

“I kept six honest serving-men, (They taught me all I knew); Their names are WHAT and WHY and WHEN and HOW and WHERE and WHO”.

**When should it be used?**

The check list can be used for problem identification, cause identification and planning. It is a simple check to help you to consider all aspects of a problem, or the effects of possible solutions.

**How does it work?**

Define the issue/subject. State it clearly. Construct a Six Word Analysis. Two examples appear below.
Example: Six Word Analysis:

<table>
<thead>
<tr>
<th>Subject: Office Relocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHY:</td>
</tr>
<tr>
<td>- do I need to relocate in the first place?</td>
</tr>
<tr>
<td>HOW:</td>
</tr>
<tr>
<td>- long a lease do I really need?</td>
</tr>
<tr>
<td>WHAT:</td>
</tr>
<tr>
<td>- floor space will I need?</td>
</tr>
<tr>
<td>WHEN:</td>
</tr>
<tr>
<td>- will I be ready to move?</td>
</tr>
<tr>
<td>WHERE:</td>
</tr>
<tr>
<td>- do I want to be positioned?</td>
</tr>
<tr>
<td>WHO:</td>
</tr>
<tr>
<td>- will I use to help me in relocating?</td>
</tr>
</tbody>
</table>

TYPES OF ISSUE

What is it?

An issue is something, which we have to do something about to address, to tackle. Issues can be thought of as: ‘things which will not go away’ even if we try to ignore them. Denial is never a good strategy.

(However, there is always a good time and a bad time to confront any particular issue, and prioritisation of addressing them is important: see sections on Prioritisation).

What sort of issues are there?

Issues can be to do with individuals, with jobs, with functions, with plant and equipment, or with whole businesses and markets.

Whatever the concern is about, issues fall into one of three time-based categories:

- **Problems** – which have their origin in the past
- **Decisions** – which have their origins in the present
- **Plans** –which have their origins in the future

**How do I determine which sort of issue I face?**
By using this simple process:

1. **Clarify the Issue**
   What facts are available? How specifically can I describe it? What examples are there to amplify the issue?

2. **Identify the type**
   Has something gone wrong – is there a deviation for which I need to know the cause? If so, there is a Problem to solve.
   Do I need to make a choice between alternatives? If so, there is a Decision to make.
   Do I need to implement a Decision? If so, there is a Plan I need to create.

   **What do I do next?**
   Apply the appropriate process – see sections, which follow.

**PROBLEM SOLVING**

**What is it?**

The Problem Solving Process provides a structure for selecting the most effective course of action for solving problems. It is composed of a series of linked questions designed to identify causes systematically to provide a sound basis for correcting and eliminating them.

**What is a problem?**

It is a deviation from that which was expected or planned: a deviation from a standard or norm:

The Problem Solving Process has eight Stages

1. Problem Statement
   A focus for our thinking
2. Problem Scope
3. Problem Limits
4. Differences
5. Changes
6. Possible Causes
7. Factual Evaluation
8. Verification
COMPETITIVE BENCHMARKING

What is it?

Competitive Benchmarking is the systematic comparison of your product and service quality with other similar groups to identify ‘best practice’. You need to ensure that your quality meets or exceeds that of your competitors. Where you do not measure up to the benchmark, competitive benchmarking allows you to analyse the other groups’ processes and adopt the ‘best practices’.

When it should be used?

Competitive benchmarking should be used at all stages in the Quality Improvement Cycle, from the selection of improvement areas, through improvement activities and implementation, to ongoing monitoring and review.

How does it work?

â€” Decide what aspects of your product or service to benchmark. This would usually be decided in relation to customer expectations, but also by looking at the key process measures and input measures which may not be apparent to the customer.

â€” Decide whom to benchmark. This may be a direct competitor or an organization that is widely recognized as the best in the industry or sector. However, it can also be useful to compare yourself with other similar groups within the company, say one department with another, or with functional groups like your own in completely different organizations, e.g. your payroll group may compare itself with payroll groups in other similar businesses.

â€” Collect data on the other group’s performance. Often you can approach the other group directly. They can learn from you, while you learn from them. If the other group is a direct competitor who would not respond to a request for information, you can still gather data from published sources, e.g. newspapers, magazines; your customers, who have experience of competitors; your staff, who may have worked for competitors; and organizations such as trade associations, from their comparisons of industry sectors.

â€” Analyze the data. Why are the other groups better or worse than you? Is it due to their policies, their performance or a physical or logistical constraint? What can you learn for improvement?

â€” Implement the lessons learned and combine to monitor the other groups’ performances. They will be improving as well.
Statistical methods

Systems theory and SPC - Statistical Process Control

The scientific quality approach is mainly based on a systems theory. The starting point is that all work is a process and part of a system. A system is a group of parts that interact to accomplish something. According to the systems theory, when the aim is to optimise activity it is essential to understand how the parts of the system interact. Systems aim at stability (minimization of variation). The development of quality is based on the management of stability and, after that, on conscious deviation from stability.

Techniques have been developed based on systems theory to manage and analyse the variation of processes (the system). One commonly used technique is the SPC (statistical process control), in which the aim is to identify variations in the process variables and the specific and random factors which cause such variations. A control chart is often used to identify variations, which makes it possible to identify the normal variations of the variable, which is being examined (random factors) and the measurement results outside the normal variations (specific factors). For the purposes of the development of quality, attention should be focused on the measurement results that are detected outside the normal variations. There is plenty of literature and training available concerning systems theory and SPC.

Other statistical techniques

More developed tools are also available for health care organizations as well as other enterprises. These methods like Taguchi, Six Sigma or the Quality Function Deployment (QFD) enable the health care organization to analyze its performance, the properties of its products etc. in a much more systematic way than we have been accustomed to so far. In general, these methods have been used very little by health care organizations so far. Lack of resources has forced health care organizations to improve their performance. The existing variation is also a challenge to be met. The experiences from other enterprises suggest that the use of these methods could also save resources thus helping health care personnel to manage the growing workload. The health care expert needs to be trained for these methods if they are to use them in their everyday practice.
REFERENCES

2. A.F. Al-Assaf, and Mubashar Sheikhi, Quality Improvement in Primary Health Care, WHO, Regional Office for the Eastern Mediterranean, Cairo 2004
3. A.F. Al-Assaf, Health Care Quality, An International Perspective, WHO, Regional Office for South East Asia, New Delhi, 1997
13. Building an Effective Patient Safety Program

P. Pierce, RN

Issues pertaining to medical errors have gained international attention. There have been numerous studies documenting a very grave situation in which there have been needless patient deaths and injuries due to preventable medical errors. Even in the best of healthcare delivery systems, it has become evident that serious errors resulting in patient harm or death can, and will, happen. As the complexity of our systems increase, so does the risk of error. It has been reported in various publications that upwards to 80% of all medical errors are systems-related. It is now more pressing than ever for organizations to invest the time, energy and resources necessary in order to develop an effective patient safety program.

The Institute for Healthcare Improvement (IHI) states that, “Leadership is the critical element in a successful patient safety program and is non-delegable.” It further states that the role of leadership is to:

• Establish the value system of the organization
• Set strategic goals and align organizational efforts to achieve these goals
• Provide resources for the creation of effective systems
• Remove obstacles for clinicians and staff
• Require adherence to practices which will support patient safety.

Culture of Safety

Key to the development of a successful patient safety program is striving for a Culture of Safety. Dr. James Reason references a “just culture” which supports the discussion of errors so that lessons can be learned from them. The critical component of this concept is the need to encourage and support the reporting of any patient safety issue, whether it is an actual event resulting in a negative outcome, or the risk of having such an event. This open communication is the hallmark of an organization’s having attained a culture of safety.

Completing a cultural assessment is essential to the development of a culture of safety. This process includes completing a survey of all levels of the organization in order to determine beliefs pertaining to reporting errors, resistance to change, as well as, to determine what gaps or obstacles in the system need to be addressed. Once the assessment is complete, a plan for implementation of changes, timeline, and accountability assignments should follow.
Occurrence Reporting

The process for reporting a medical error/occurrence or a high risk situation should be as simple as is possible. The most typical reporting method is through the use of an occurrence report (ATTACHMENT 1) which may be designed to cover a wide variety of events. Due to the complexity of the medication management process, it may be beneficial to utilize a separate medication error reporting form in order to capture enough detail to fully analyse the situation (ATTACHMENT 2). While utilizing an occurrence report is, perhaps, the most common-sense way to collect this information, there is much that needs to be considered in order to make the system effective. Issues to consider include:

- Development of an anonymous reporting form, which is simple for front line staff members to complete
- Creation of incentives or rewards for reporting
- Provision of education to management and staff as to the rationale for encouraging the reporting of errors
- Adoption of a non-punitive environment which encourages reporting
- Establishing a baseline
- Responding in a timely manner to reports and involving front-line staff directly involved in the process in actions taken to remedy the situation
- Closing the loop by communicating with staff regarding any performance improvement activities undertaken in response to occurrence report data
- Soliciting staff input into redesign strategies
- Posting results of monitoring in graphic displays in staff and/or public areas in order to heighten awareness and emphasis as to the criticality of these activities
- Involving patients in the process, such as by participating in work redesign teams

Program Structure

An organization has several options as to the structure of a patient safety program. Of great importance is the need to have multidisciplinary involvement. Integration of patient safety and quality improvement activities should increase the efficiency and effectiveness of the program. This can be accomplished by either combining the patient safety and quality improvement functions under one committee, e.g. a Quality Council, or having a separate Patient Safety Committee that reports to the Quality
Council. Medical staff participation is elemental to the success of the program. The senior administrator responsible for the quality improvement activities of the organization may oversee the program. Another approach would be to create a risk management position. Such a position would generally be filled by someone with a clinical background who has had experience in dealing with quality and patient-safety related issues. The primary focus for such a position would be to:

- Monitor situations, which place the patient and the organization at risk for a negative outcome and address such situations in a proactive manner
- Aggregate, analyse, and report data obtained through the occurrence reporting system
- Lead the investigation of significant occurrences such as sentinel events
- Collaborate with others on the development of risk reduction and remediation strategies
- Provide Leadership, Administration, and the Governing Body with regular status reports on these activities
- Educate all levels of staff on the importance of the patient safety program and the occurrence reporting system and regarding initiatives undertaken, based upon information received through the occurrence reporting system.

High Volume/High Risk Processes

Addressing the high volume/high risk processes of any healthcare organization is an enormous undertaking. It is important to build in a system that has multiple safety-checks. Even the best of systems can still suffer what Dr. James Reason describes as a “latent failure.” His well-known diagram of the “Swiss Cheese” model of complex systems failure has been widely used in discussions pertaining to medical errors. Reason’s theory is grounded in the belief that medical errors are the result of systems failure and not solely based upon the actions of an individual. He theorizes that serious medical errors are the result of the combination of latent and active failures. Latent failures are weaknesses built into a system due to poor design or decisions and which weaken the system’s defenses. Active failures are actual errors made by individuals providing the service or care. If these two forms of failure align, the result can be a catastrophic incident resulting in patient injury or death. Reason’s “Swiss Cheese” diagram depicts the process of failures at successive levels of defense by aligning the holes in the cheese to demonstrate the vulnerability in the system which results in the disaster. This model can be transposed upon the complex...
healthcare delivery system in which there are multiple opportunities built in
to catch an error but which, even in the best of organizations, can fail.

Given the inordinate complexity of the healthcare delivery system, it
is critical to be able to analyse each step in an individual process. For
example, when evaluating the blood administration process the following
aspects of care must be evaluated:

• Ordering
• Distribution
• Administration
• Monitoring the effects

The monitoring of this high-risk process starts with the physician’s
order. The medical staff may have already established criteria for blood
administration. Therefore, before a physician orders blood, he needs to
determine whether or not the patient’s hemoglobin and hematocrit are low
enough to warrant administration of blood. The administration of blood is a
high risk process which can result in patient injury or death if the patient
suffers a transfusion reaction. In addition, blood products are scarce in most
parts of the world and are quite expensive to process. Thus, there is a need
to monitor the ordering component of this process.

The process for distributing the blood is multi-phasic. The nursing
unit must communicate to the lab that the physician has ordered the blood.
The lab must, in turn, draw a specimen for the type and crossmatch. The lab
 technician may place a special numbered armband on the patient at this time
which links the patient and the blood specimen. The lab must make certain
that they are crossmatching blood for the correct patient with the correct
blood specimen. When the blood is released from the lab to the nursing
unit, the nurses must check to be certain they are receiving the correct unit
of blood for the patient. As is demonstrated by this discussion, there are
multiple components to the distribution aspect of blood administration.

When the nurse goes to the patient’s room to hang the blood, he or
she must first verify that the correct unit of blood is being hung for the
correct patient. A double check system involving two caregivers is
preferable. Once it has been verified that it is the correct unit of blood, the
transfusion begins. As the development of a transfusion reaction is a
significant event, the nurse must monitor the patient closely while the unit is
running. The patient’s vital signs will be monitored for any sign of a
reaction. It is, also, important that the nurse run the transfusion in over an
appropriate amount of time. If the unit hangs for too long, the blood begins
to break down, which poses a risk to the patient. All of these issues are a
clear indication of the need for monitoring the administration of blood, as
well as, to monitor the effects of the transfusion.
This same ordering/distribution/administration/monitoring the effects model can be used for medication administration. Specifically, one would consider the following:

- **Ordering** — legibility, use of abbreviations, correct dose and frequency, appropriateness of the medication, completeness of the order
- **Distribution** — pharmacy placing the correct medication in the correct patient’s bin or medication drawer, with medications that may be mistakenly administered in an alternate route (e.g., IV rather than via a feeding tube) clearly marked with the route
- **Administration** — right patient, drug, dose, route and time
- **Monitoring the effect** — adverse or allergic drug reactions, food/drug or drug/drug interactions

It is obvious, given the above examples, that the need to have a systematic and consistent manner to monitor and analyze all aspects of high risk processes is critical.

**“PATIENT SAFETY SOLUTIONS”**

In 2005, the World Health Organization (WHO) established the World Alliance for Patient Safety. Six action areas were identified, to include the development of “Solutions for Patient Safety.” Later that year, WHO announced that Joint Commission International (JCI) had been designated as a WHO Collaborating Centre for Patient Safety Solutions, chartered to develop and disseminate solutions for world-wide patient safety concerns. Activities will be focused upon design of optimum processes which will prevent errors from reaching the patient. WHO defines the term “Patient Safety Solution” as “any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.”

Patient Safety Solutions selected nine high-risk processes as its initial undertaking:

1. Look Alike-Sound Alike Medication Names
2. Patient Identification
3. Communication During Patient Hand-Overs
4. Performance of Correct Procedure at Correct Body Site
5. Control of Concentrated Electrolyte Solutions
6. Assuring Medication Accuracy at Transitions in Care
7. Avoiding Catheter and Tubing Mis-Connections
8. Single Use of Injection Devices
9. Improved Hand Hygiene to Prevent Health Care-Associated Infection
Look Alike/Sound Alike Medication Names

There are a multitude of steps involved in the medication delivery system, any one of which can fail and lead to a medication error. Problematic issues include:

- Legibility
- Unclear dose expressions to include the use of a trailing zero (X.0) or a decimal point without a leading zero (.X), both of which can result in a medication overdose
- Dangerous abbreviations such as “QD” which may be misread as part of the medication dose, resulting in a medication overdose
- Range orders (“Demerol 25-50 mg IV every 3-4 hours prn pain), which places nurses in the position of “prescribing” the medication, in essence, as they choose which dose and which time to administer the medication

While all of the above-noted issues have a negative impact on the medication delivery system, WHO selected Look-Alike, Sound-Alike Medication Names as one of the nine problems to be addressed by Patient Safety Solutions. As medical technology increases, so does the need for new medications. In 2004, the US reported having in excess of 33,000 trademarked and 8,000 nonproprietary (generic) medication names. Both The Joint Commission and the Institute for Safe Medication Practices have posted look-alike, sound-alike (LA/SA) medication lists. Note the use of “tall man lettering” which differentiates the following medications from one another:

- humALOG versus humULIN
- epINEPHrine versus epHEDrine
- diTROPan versus diPRIVan
- novoLIN versus novoLOG

In addition to the sound-alike medications, there has been a considerable amount of attention given to “look-alike” medications which could be easily mistaken for one another. In 2006, there was a very tragic medical error which occurred in the US in which six premature infants were given Heparin Sodium Injection 10,000 units/mL rather than Hep-Lock Solution 10 units/mL. It was reported that three of the infants died as a result of this error.

In spite of considerable efforts to the contrary, new medications continue to be approved with names that are similar to that of another medication. Strategies to reduce the risk of LA/SA errors include:
• Requiring that all prescriptions and medication orders include the brand name and generic name, dosage form, strength, directions, and indications
• Storing LA/SA medications in separate areas from one another and NOT using an alphabetic storing system in the Pharmacy
• Using “tall man” lettering in order to emphasize the spelling differences
• Providing regular LA/SA education to staff
• Reviewing each new medication closely in order to ascertain that it will not pose a LA/SA risk before adding it to the formulary
• Placing different colored labels or using different colored syringes for medications which can only be given one route - e.g. oral medications, so that a staff member does not inadvertently give the medication intravenously
• Printing clear alert messages for staff when dispensing medications from the Pharmacy
• Limiting the practice of accepting verbal or telephone orders to emergent situations only, as this is an area that is high risk for a sound-alike error being made in transcription
• Labeling each medication with both the brand name and generic name
• Providing patients with detailed education regarding their medications so that they are alert to the possibility of a LA/SA error

Patient Identification

Failure to correctly identify patients can result in any manner of medical errors to include administration of the wrong medication, wrong site/wrong patient surgery, blood transfusion errors, test/procedure errors, treatment errors based upon the wrong test results, and even discharging a newborn to the wrong family. In 2003, when The Joint Commission approved adding National Patient Safety Goals to the accreditation process, correct patient identification was the first goal.

Staff education will have a positive impact on the patient identification process. Staff members must be held accountable for verifying that they have the correct patient before giving medication, obtaining specimens, or performing any test, treatment or procedure. Even the most attentive staff members can get distracted and make an error due to misidentification of a patient. Instituting a process for requiring two patient identifiers will reduce the risk of errors, particularly if the use of the room number as one of the identifiers is forbidden. Typically, the patient’s name and either date of birth or medical record number are selected as the
identifiers. The patient should be asked his or her name, rather than just being required to acknowledge whether or not the staff member had it correct. While this may have the potential to annoy the patient/family, it is clearly in their best interest for staff to be diligent in the identification process. Should the patient be unable to identify him/herself, a second staff person or a family member would then verify the patient’s name. Patients and family members should be encouraged to be active participants in the patient identification process.

Phlebotomists must be required to label the specimens at the patient’s bedside or in the patient’s presence to decrease the chance that they will get distracted and label the tube with another patient’s name. Also, staff must be attentive when posting test results on a patient’s medical record or when communicating results by phone to the nursing staff or physician. In these instances, the two identifiers apply, as well.

**Communicating During Patient Hand-Overs**

Patients are typically cared for by multiple practitioners, staff persons, and departments during a course of treatment. This has become increasingly true as medical technology has expanded and medical specialists have become more available. Communication gaps between caregivers disrupt the continuity of care and pose patient safety risks. Joint Commission has cited communication breakdown as the leading cause of sentinel events reported to the Joint Commission for the 1995-2006 time period.

Hand-over communication is the process of providing patient-specific information from one caregiver to another. These hand-overs may take place during shift change on a nursing unit, upon transferring a patient to another unit or facility, when transferring care to a call partner or consultant, and at discharge when the patient’s care is transferred back to the primary care physician or to a provider such as home health care. The information shared typically includes the patient’s current condition, care needs, treatment goals, and any recent changes in the patient’s condition. There is not a universally accepted protocol for this hand-over process, although this is a topic of much study and discussion currently.

The most critical feature of this *active* communication process is that the person receiving report is allowed the opportunity to ask questions before assuming responsibility for the patient’s care. One methodology that has been adopted by many hospitals in the US is called “SBAR,” which stands for:

- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation
While the specific methodology chosen is up to each Organization, the primary focus remains the need to establish an organization-wide standardized process for hand-over communication. Involving staff in the initial decision-making/selection process for the hand-over communication methodology should include development of a checklist of critical pieces of information to share with the next caregiver. It may be helpful initially to post reminders in report areas until the process becomes second nature for staff. Education will need to be built into the initial orientation and ongoing staff education programs, as well, to include the medical staff. As with other patient safety-related activities, patients and families should be encouraged to be actively involved in their healthcare decisions and knowledgeable about their medical conditions and healthcare needs.

**Performance of Correct Procedure at Correct Body Site**

Wrong site surgeries, while not as prevalent as other medical errors, are extremely high profile events when they do occur, with potentially devastating consequences for the patient. These are considered to be preventable situations which occur due to communication breakdowns, insufficient information or faulty assumptions on the part of surgical/procedural team member(s). Evaluation of root cause analyses performed for wrong-site surgeries has revealed the following contributing factors:

- Lack of consistent process for marking the surgical site
- Lack of consistent process for the surgical team to verify the procedure before it begins
- Incomplete patient assessment, to include unavailability of necessary information such as radiology films
- Communication barriers among members of the surgical team, with not all members feeling as though they are “equals” to the other team members and, as a result, are hesitant to voice concerns or questions
- Surgical scheduling issues such as cases running behind, which lead to staff stress and pressure to get the case done quickly
- Multiple surgeons involved in the case
- New equipment in the operating room
- Unusual physical characteristics of the patient, either anatomically or related to morbid obesity
- Emergency cases
- Multiple procedures being performed during a single visit to the OR
The Joint Commission has done an enormous amount of work with multiple professional organizations on the development of a “Universal Protocol” for prevention of wrong site surgery. The steps of this protocol include:

1. Pre-procedure verification, which includes the patient, site, side, and implants or prostheses, as applies. Missing information (e.g. x-rays) or discrepancies must be addressed before the case begins.

2. The person performing the procedure should mark the site unambiguously (e.g. “X” is discouraged as it means “NO” to many) with an indelible ink marker. The patient should be involved in the verification process. The site should be marked if it involves right/left distinction, multiple structures (fingers, toes), or levels (epidurals, spine procedures).

3. Prior to the start of the case, all members of the surgical team must take a final “timeout” surgical pause in order to verify all of the above. The timeout process should be documented in the patient’s record, to include the names/disciplines of all persons participating in this verification process.

Control of Concentrated Electrolyte Solutions

Misadministration of concentrated electrolytes has resulted in numerous patient deaths. The physiologic impact of these medications is so dramatic that attempts at clinically reversing the process are seldom successful. Strategies proven to prevent such errors include:

- Remove all concentrated electrolytes from floor stock, storing them only in the Pharmacy.
- Require that all electrolyte solutions, such as intravenous potassium chloride/phosphate and hypertonic (>0.9%) saline, be prepared by a trained and qualified pharmacist or, in the absence of a pharmacist, a trained and qualified individual (pharmacy technician, physician or nurse).
- Standardize and limit drug concentrations.
- Use premixed electrolyte solutions when available.
- Provide staff education regarding the dangers associated with administration of electrolytes.
- Assess staff competence to prepare and administer concentrated electrolytes.
- Require that a second trained and qualified individual verify electrolyte solution, utilizing a checklist during the process (concentration calculations, infusion pump settings, and correct line attachments).
- Flag the medication with a HIGH RISK WARNING label.
• Utilize an infusion pump to administer the concentrated electrolyte solution or, if pump is unavailable, use a device to control the drip rate (e.g. Buretrol tubing).
• Monitor the patient and infusion rate closely.
• Require that physician orders for concentrated electrolytes are complete, to include the rate of the infusion.

Assuring Medication Accuracy at Transitions in Care

Medication errors may result in several hundred thousand patient deaths each year. One critical point in the medication management process is reconciling the patient’s medications upon entry into the healthcare system, transfer to a new level of care, and at discharge. Reconciliation is done in order to avoid errors related to omissions or duplications (often associated with generic versus name-brand drugs), as well as, to prevent adverse drug reactions (drug/drug or food/drug) or dosing errors.

The medication reconciliation process recommended by Joint Commission consists of five steps:
1. Compiling a list of the patient’s current medications (referred to as the “Best Possible Medication History” (BPMH) by WHO)
2. Obtaining a list of medications being prescribed
3. Comparing the lists
4. Making clinical decisions based upon the comparisons, which includes whether or not to continue or discontinue the patient’s home medications upon admission to the facility
5. Communicating the new list to the patient and to caregivers

The medication reconciliation process must occur any time the patient is admitted, transferred or discharged from a facility. These “interfaces of care” are the points at which most reconciliation errors are made. Anytime a discrepancy is noted, the prescriber must be notified and changes to the orders made, as appropriate. Involving the patients and families in this process is an important step. Educating patients to keep a current and complete list of all medications with them will make the reconciliation process much smoother. Unfortunately, many patients possess minimal knowledge regarding their medications, dosages, and indications, which makes the information gathering process especially challenging.

Strategies, which have been shown to improve the medication reconciliation process and reduce medication errors, include:
• Develop a standardized system to collect and document complete information on all of the patient’s medications, to include over-the-counter medications, nutritional supplements, herbal preparations, and
vitamins. List the source of the information and contact the patient’s pharmacist or primary care physician for additional information, if needed.

• Adopt and enforce policies and procedures which cover reconciliation and updating the medication list each time the patient is admitted, discharged, transferred or changes level of care within the facility. Utilize a standardized form for this process.
  • Place the list of home medications in a prominent place in the medical record so that it is easily seen.
  • Involve patients and families in the process, to include education pertaining to safe medication use, the medications they are taking, the indications for the medications, as well as, any possible side effects or adverse reactions they may experience.
  • Communicate the patient’s list of medications to the next level of care.
• Provide patients and families with an easy tool to use for keeping a current and complete list of all medications. Encourage patients to use a single pharmacy and to keep all treating physicians aware of medications, which have been added by other physicians.
• Provide ongoing staff education regarding the medication reconciliation process. Monitor the effectiveness of this education, as well as, staff compliance through auditing the completeness of the reconciliation process. Also, monitor for medication errors related to this process.
• Discourage prescribes from writing “blanket” orders, such as “continue home medications” or “resume preop medications”, as this weakens the reconciliation process and increases the chance of an error. For example, a patient may be admitted to the hospital for an acute myocardial infarction and is placed on heparin. If the patient is taken to the operating room for bypass surgery and postoperatively the surgeon writes, “resume preop medications”, a catastrophic medication error could be made resulting in the patient’s death due to postoperative hemorrhage. Use of blanket orders instills a false sense of security and minimizes the critical thinking needed in order to effectively perform the reconciliation process.

Avoiding Catheter and Tubing Mis-Connections

Tubing and catheter misconnections, which can result in patient death or permanent disability, are an increasing patient safety risk due to the multiple lines a patient may have at any given time. This is a direct result of our expanding medical technology and treatment options. Tubing misconnections include the following possibilities:

• Enteric feeding tube to a peripheral or central intravenous line
• Bladder irrigation to a peripheral or central intravenous line
Intravenous infusion to an epidural line
Epidural infusion to a peripheral or central intravenous line
Capnography sampling tube to an intravenous cannula
Enteral feeding tube to a hemodialysis line
Oxygen tubing to an intravenous catheter
Blood pressure insufflator tube to a peripheral or central intravenous line

In addition to tubing misconnections, staff may make errors related to directly administering medications through the wrong tube or line. Examples of this would include the misadministration of an oral medication (e.g. antacid or cough syrup) into an intravenous line rather than through the intended gastric tube. Root cause analysis of tubing misadministration events has revealed the following contributing factors:

- Use of Luer-lock connectors which are used extensively to link medical devices and lines, to include tubes or catheters which are functionally dissimilar
- Use of extension tubing for unintended purposes, such as to extend feeding tubes, or irrigation, epidural, or central lines
- Positioning functionally dissimilar lines and tubes in close proximity to one another
- Transferring a patient to a new care setting, without appropriate hand-over communication
- Staff fatigue related to working consecutive shifts (e.g. double shifts)

Strategies, which have been proven to decrease the occurrence of tubing misconnections, include:

- Label all tubes and catheters, particularly those that are high-risk in nature (e.g. epidural, arterial, central).
- Colour-code tubes and lines.
- Require that staff trace all lines back their origin before connecting/disconnecting devices or lines and before administering medications.
- Include review of all tubes and catheters during staff communication hand-overs.
- Refrain from using Luer-lock syringes to administer oral medications or enteral feedings.
- Educate staff regarding the dangers of tubing misconnections and strategies to prevent this type of error.
- Purchase products which have been designed to enhance safety and prevent misconnections and examine all new products for potential misconnections risks.
• Educate patients and families that they are not to disconnect or reconnect devices and are to call staff for assistance.

Single Use of Injection Devices

Unsafe injection practices, including reuse of needles and syringes, have resulted in the spread of HIV, hepatitis B and hepatitis C. The WHO developed a mathematical model which suggests that in the year 2000, reuse of injection devices accounted for an estimated 22 million new cases of Hepatitis B, two million cases of Hepatitis C, and approximately 250,000 cases of HIV. Add to this the reality that there are millions of people worldwide who are intravenous drug users, and it becomes apparent that the negative impact on world health is staggering. It is imperative that immediate action is taken to educate healthcare workers in order to stop the dangerous practices, which place patients at extremely high risk for contracting a chronic or life-threatening blood-borne disease.

Strategies, which have been recommended by WHO in order to reduce the risk of patient harm, include:

• Make single use of injection devices a high priority on an organizational, national and international level.
• Provide ongoing education to healthcare workers regarding basic infection control principles and practices, the effectiveness of non-injectable medications (to include patient/family education regarding same), and new safety injection alternatives (e.g. “needle-less” systems).
• Evaluate the effectiveness of the healthcare worker training programs.
• Provide education to patients and families regarding treatment alternatives to injectable medications, transmission of blood-borne pathogens, and safe use of injectable devices.
• Adopt safe waste management practices.
• Consider adoption of a “needle-less” system.
• Allocate sufficient resources in order to promote organization-wide safe practices, to include the process for procurement of equipment.

The initial cost of the newer “needle-less” systems may be higher than the standard needle and syringe systems. However, it is likely that an organization’s cost: benefit analysis will give evidence of an overall decrease in the cost of care as the incidence of infections associated with re-use of injection devices is eliminated.
Improved Hand Hygiene to Prevent Health Care-Associated Infections

Healthcare-associated infections (HAIs) may affect more than a million patients per year worldwide. While hand hygiene has been clearly shown to reduce the incidence of HAIs, hand hygiene compliance among healthcare workers is low. Suggested strategies for improving hand hygiene include:

- Make hand hygiene an organizational priority, to include allocation of appropriate resources and leadership commitment.
- Adopt the WHO Guidelines on Hand Hygiene in Health Care, which include a focus on multidisciplinary, multimodal strategies:
  1. Make alcohol-based handrubs readily accessible at the point of care.
  2. Ascertain that caregivers have access to safe continuous water supply at all taps.
  3. Provide education to healthcare workers regarding correct hand hygiene techniques.
  4. Post hand hygiene reminders.
  5. Monitor hand hygiene compliance through direct observation and staff feedback.
  6. Consider local production of handrubs using WHO recommendations in areas where alcohol-based handrubs are not available or are too costly.

Encourage staff to wash their hands in the presence of patients prior to touching them. In addition, it is important to educate patients and families regarding hand hygiene and empower them to remind staff to practice good hand hygiene.

Conclusions

It is evident that patient safety is an international concern. The World Health Organization is making strides in this area through the activities of the Collaborating Centre for Patient Safety and Patient Safety Solutions. Patients can only benefit from any activities which involve collaboration of a multidisciplinary team, most especially if it involves international healthcare leaders. There are a wide variety of patient safety resources available through the internet (ATTACHMENT # 3).

On an organizational level, every effort should be made to adopt a true culture of safety. Encouraging and empowering staff to provide open and honest assessments as to the safety and effectiveness of the care delivery system, as well as, sharing any medical errors or near-miss situations will
bolster the integrity of the system. Improved patient outcomes, increasing patient and staff satisfaction scores, increased staff retention, and lower costs of care due to fewer complications will solidify an organization’s place in the healthcare community locally and at large.
REFERENCES


ATTACHMENT 1

Non-Employee Occurrence Report

Confidential: DO NOT photocopy. Forward to your Manager. DO NOT place in the patient record. This information is used for evaluating the quality of patient care, made for the purposes of reducing morbidity or mortality, and as such privileged pursuant to the Oklahoma Statute Title 63, Section 1-1709/1709.1

ALL BLUE SECTIONS MUST BE COMPLETED ON ALL OCCURRENCES

PRINT ALL INFORMATION

Date of occurrence: ___________ Time of occurrence: ___________ Location (dept, unit, room #): __________________

Person involved (use patient ID sticker below, or name-last, first):

Status: __ Patient __ Visitor __ Volunteer __ Medical Staff __ Student __ Agency __

Address:

__________________________________________________________________________

FOR PATIENT OCCURRENCES ONLY: Admitting Dx:

__________________________________________________________________________

DESCRIPTION OF THE OCCURRENCE ____________________________________________

__________________________________________________________________________

Patient Assessment after event:

__________________________________________________________________________

Area event occurred:

__Patient Room __Patient Bathroom __Other patient area __Public area (inside)

__Hospital grounds (outside) __Corridor __Stairway/elevator __Patient's Home

__Physician's office __Other (specify) _____________

Mental Status PRIOR to event:

__Alert __Confused/disoriented __Sedated __Unconscious __Other ______

NATURE OF OCCURRENCE: (CHECK ALL THAT APPLY)

Falls

Bed position __High __Low __ NA
Bed Alarm __On __Off __ NA
Side rails __Up __Down __NA
Restraints __Yes __No __NA
Type:

High Risk Fall? __Yes__No__NA

Notify Family of all falls.

Nature of Fall:

493
<table>
<thead>
<tr>
<th>Event Type</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slip/Trip</td>
<td>__Found on floor __From bed __From Chair/wheelchair/commode __Assisted to floor __While standing __Patient self reported, not witnessed __Other (specify) ________________</td>
</tr>
<tr>
<td>Treatment/Procedures:</td>
<td>__Incorrect procedure __Improper performance/technique __Wrong patient __Omitted/missed treatment __Improper prep __Undesired result/adverse reaction __Other: ______________________</td>
</tr>
<tr>
<td>Equipment:</td>
<td>__Unavailable __Expired date __Malfunction/breakage/defective __Incorrect Count __Improper utilization __Puncture by used sharp __Puncture by sterile clean sharp __Other: ___________________</td>
</tr>
<tr>
<td>Miscellaneous:</td>
<td>__Assault __Burn __Damage to facility __Left AMA __Consent __Missing __Not obtained __Suicide attempt __Unanticipated or unexplained death __Self inflicted injury __Elopement __Refusal of Medical Treatment __Altercation __Infectious disease exposure __Toxic/Hazardous material exposure __Other: ______________________</td>
</tr>
<tr>
<td>Damaged/missing property:</td>
<td>Notify Security</td>
</tr>
</tbody>
</table>

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Safe Medical Device Act (SMDA) Criteria: Medical use/misuse contributed to patient injury: Name of equipment: ______________________ ID #: ______________

Complete the following steps: 1. secure patient; 2. contain equipment, parts, packaging; 3. contact Risk Management or Clinical Equipment immediately; 4. forward to Risk Manager; 5. notify supervisor.

Name of Family notified: ___________Date: ___________Time: ___________
Name of Supervisor notified: ___________Date: ___________Time: ___________
Name of Physician notified (for all patient events): ___________Date: ___________Time: ___________
Exam/treatment ordered? __YES __NO __N/A __REFUSED. If yes or refused-nature of exam/test/treatment: _________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
Name(s) & title(s) of person(s) involved: ________________________________
Employee (y/n) _______________________________________________________
Witness name(s), address(es), phone number (if not employee)
___________________________________________________________________
___________________________________________________________________
Person completing form (print): ___________Person completing form (signature): ___________Title ___________Date/Time__________
FORWARD TO SUPERVISOR
PLACE PATIENT LABEL HERE
Deaconess Hospital
COMPLETED REPORT FORWARDED TO RISK MANAGEMENT
NON-EMPLOYEE OCCURRENCE REPORT

This Side to be completed by Supervisor
SUBMIT TO RISK MANAGEMENT WITHIN 72 HOURS OF OCCURRENCE: PLEASE PRINT ALL INFORMATION
Nature of injury Patient Visitor
__ No apparent injury
__ Anaphylactic reaction
__ Asphyxia required required
__ Burn/Scald
__ Concussion
__ Fracture/Dislocation
__ Infectious Exposure
__ IV Infiltration
__ Laceration/Abrasion/Skin Tear
__ Sprain/Strain/Contusion
__ Unknown at this time
__ N/A- property occurrence
__ Other: _____________________________

Patient
__ No injury
__ No medical exam/treatment required
__ Medical treatment given: no additional cost or length of stay
__ Hospitalization required
__ Medical exam/treatment refused
__ Death
__ Other: _____________________________

Visitor
__ No injury
__ No medical exam/treatment required
__ Medical exam/tx given
__ Medical exam/tx refused
__ Hospitalization required
__ Death
__ Other: _____________________________

CORRECTIVE ACTION (check all that apply)

<table>
<thead>
<tr>
<th>Policies, Procedures</th>
<th>Target/complete date</th>
<th>Initials</th>
<th>Equipment/ supplies/ facility</th>
<th>Target/ Complete date</th>
<th>Initials</th>
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<td>Evaluation</td>
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<td>Recommend Revision/change</td>
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<td>Recommend</td>
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<td>Develop</td>
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<td>Revision/change Immediately</td>
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<td>Enforce</td>
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<td>Tagged/Secure</td>
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<td>Monitor/Instructions</td>
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<td>Recommend Additional /purchase</td>
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<td>QI Monitor/ initiate</td>
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<td>Other</td>
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<td>In-service Education</td>
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<td>Individual Counseling</td>
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<tr>
<td>Competency demo</td>
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<td>Proctor assignment</td>
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<tr>
<td>Corrective action plan</td>
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ATTACHMENT 2
Medication Error Report
Confidential: Do not photocopy. This information is used for evaluating the quality of patient care, made for the purposes of reducing morbidity or mortality, and as such is privileged pursuant to the Oklahoma Statute Title 63, Section 1-1709.

COMPLETE ALL INFORMATION REQUESTED IN BLUE AND FORWARD TO SUPERVISOR.
PRINT ALL INFORMATION.

Date of error: ___________ Time (military) of error: __________ Location where initial error was made: __________________________________________________________________________________________
Medication(s) involved in Error: ________________________________________
Brief Description of error: __________________________________________________________________________________________

Type of Error:
□ Extra Dose □ Wrong drug □ Wrong patient □ Wrong Preparation □ Wrong route □ Wrong time □ Wrong administration technique □ Omission □ Other: ________________________________________________
□ Improper dose/quantity-Dose ordered: __________________ Dose given: __________________________________________

Prescribing Wrong dosage form-Med ordered: __________________ Med given: __________________

Node (Where in the medication process did the initial error occur?):
□ Prescribing □ Monitoring □ Documenting □ Dispensing □ Administering

Level of staff that made initial error:
□ RN □ LPN □ HUC □ Pharmacist □ CRNA □ Pharmacy tech □ Physician □ PA □ RT □ Other: __________________

Recommendations to avoid similar error:
________________________________________________________________________________________
________________________________________________________________________________________

Possible cause(s) of error (check all that apply):
followed □ Pump, failure/malfunction □ Pump, improper dose □ Transcription-inaccurate/omitted □ Workflow disruption □ Verbal order (confusing/incomplete/misunderstood) □ Written order (confusing/incomplete/misunderstood)

Factor(s) possibly contributing to the error:
□ Code situation □ Computer system/network down □ Cross coverage □ Distractions □ Emergency situation □ Factors not determined □ Identification failure □ No access to patient information □ Patient transfer □ Poor lighting □ Range order □ Shift changes □ Staff, agency/temp □ Staff, inexperienced □ Staffing, insufficient □ Work load increase □ Not determined: ____________

Supervisor and physician must be notified of all errors that reach the patient.
Supervisor notified: Yes _________ Date: _____________ Time: ________________ No
Physician notified: Yes _________ Date: _____________ Time: ________________ No

To be completed by Manager. Forward to Risk Manager within 72 hours.
Result of the error:
□ Airway/ventilation □ Antidote administered □ CPR administered □ Drug therapy started/change □ Hospitalization, initial □ Hospitalization, 1-5 days □ Hospitalization, 6-10 days □ Hospitalization, >10 days □ Laboratory tests performed □ Narcotic antagonist administered □ Observation initiated/increased □ Oxygen Surgery performed □ Transferred to higher level of care □ X-ray/MRI/other diagnostic test □ None □ Other: ____________

Actions taken to avoid similar error:
□ Communication process enhanced □ Computer software modified/obtained □ Education/training □ Environment modified □ Policy/procedure instituted □ Informed staff who made the initial error □ Formulary changed □ Informed staff who was involved in error □ Staffing practice/policy modified □ None □ Other: ____________

Severity Level/Outcome-Risk Management to complete:
□ Category A: Circumstances or events that have the capacity to cause error □ Category B: An error occurred; medication did not reach the patient □ Category C: An error occurred that reached the patient but did not cause harm □ Category D: An error occurred that resulted in the need for increased monitoring but no patient harm □ Category E: An error occurred that resulted in treatment or intervention and caused temporary patient harm □ Category F: An error occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm □ Category G: An error occurred that resulted in permanent patient harm □ Category H: An error occurred that resulted in a near-death event □ Category I: An error occurred that resulted in patient death
Product information (Pharmacy to complete)
Generic name: _____________________________________
Dosage form (e.g. cream, tablet, etc.):__________________
Intended route of administration: _____________________
Strength/concentration: ______________________________
______________________________________________________________________________
Signature of Pharmacy Coordinator Date reviewed: ________________________________

Additional Information/details not addressed previously:
______________________________________________________________________________
______________________________________________________________________________

Physician follow-up________ Date: ________________ Time: ____________
Signature of Unit Manager: ____Date: _______________Time: ______________
Signature of Risk Manager_________ Date: _______________Time: ____________

PLACE PATIENT LABEL HERE                  Deaconess Hospital
MEDICATION ERROR& SUSPECTED ADVERSE DRUG REACTION FORM
Not a Chart Form Form # PHR0040 (rev 06/22/05)

SUSPECTED ADVERSE DRUG REACTION FORM
Protected BY O.S. Title 63, 1-1709
An adverse drug reaction is defined as a detrimental response to a medication that is undesired, unintended and unexpected in doses recognized in accepted medical practice. The medication is discontinued, (and/or) A medication is ordered to treat the reaction, (and/or) The patient's hospital stay is prolonged.

Admitting Diagnosis: ____________________________________________
Allergies stated before reaction: ________________________________
Drug(s) suspected of causing reaction: ____________________________
Date/Time of reaction: ____________________________
Detailed description of reaction:
___________________________________________________________________
___________________________________________________________________
Treatment and action taken:
___________________________________________________________________
___________________________________________________________________

CHECK ALL THAT APPLY:
Allergic:
□ Anaphylaxis □ Fever □ Angioedema □ Urticaria
Cardiovascular:
□ Angina □ Hypertension □ Hypotension □ Tachycardia □ Bradycardia □
Syncope □ Dysrhythmia/palpitations □ QTc prolongation □ Asystole
<table>
<thead>
<tr>
<th>System</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>Hearing loss □Tinnitus□ Visual disturbance □Swallowing difficulty</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>□Diarrhea □Constipation □Nausea □Vomiting □ Ulceration/bleeding □Gastritis</td>
</tr>
<tr>
<td>Hepatic/renal</td>
<td>□Elevated liver enzymes □PT/INR (inc. or dec.) □BUN/creatinine □Metabolic balance □Hypokalemia □Hyperkalemia □Hypoglycemia □Hyperglycemia</td>
</tr>
<tr>
<td>Neurologic</td>
<td>□Headache □Seizures □Vertigo □Somnolence □Dyskinesia □EPS □Rigors/chills</td>
</tr>
<tr>
<td>Respiratory</td>
<td>□Wheezing □Dec. respirations □Inc. respirations □Cough □Bronchospasm</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>□Depression □Confusion □Hallucinations □Psychosis □Agitation □Combative</td>
</tr>
<tr>
<td>Skin</td>
<td>□Pruritus □Rash edema phlebitis □Flushing □Red man syndrome □Sweating</td>
</tr>
<tr>
<td>Hematologic</td>
<td>□Bleeding □Thrombocytopenia □Leukopenia □Thrombosis</td>
</tr>
<tr>
<td>Other</td>
<td>(describe):</td>
</tr>
</tbody>
</table>

Status of patient at time of report: Pt. Recovered □Yes □No □Recovering, but not fully recovered

- Physician notified: ____________________________ , M.D., Date: __________ Time: __________
- Pharmacist notified: ____________________________ , R.Ph./Pharm.D., Date: __________ Time: __________ Signature: ____________________________
- Supervisor/Manager notified: ____________________________ , Date: __________ Time: __________ Signature: ____________________________

Monitor and treat the patient and report the suspected reaction to the responsible physician. Document the suspected reaction in the patient’s medical record if confirmed by the physician. This form is not a permanent part of the patient’s medical record.

Forward to Risk Manager for review.

Pharmacy follow-up

- Mild ADR: A reaction that is self-limiting and requires no treatment and/or does not prolong hospital stay.
- Moderate ADR: A reaction that requires treatment and/or prolongs hospital stay.
- Severe ADR: A reaction that 1) is life-threatening or contributes to the death of the patient; 2) is permanently disabling; 3) requires intensive medical care; 4) or takes longer than 15 days for recovery to occur.
Current medications:
___________________________________________________________________
___________________________________________________________________
Pertinent labs:
___________________________________________________________________
___________________________________________________________________
Chart Review:
___________________________________________________________________
___________________________________________________________________
Drug Adjustment: □ Dose decreased □ Drug Discontinued
□ Extra Treatment Required □ Yes □ No
Prolonged hospital stay: □ Yes □ No
Drug reaction relationship: □ Certain □ Probable □ Possible □ Unlikely
Pharmacy and Therapeutic Committee review
P & T review:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
□ Report forwarded to the FDA
P & T
physician_________________________________________________________
Date__________________________

PLACE PATIENT LABEL HERE
Deaconess Hospital
MEDICATION ERROR & SUSPECTED ADVERSE DRUG REACTION FORM

Not a Chart Form

Provided with courtesy by Deaconess Hospital of Oklahoma City
Attachment 3
Patient Safety-Related Websites

Agency for Healthcare Research and Quality
http://www.ahrq.gov

Australian Council for Safety and Quality in Health Care
http://www.safetyandquality.org

Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov

ECRI (formerly the Emergency Care Research Institution)
http://www.ecri.org

Food and Drug Administration
http://www.accessdata.fda.gov

Health and Safety Executive
http://www.hse.gov.uk

Institute for Healthcare Improvement
http://www.ihi.org

Institute for Safe Medication Practices
http://www.ismp.org

Institute of Medicine of the National Academies
http://www.iom.edu

Joint Commission International Center for Patient Safety
http://www.jcipatientsafety.org

Joint Commission on Accreditation of Healthcare Organizations
http://www.jcaho.org

Leapfrog Group
http://www.leapfroggroup.org

Massachusetts Coalition for the Prevention of Medical Errors
http://www.macoalition.org
Medical Device Safety Reports
http://www.mdsr.ecri.org

MedWatch
http://www.fda.gov/medwatch

National Patient Safety Agency
http://www.npsa.nhs.uk

National Patient Safety Foundation
http://www.npsf.org

National Quality Forum
http://www.qualityforum.org

Partnership for Patient Safety
http://www.p4ps.org

U.S. Pharmacopeia Center for Advancement of Patient Safety (CAPS)
http://www.usp.org/patientSafety

VA National Center for Patient Safety
http://www.patientsafety.gov
14. Ethical Issues in Healthcare Accreditation

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The International Standards for Healthcare Accreditation Bodies endorsed by ISQua (International Society of Quality in Health Care) in 2000 are a set of standards that have been developed for peer assessment and international accreditation by ISQua of national health accreditation bodies. They form part of ALPHA (Agenda for Leadership in Programs in Healthcare Accreditation), which is a quality improvement framework to assist accrediting bodies in the health sector to develop and improve their standards and services. Standard 1, criteria 1.1.3 provides for the requirement that accreditation bodies should have defined a statement of ethical principles that will guide the behavior of the accreditation body and its officers:

“An explicit statement of ethical principles guides the behavior of the accreditation body, including the avoidance of conflicts of interest”.

Although ethical principles can be expressed as standards, or a written code, ethical behavior should not be regarded as the strict and indiscriminate application of a set of rigid criteria to life/work situations. Ethics constitutes the most essential nature of leadership- the personal value system that either underscores or undercuts every decision. They are moral principles by which an individual or an entity can be “guided”.

Organizational Ethics

An accrediting body has an ethical responsibility towards its clients and the community it serves. It is expected to have a code of ethics that each of its members (leaders and surveyors) must understand and follow. A code of ethics defines the fundamental principles and values that underpin an accrediting body’s mission and responsibility. In fulfilling its mission and responsibility, the operations, services and products of an accrediting body should all be provided within ethical norms that safeguard, protect and promote the rights of individual clients (hospitals applying for accreditation) as well as those of the community. The accrediting body should operate within a defined code of ethics to:

- Provide information to clients on the range of services available from the accrediting body, their prices, and contractual conditions, the rights and responsibilities of clients, and the standards of service they can expect.
- Promote a spirit of partnership with clients, continuous quality improvement, continuity of service, and the client’s best interest.
- Recognize its clients’ individual character by ensuring that its services and personnel are appropriate and sensitive to the cultures of the communities served by each organization
- Disclose ownership and any conflict of interest
- Honestly portray its services and activities to clients
- Provide clear policies (eligibility requirements, application, payment, decision process, and appeal of decisions) and communicate these policies to clients
- Resolve conflicts when they arise. The accrediting body must have a clearly documented complaints procedure which is communicated to clients and ensures that complaints are dealt with impartially and in a timely manner.

**Surveying Ethics**

It is imperative that accreditation surveyors be ethical (i.e., honest and impartial) and behave appropriately (i.e., with professional conduct) in carrying out their responsibilities. Professional conduct is the manner in which a surveyor conducts himself/herself. Integrity, objectivity, independence, competency, and confidentiality are character attributes that combine to make up the particular conduct of any surveyor during an accreditation site visit. Ethical standards serve as a general behavioral guide for surveyors. However, surveyors often rely on personal judgments and past experiences to determine ethical conduct in specific situations.

**Integrity**

**Definition**

All members of the survey team should demonstrate integrity in all aspects of their work. They should conduct themselves in a professional manner, and strive for exemplary levels of honesty. The relationship with fellow colleagues and external contacts should be one of honesty and fairness. This establishes an environment of trust, which provides the basis for reliance on all activities carried out by the survey team.

Surveyors should conscientiously complete surveys in conformance with surveying standards: Each surveyor is expected to act in good faith, responsibly, with due care, competence and diligence, without misrepresenting material facts or allowing their independent judgment to be subordinated.
relationship with external contacts

A surveyor’s temperament is often elemental to making a survey a success. By approaching the organization being surveyed in a diplomatic and objective manner, a surveyor can set a tone of success for a survey. Many organizations being surveyed are reluctant to welcome surveyors into their world. Resentment, fear and anxiety are obstacles that must be overcome. Maintaining open communication channels throughout a survey is essential. Frequent and timely communication of findings, questions and concerns give opportunities to request clarifications, address corrective action, examine the scope of the situation, and discuss the progress of the survey.

Surveyors should strive to maintain the principle of good relationships. They should endeavor to coordinate survey plans and activities with the liaison person designated by their client, internal auditor (or PI leaders), and other external reviewers, to ensure the most effective survey coverage is achieved and duplication of effort is minimized. They should display sensitivity to cultural differences in dealing with the above parties.

Accreditation surveyors should uphold the principle of honest communication in dealing with their clients and colleagues. They should not make false or misleading statements of any kind to any of these parties.

private personal gain

Surveyors should not accept anything of value (fee, gratuity or gift over and above the pre-survey agreement) from anyone that would impair or be presumed to impair their professional judgment. And they may not use the property, information or position of the organization being surveyed or the accrediting body for improper personal gain.

Surveyors are not expected to blatantly market their services at anytime during the survey process. They must refrain from representing their acts or statements in such a way as to lead others to believe that they officially represent the accrediting organization, unless they are duly authorized to do so by the highest authorities in their organization.

Objectivity

Definition

Objectivity is a fair and impartial mental attitude which surveyors should maintain in performing surveys. It is a state of mind that has regard to all considerations relevant to the activity or process being examined
without being unduly influenced by personal interest or the views of others. Accreditation surveyors should display appropriate professional objectivity when providing their opinions, assessments and recommendations. They should base findings on observed, measurable, and verifiable evidence.

Objectivity is an essential surveyor characteristic. A lack of objectivity on the part of one or more survey team member undermines the validity of the survey findings and may render the accreditation decision inaccurate. A biased attitude in assessing performance not only results in misleading conclusions, but can also be harmful to the public, the healthcare organization being surveyed, and the accrediting entity.

Below are issues that can pose a threat to objectivity while conducting accreditation surveys.

Accreditation Objectives

Accreditation surveyors use criteria developed by a standard-setting entity and endorsed by the accrediting entity as a primary resource to assess the performance of client organizations. These criteria, published in the form of standards for healthcare facilities to comply with, reflect the objectives (mission and philosophy) of the standard-setting and accrediting entities, rather than the objectives of the healthcare organization which is desirous of accreditation.

An ethical conflict may arise when inconsistency exists between the objectives of the organization, and those set forth by the accrediting body. Such inconsistency is less likely to be encountered in the course of internal audits whereby an organization’s performance is assessed towards its own objectives, which represent the primary resource for assessing performance for internal auditors. In such case the question to answer would be whether the organization is achieving the results it is intending to achieve. And no questioning of the organization’s objectives is involved. Whereas in accreditation, which is by definition an external review process, the objectives of the external, accrediting entity take precedence on those of the organization being surveyed. In theory, there should not be a conflict if we assume that both entities strive to reach the same objective of improving quality of care and patient safety. However, in real-life situations, and drawing on examples from the context of healthcare organizations in the Middle East trying to achieve Joint Commission International (JCI) accreditation for hospitals, such assumptions are not always valid. A facility management and safety standard (FMS.4) for example, implies that healthcare organizations has planned its response to likely community emergencies, epidemics, and natural or other disasters. While this standard can be interpreted as concerning both internal and external emergencies, it is frequently found that not all hospitals desirous of JCI accreditation, in
particular those hospitals offering tertiary care, would be interested in or capable of fulfilling a significant role as prescribed by standard FMS.4 in responding to likely external emergencies, and some of these hospitals may have gone further to being exempt by local authorities from being considered as receiving sites in the event of such emergencies. Numerous other examples can be found in the JCI Patient and Family Rights (PFR) chapter where the intent of a number of standards, although based in many instances on universal human rights, may not be evident for all healthcare organizations. Areas such as clinical research, organ and other tissue donation, and respect to the patient and family requests for pastoral services could reveal inconsistency between the values cherished by the healthcare organization being surveyed and those of the accrediting entity on cultural and legal grounds. In order to uphold the principle of objectivity, surveyors need to be aware of the situations where a particular healthcare organization’s objectives should be observed regardless of the standard’s aspirations.

This being said, however, there are situations where the surveyor has an obligation to draw the healthcare organization’s attention to areas that deserve improvement. Such as encouraging the organization to consider any risk that may be material to the organization’s risk management, even if it is not included in management’s risk priorities. In such a case, the surveyor’s observations would not be considered as a breach of objectivity. The same applies in the event of detecting unsafe, unethical or illegal activities. After all, by taking the decision to go for accreditation in the first place, organizations desirous of accreditation acknowledge the value of accreditation and reveal their trust in the wisdom and judgment of the accrediting body. By accepting to engage in the voluntary experience of accreditation, healthcare organizations make an ethical commitment to excellence, and an implicit consent to endorse the standards set forth by the accrediting body as measures of the excellence those organizations are seeking. Such consent should be based on the full acceptance of the mission and philosophy of the accrediting body and on an appreciation of the values it holds dear.

**Objectivity of Standards**

Objectivity is threatened when conclusions made about compliance with standards are inaccurate. An inaccurate conclusion about the performance of a process can be in the form of declaring that the process is compliant with standards when this is not the case (false favorable performance), or in the form of declaring the process as non-compliant when it actually is (false unfavorable performance). If accreditation will be used as an objective tool to measure the performance of healthcare
organizations, accreditation standards should be objective, i.e., they should be of high degree of sensitivity in order to increase the likelihood of detecting non-compliance when it exits, as well as high specificity so that non-compliance can be ruled out with more certainty when it does not exist.

Surveyors should be aware that the ability of standards to predict the true performance is not the same for all standards (and their measurable elements) and depends on multiple factors. Let us take an example on the ability of measurement to detect favorable performance when it exists. If a surveyors wanted to assess the compliance of a healthcare organization with the requirements pertaining to a discharge policy. He or she might be interested in finding out firstly, whether a written policy is available or not, and then go on to assess whether the written policy is communicated to staff or not. If the surveyor views the policy, then he or she can be confident that the healthcare organization is compliant with the first requirement, simply because it is impossible (no chance) that the surveyor views the policy if it did not exist, and the judgment he or she would make, even from only one sighting of the policy, can be considered objective. The surveyor now proceeds to assess compliance with the second requirement, that is, staff knowledge about the policy by selecting a nurse and asking him or her about the policy. If the nurse’s answers indicate a finding of favorable performance, the surveyor must not be as confident about this finding as he or she was in the case of assessing the availability of the policy. The surveyor must bear in mind that it is possible that bias was responsible for the selection of this particular nurse, who might not be representative of all staff. If bias was indeed there (nurse happens to be the discharge nurse, for instance) in the data collection process, then the finding will not be objective.

Fairness should be a quality inherent to the standards against which performance of the healthcare organization will be assessed. Standards should be rational and achievable for most healthcare organizations, not exorbitant or overstretching. They should differentiate healthcare organizations on the basis of their performance, and not discriminate against any of them on the basis of uncontrollable characteristics such as their ownership, size, or level of care provided. Surveyors must be objective when applying the same standards to different organizations; they should be sensitive to the particularities of each organization, and yet, avoid the inconsistence application of standards so as to use them as “double standards”.

For all the reasons mentioned above, standards should be derived from appropriate research to ensure they are based on sound information and practice, in that they can serve as valid tools to assess performance and lead to objective conclusions. A surveyor must be cognizant of the limitations of standards when making conclusions about performance. Standards may not
always be “gold standards”, and surveyors must realize that personal judgment and common sense may quite rightly be required.

**Objectivity of the Survey Process**

The survey process and methodology influence the degree to which a survey can be considered objective.

It is the accreditation surveyors’ responsibility to ensure that accreditation findings, conclusions and recommendations are adequately supported by relevant and sufficient evidence. Surveys are usually densely packed with activities that should be performed within specific time and resource confines. If these confines hampered data collection, they would lead to reliance on inaccurate findings that will not represent the true or actual performance of the organization being surveyed. It would be unethical to generalize inaccurate survey findings, since in the case of reaching a false favorable performance conclusion, in other words, failure to detect unfavorable performance, the public will continue to be exposed to harm, and the organization being surveyed will lose the opportunity of improvement that the survey should have offered. Moreover, healthcare organizations with the same level of performance will be awarded lower “scores”, and the accreditation system will be unjust. Whereas when the survey concludes a false unfavorable performance, the organization being surveyed will be unduly discredited, and the system will again be unjust since healthcare organizations with the same level of performance will be awarded higher “scores”. In either case, the accreditation process will be harmful to its clients, and its benefits will be hampered.

Therefore, one way to improve objectivity of an assessment is by increasing the number of observations. Enlarging the sample size improves the chances of obtaining a more accurate finding by increasing the homogeneity of the sample of observations drawn, and minimizing the role of random chance. However, increasing the sample size might not always be feasible due to time constraints in accreditation site visits; (this is particularly true in small-size healthcare facilities where limited volume implies scarcity in the occurrence of events in question) , nor is increasing the sample always ethical in healthcare settings. For example, if the surveyor observes a healthcare provider performing a high-risk procedure that is non-conformant with the prescribed standard, it would not be a wise practice to request an additional observation as this would jeopardize patient safety and infringe the ethical principle of non-malfeasance. When the sample size cannot be increased for one reason or another, a surveyor may have recourse to other, more readily available or safer, sources of evidence to verify their findings, such as interviewing staff about the procedure or reviewing written policies and procedures to determine compliance, and
conclude whether the observed non-conformance represent the norm or standard practice, or rather a one-time deviation from common practice at the healthcare organization.

Another strategy to improve the objectivity of surveyors and hence the objectivity of the survey findings is to use the opinion of multiple surveyors. Judgments are less likely to be biased when they draw on the opinion of more than one person who can look at the same facts from different angles. Accreditation surveys usually employ a team of surveyors in order to ensure a balanced mix of experience and expertise. Surveyors may individually engage in separate activities but will get together at the end of the day to corroborate findings. And in the case of a number of standards, the input of all survey team members is required before the status of compliance with these “consensus standards” can be determined.

**Independence**

**Definition**

The principle of independence implies that accreditation surveyors should be independent of the activities they survey, free of conflict of interest in any specific situation, and not subject to internal or external pressure to influence their findings.

Accreditation surveyors should have a reporting relationship to their client, who may or may not be independent of the organization being surveyed. However, to uphold the principle of independence, surveyors should be free from internal or external influences and are not to subordinate their judgment on accreditation survey matters to that of others. Situations when a surveyor’s independence is prejudiced are situations in which either a personal interest conflicts with the surveyor’s official duties, or in which the goals of one of the surveyor’s institutional roles conflict with the goals of another of his or her institutional roles). These are “conflict of interest” situations.

**Conflict of Interest**

Avoiding real or perceived conflicts of interest in personal and professional relationships is crucial for the surveyor to uphold the standard of independence. The ability to maintain principles of fairness and objectivity may also be hampered if a conflict of interest exists.

Accreditation surveyors should strive to avoid conflict of interest. When such conflicts arise, surveyors should disclose any potential conflict of interest to appropriate interested parties (i.e., their survey team leader or
their client). Furthermore, and if necessary, surveyors should remove themselves from the decision-making process.

The subject of conflict of interest often arises in the context of accreditation. Situations encountered prior to and during accreditation surveys include:

- Close relationships within the organization being surveyed, i.e., with staff with current executive responsibilities
- Acceptance of a gift with more than a nominal value
- Desire to be hired by the organization being surveyed
- Previous employment of the surveyor by the organization being surveyed or a major competitor of the organization under evaluation, regardless of the reason for separation (usually within the previous 12 months)
- Attempt to appear independent from the organization they are employed by in order to conduct an accreditation survey for that organization (this would also be considered a breach of integrity)
- Entering into an activity that may be in conflict with the interest of the accrediting entity or which would prejudice their ability to carry out objectively their duties and responsibilities as surveyors
- Prior involvement by the surveyor in developing the quality program used by the organization being surveyed. Such involvement includes holding previous executive or consultancy responsibilities towards the quality program in question. Independence is presumed to be impaired when accreditation surveyors survey an organization with which they had consulted. Such situation would make it difficult for the surveyor to maintain objectivity when the organization processes are evaluated for compliance with standards. Given the importance of this issue and its relevance to healthcare organizations, an attempt is made at analyzing the ethical issues involved in assuming the dual responsibility of surveying and consulting for the same healthcare organization.

**Separation of roles:**

**Should accrediting agencies act as consultants as well as surveyors?**

Accreditation represents a general understanding that the organization cares. It is a statement to the community that the organization is accountable. It makes a statement to the legal system that the organization has taken the initiative to be aware of and comply with the laws and regulations in the country. It also makes a statement to the internal customers that the organization is interested in their environment and work...
outcomes. Accreditation also offers quantitative and intangible benefits to healthcare organizations and their external customers.

Accreditation is usually awarded after a period of preparation towards compliance of a set of standards promulgated by a specific accrediting agency. Once the healthcare organization decides to prepare towards accreditation, it usually engages a consultant to help it interpret and comply with the accreditation standards. Once they feel they are ready to be externally evaluated, they ask the accrediting agency to “survey” that facility and award accreditation.

On the international scene there are only three or four accrediting bodies that award accreditation to healthcare organizations around the world. There is the Australian Accreditation Commission, the Canadian Council on Health Services Accreditation, The College of American Pathologists and the Joint Commission International. JCI in particular has awarded accreditation to a number of organizations world-wide and they are affiliates of the much larger and older accrediting agency, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and their consulting arm, Joint Commission Resources (JCR).

As accreditation becomes a more sought after award by healthcare organizations internationally, the question of whether the same organization should be engaged in the business of surveying the healthcare organization and awarding the accreditation and helping the organization prepare and pass the accreditation survey. This question has been answered by the Joint Commission primarily due to mounting pressure by their consumers that eventually led to the US Congress intervening and resolving this issue.

In particular, the US Congress pressured the Joint Commission to distinguish and separate between their services in the preparatory phase towards accreditation and the surveying and awarding of accreditation. It is now prohibited for surveyors to act as consultants and visa versa. As per the quote of the Joint Commission on their website:

“The Joint Commission and JCR maintain strict policies that prohibit the Joint Commission from sharing any confidential information about accredited organizations with JCR. The fact that an organization has obtained services from JCR is kept completely separate from Joint Commission accreditation decisions.”

Therefore, it is now the rule that there are two separate organizations reporting to the same “board”. One organization is dedicated to educating, consulting and assisting organizations (on a for profit basis) prepare for accreditation. They identify and assign consultants to work with the individual organizations to interpret and comply with accreditation standards. These consultants are not allowed to serve as Surveyors whether for this organization or for another. The other organizations related to accreditation are JCAHO (for domestic US programs) and JCI (for
international programs). These organizations’ main mission is to provide external evaluation through on-site surveys to verify and measure compliance of healthcare organizations to accreditation standards and award accreditation to “deserving” healthcare organizations. These “surveyors” are prohibited from consulting on accreditation matters outside their normal duty during the survey process where they may offer “consulting” advice for free to the organization being surveyed.

As a compromise, certain accrediting bodies such as the Australians or Canadians decided that their surveyors are not allowed to survey organizations they have either worked with or assisted during the preparation process. These individuals can still survey other organizations that are not exposed to their services before. This practice is now being reviewed by both of these organizations as they may create a situation of a “conflict of interest” serving both as the evaluator and the consultant.

It is therefore, recommended that the “surveying and accrediting” components of the accreditation system be separated completely from the business of consulting and preparing for accreditation. Doing both by the same organization may create a “conflict of interest” situation thus negatively affecting the credibility of the accreditation process.

**Competency**

**Definition**

Proficiency in applying surveying standards, procedures, and techniques is required in performing accreditation surveys. Proficiency means the ability to apply knowledge to situations likely to be encountered and to deal with them without extensive recourse to technical research and assistance.

Members of the accreditation survey team should apply the knowledge, skills and experience needed in the performance of their duties. They should carry out their work in accordance with the accrediting body’s standards and code of ethics. They should not accept or perform work that they are not competent to undertake unless they receive adequate advice and support to competently carry out the work.

Surveyors should have adequate qualifications, technical knowledge, training, and proficiency in the discipline of surveying to perform their assigned survey tasks.

Proficiency is the responsibility of the organization managing surveying activities and of each individual surveyor. Qualifications of the assigned survey team should be commensurate with the objectives, scope, and complexities of the survey assignment.
Surveyors should have demonstrated abilities in areas needed to perform surveys, including, but not limited to:
  a. Interpersonal and communication skills.
  b. Work scheduling and planning.
  c. Analytical abilities to evaluate potential deficiencies noted during the survey.

The accreditation survey team members should collectively possess the knowledge and skills essential to the practice of the profession. Each member of the team, however, need not be qualified in all disciplines.

**Due professional care**

Surveys should be performed with proficiency and due professional care. Due professional care is the care and skill that a reasonably prudent and competent accreditation surveyor will apply in performing their duties. Surveyors are responsible for ensuring that they conduct their own work with due professional care. They should undertake only those services they can reasonably expect to complete with professional competence. They should use surveying skills and judgment based on appropriate experience, training, ability, integrity, and objectivity.

In exercising due professional care, accreditation surveyors should be alert to the possibility of errors and omissions, inefficiency, waste, ineffectiveness, and conflicts of interest. They should also be alert to those conditions and activities where non-compliance is most likely to occur. In addition, they should identify inadequate controls and recommend improvements to promote conformance with standards.

Exercising due professional care is working with competence and diligence. It does not imply infallibility or extraordinary performance. Due care requires the surveyor to conduct examinations and verifications to a reasonable extent. Accordingly, accreditation surveyors cannot give absolute assurance that non-compliance does not exist. Surveyors should be aware and foster an awareness of the limits of their own expertise when conducting accreditation surveys. If it is determined that a final accreditation report contains an error², the accrediting body should consider the need to issue an amended report which identifies the information being corrected as well as the revised accreditation decision. The amended report should be distributed to all individuals who received the accreditation report being corrected.

A violation of due care results when a surveyor fails to exercise reasonable care or competency in the course of providing guidance for the

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² An error is defined as an unintentional misstatement or omission of significant information in a final audit report [BEAC Adopted].
healthcare organization being surveyed. Accreditation surveys are consultative in nature, and surveyors often find themselves in positions where they are expected to provide guidance. A surveyor has to be careful not to tell the organization being surveyed how to do their work or what decisions to make. If a surveyor provides guidance, even if the guidance fixes the problem, the organization being surveyed still owns the solution. If the recommended solution is not the best, there may be false favorable compliance that will reflect back on the surveyor.

**Continuing Professional Development**

Accreditation surveyors are responsible for continuing their education in order to maintain their proficiency and skills. They should strive to remain current regarding advances in their field of expertise to the extent required for excellent work in their particular fields. They should also keep informed about improvements and current developments in surveying standards, procedures, and techniques. The organization responsible for managing the surveys should make provision in its plans for the basic training and continuing professional development of all surveyors.

Continuing education may be obtained for example through membership and participation in professional societies; attendance at conferences, seminars, college courses, and in-house training programs; and participation in research projects.

**Quality Improvement**

Accreditation surveyors have an obligation to continually strive for improvement in the effectiveness and quality of their service.

The accrediting organization should develop a program of review to ensure that due professional care is achieved. This will principally be achieved through quality improvement and performance appraisal methodologies. Supervisors should regularly discuss surveyors’ performance with them and identify any areas in which improvement or training is required. The purpose of performance appraisal is to ensure that survey objectives are met, and to provide opportunities for developing surveyors’ knowledge and skills.

Last but not least, surveyors should avoid abusing the power that their competency and special knowledge and skills give them. In particular, they should avoid conflating expertise in accreditation surveying with authority, and never abuse their position of power or their professional proficiency in order to exploit those they serve.
Confidentiality

Definition

Maintaining confidentiality implies the active protection and safeguard of confidential, sensitive, proprietary information and medical records in a manner designed to prevent the unauthorized disclosure of information. Members of the accreditation survey team should safeguard the information they receive in carrying out their duties. They should take all reasonable steps to protect the confidentiality of the survey findings, data collected, and the anonymity of interviewees.

In today’s complex healthcare environment, where special problems and strategies for addressing patient confidentiality issues are prevalent, the question of confidentiality can be a major cause for concern during and after accreditation site visits. Information acquired through accreditation surveys can be divulged to surveyors by patients, patients’ families, and staff members of the organization being surveyed. Accrediting bodies possess a great deal of confidential, sensitive, proprietary information and medical records including:

- Data harvested from organizations being surveyed through reports and accreditation surveys;
- Intelligence provided by persons with an interest in influencing accreditation decisions (e.g., staff, and complainants);
- Decisions and reports generated by the accreditor in the accreditation process; and
- Material regarding accreditation standards and procedures. [9]

Disclosure of Survey Findings

Issues of control of information are of prime importance to both accrediting bodies and those affected by their decisions. An accrediting body must have a clear policy on the release of information gathered from a healthcare organization during the accreditation process. Such a policy should be known to the client and the public.

The relationship between the survey team members and the client should be one of confidentiality and discretion. Certain information may not be appropriate for disclosure to all report recipients because it is privileged, proprietary, or related to improper or illegal acts. Such information, however, may be disclosed in a separate report. If the conditions being reported involve senior management, report distribution should be to the board of the organization.
Surveyors should be prepared to sign agreements or utilize techniques to safeguard the confidentiality of data and information in the hospital being surveyed before being recognized as members of the survey team. There should not be any unauthorized disclosure of survey information unless there is a legal or professional requirement to do so. The survey team members should not disclose information or documents obtained during the survey or the final report to any third party without the express approval of the client, and where appropriate, with approval of the organization that has been surveyed.

Besides the management of the organization being surveyed, the accrediting entity may be legally obligated to disclose survey findings to the following parties:

- Internal or external legal counsel.
- Funding or contracting organizations.
- Governmental or other regulatory authorities.
- Other external reviewers.

Confidentiality and Enhancing Public Accountability

Surveyors of health care organizations should strike a balance between their obligation to safeguard confidentiality, and their duty to inform the public about the performance of healthcare organizations. Accreditation is one tool that helps ensure the accountability of these organizations to the communities they serve, and therefore, surveyors should not hesitate to reveal to concerned authorities all material facts known to them which, if not revealed, could conceal unsafe, unethical, or illegal practices.

Therefore, a surveyor must maintain confidentiality, but not to the point of performing an inadequate survey.

Maintenance of Survey Records

Survey working papers contain information that proprietary to the organization being surveyed, but the physical working papers are the property of the accrediting body. Survey working paper files should generally remain under the control of the surveying function in the accreditation program, and should be accessible only to authorized personnel.

Accreditation programs should develop retention requirements for survey records and working papers, whether they are held on paper or electronically. These retention requirements should be consistent with the organization’s guidelines and any pertinent legal or other requirements.
Surveying ethics is perhaps the area that demands the most skill from a surveyor. A surveyor’s use of questionable or unethical methods during or following an accreditation survey can quickly erase any favorable impressions and be detrimental to the surveyor and the accrediting body as a whole. To date however, very little information is available on the topic of surveying ethics, and many ethical questions remain unanswered.
REFERENCES


Glossary

This section lists terms that are used in the accreditation process. Some terms have already been encountered in previous chapters. The definitions used are those of the Joint Commission on Accreditation of Healthcare Organizations. Worth noting that some modifications have occurred in the definition of some of the following terms (e.g. scoring scale), but the overall meaning is still reflective. For instance, the joint commission’s new website is www.jointcommission.org, when it was www.jcaho.org.

Accredited. The determination that an eligible organization meets applicable Joint Commission standards in all performance areas.

Accreditation Cycle. The term, or cycle, at the conclusion of which accreditation expires unless a full survey is performed.

Accreditation Date. The date of the accreditation decision that is awarded to an organization following its full survey.

Accreditation Decision. The conclusion reached about an organization's status after evaluation of the results of the onsite survey, recommendations of the surveyor(s), and any other relevant information such as documentation of compliance with standards, documentation of plans to correct deficiencies, or evidence of recent improvements. There are seven levels of Accreditation: accredited with commendation, accredited with recommendations for improvement, accredited without recommendations for improvement (accredited), provisional accreditation, conditional accreditation, preliminary nonaccreditation, or adverse decision, in appeal.

Accreditation Decision Grid. A single-page display of the performance areas that summarizes the standards in each Joint Commission accreditation manual. The grid format allows for the presentation of a numerical summary of aggregated compliance scores for a number of related Joint Commission standards. Each score on the grid reflects an organization's assigned level of compliance for standards relating to a key performance area.

Accreditation Duration. The time period during which a health care organization, found to be in compliance with Joint Commission standards, is awarded accreditation. To maintain accreditation satisfactory resolution of any identified issues is required.
Accreditation Hearing and Appeal Process. The process through which an organization that has been denied accreditation exercises its right to a hearing by an Appeals Hearing Panel, followed by a review of the panel's report and recommendation by the Joint Commission's Board of Commissioners.

Accreditation Manuals. The Joint Commission books delineating current standards pertaining to specified types of health care organizations or services. The books are designed for use in organization self-assessment and include the standards used to evaluate organizations during onsite surveys. The manuals are Comprehensive Accreditation Manual for Hospitals; Comprehensive Accreditation Manual for Ambulatory Health Care; Comprehensive Accreditation Manual for Behavioral Health Care; Comprehensive Accreditation Manual for Long Term Care; Comprehensive Accreditation Manual for Long Term Care Pharmacies; Comprehensive Accreditation Manual for Home Care; Comprehensive Accreditation Manual for Health Care Networks; Accreditation Manual for Preferred Provider Organizations; and Comprehensive Accreditation Manual for Pathology and Clinical Laboratory Services. New Manuals are constantly being issued with a rapidly changing healthcare industry.

Accreditation Survey. An evaluation of a health care organization to assess its level of compliance with applicable Joint Commission standards and to make determinations regarding its accreditation status. The survey includes evaluation of documentation of compliance provided by organization personnel; verbal information concerning the implementation of standards, or examples of their implementation, that will enable a determination of compliance to be made; and onsite observations by surveyors. The survey also provides the opportunity for education and consultation to organizations on standards compliance and performance improvement.

Accreditation Watch. Though not a separate accreditation decision, Accreditation Watch is an attribute of an organization's existing accreditation status. An organization is placed on Accreditation Watch if it experiences a sentinel event and the Joint Commission determines that there is a reasonable potential for reducing the likelihood of such events in the future. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes the loss of limb function.

Accredited with Commendation. The highest accreditation decision awarded to a health care organization that has demonstrated exemplary performance overall.
Accredited without Recommendations for Improvement (Accredited).  
Accreditation decision given to a health care organization that meets applicable Joint Commission standards in all performance areas.

Accredited with Recommendations for Improvement. Accreditation decision given to a health care organization that generally meets the standards, but does not meet certain important standards in at least one performance area. Most organizations fall into this category. In order to remain accredited, they must achieve compliance with the identified standards within a specified period of time.

Adverse Decision, In Appeal. When an accreditation decision of Preliminary Nonaccreditation is given, the organization has the opportunity to request review of this decision through an appeal process prior to a final determination of Not Accredited.

Areas Having Specific Recommendations for Improvement. This section of a health care organization's performance reports lists the performance areas in which recommendations for improvement have been identified. A recommendation for improvement is provided when an organization does not demonstrate adequate compliance with specific Joint Commission standards. An accredited organization must resolve recommendations for improvement within a specified period of time to remain accredited. As an organization improves its performance in an area, "RESOLVED" is displayed to the right of the performance area on the performance report.

Comparing Scores (on Performance Reports). The smaller the differences in scores between organizations, the less likely there is an actual difference in the levels of performance between them. There may be no real difference between an organization that scores 88 and an organization that scores 81. However, the greater the difference in scores, the more likely there is a difference in patient care. The Joint Commission does not "grade on the curve." That is to say, the scoring does not indicate an organization's ranking in relation to others. Rather, the score indicates how well it measures up against an absolute standard which reflects the level of performance that every organization would wish to meet.

Conditional Accreditation. An accreditation decision that results: When an organization is not in substantial compliance with Joint Commission standards, but is believed to be capable of achieving acceptable standards compliance within a stipulated time period. Findings of correction, which serve as the basis for further consideration of awarding full accreditation,
must be demonstrated through a short-term follow-up survey, or; When the Joint Commission finds that an accredited organization has had one or more adverse clinical events that potentially reflect underlying systems issues for which the organization could reasonably be held accountable for accreditation purposes. The organization’s analysis of the causes of the event(s) and the organization's remedial actions must be demonstrated through a short-term follow-up survey.

**Current Status.** This is the current level of accreditation. Follow-up activities that occur after the full survey may result in a change in the accreditation level. However, Accreditation with Commendation can only be achieved at the time of the full survey. Organizations that are accredited with recommendations for improvement are required to bring the cited areas into compliance with the standards within specified time frames. Each year, 5 percent of all organizations are selected for random, unannounced surveys of standards or areas identified as being problematic for a large percentage of institutions. These random, unannounced surveys take place 9 to 30 months following the triennial full survey. In addition, the Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff, or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

**Database.** A collection of stored data.

**Effective Date.** The date that the current status became effective. The effective date will be the same as the accreditation decision date if the organization's accreditation decision is Accredited or Accredited with Commendation, or if an organization whose accreditation decision was Accredited with Recommendations for Improvement has not resolved any outstanding recommendations.

**Focused Survey.** A survey conducted during the accreditation cycle to assess the degree to which an organization has improved its level of compliance relating to specific recommendations. The subject matter of the survey is typically an area(s) of identified deficiency in compliance; however, other performance areas may also be assessed by a surveyor(s), even though they may not be previously identified deficiencies.

**Full Survey.** An evaluation of an organization to assess its level of compliance with applicable Joint Commission standards and to make determinations regarding its accreditation status. The survey includes evaluation of documentation of compliance provided by organization staff;
verbal information concerning the implementation of standards or examples of their implementation; and on-site observations.

**Grid Element.** A performance area that receives a discrete score on the Joint Commission accreditation decision grid.

**Grid Element Score.** A number representing the aggregated scores of individual standards in a grid element.

**Health Care Organization.** A generic term used to describe many types of organizations that provide health care services.

**In Process.** When an organization receives a Recommendation for Improvement, it must work to rectify the situation within a specified time frame. The time during which this occurs is referred to as In Process.

**Most Recent Update.** This is the date of the most recent update activity covered by a specific performance report for a health care organization. As a result of the full survey, most organizations receive recommendations for improvement in individual performance areas. Follow-up activities, which include written reports and onsite focused surveys, are then undertaken to assess improvement in these areas. Follow-up activities may result in new recommendations for improvement.

**National Comparative Database.** The Joint Commission's National Comparative Database used in presenting information in performance reports is comprised of full survey data from like health care organizations. If an organization's service is designated as not applicable (NA), it did not contribute to the comparative database in the area.

**Not Accredited.** An accreditation decision that results when a health care organization has been denied accreditation, when its accreditation is withdrawn by the Joint Commission, or when it withdraws from the accreditation process. (This designation also describes any organization that has never applied for accreditation; however, these organizations are not listed in the Joint Commission's Internet Directory of Accredited Organizations.)

**ORYX.** The name of the Joint Commission's initiative to integrate performance measures into the accreditation process.

**Overall Evaluation Score.** The Overall Evaluation Score is derived from an assessment of an organization's compliance with all applicable Joint
Commission standards at the time of the full survey. It is based on a scale of 0 to 100, with 100 representing the highest possible score.

**Performance Area.** A particular function of a health care organization which contributes to the effectiveness and competency of the whole. Joint Commission standards are grouped by performance area, and each area receives an aggregate score.

**Performance Area Scores.** Each performance area is scored at the time of the full survey. This score is indicated in the "Full Survey Performance Area Scores" column of an organization's performance report. Scores are based on a scale of 1 to 5 (see Scoring Scale), with 1 representing the highest possible score. If the score for a specific performance area has been updated, this updated score appears in the "Updated Performance Area Scores" column.

**Performance Improvement.** The continuous study and adaptation of functions and processes of a health care organization to increase the probability of achieving desired outcomes and to better meet the needs of patients and other users of services; the third segment of a performance measurement, assessment, and improvement system.

**Performance Measure.** A measure, such as a standard or indicator, used to assess the performance of a function or process of any organization.

**Preliminary Non-accreditation.** An accreditation decision that is assigned to a health care organization when it is found to be in significant noncompliance with Joint Commission standards or when its accreditation is preliminarily withdrawn by the Joint Commission for other reasons (for example, falsification of documents) prior to the determination of the final accreditation decision (for example, not accredited). Preliminary non-accreditation is an appealable accreditation decision.

**Provisional Accreditation.** An accreditation decision that results when a health care organization has demonstrated substantial compliance with the selected structural standards used in the first of two surveys conducted under the early survey policy. The second survey is conducted approximately six months later to allow the organization sufficient time to demonstrate a "track record" of performance. Provisional accreditation status remains until the organization completes a full survey.

**Reference Database.** An organized collection of similar data from many health care organizations that can be used to compare a health care organization's performance to that of others.
Resolved. See "Areas Having Specific Recommendations for Improvement".

Scoring Scale. The scoring scale or compliance level is used to measure the extent to which a healthcare organization meets a specific standard. Scoring is done on a scale of 1 to 5, where 1 is the best. Definitions of the scores are as follows:

Score 1: Substantial compliance means the organization consistently meets all major provisions of the standards in this performance area.
Score 2: Significant compliance means the organization meets most provisions of the standards in this performance area.
Score 3: Partial compliance means the organization meets some provisions of the standards in this performance area.
Score 4: Minimal compliance means the organization meets few provisions of the standards in this performance area.
Score 5: Non-compliance means the organization fails to meet the provisions of the standards in this performance area. NA Not applicable indicates that the performance area does not apply to the organization.

Sentinel Event. Sentinel event is an event which has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition. The following events are also considered sentinel events even if the outcome was not death or major permanent loss of function: suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital, residential treatment center, crisis stabilization center); infant abduction or discharge to the wrong family; rape; hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities; and surgery on the wrong patient or wrong body part.

Standard. A statement that defines the performance expectations, structures, or processes that must be substantially in place in a healthcare organization to enhance the quality of care.

Survey. See Accreditation Survey.

Updated Overall Evaluation Score. The Updated Overall Evaluation Score provided on performance reports is calculated after follow-up and other monitoring assessments have been conducted. The updated score assumes continued standards compliance in those performance areas which were in compliance at the time of the original full survey. The maximum updated overall evaluation score that can be achieved is 94. Some organizations
Healthcare Accreditation Handbook demonstrate acceptable (significant), but not total compliance at the time of their full surveys, and they are not assigned follow-up activities. In these instances, updated overall evaluation scores are usually not provided. Some organizations achieve an overall evaluation score greater than or equal to 94 at the time of their full surveys. If they are assigned follow-up activities, individual performance area scores are updated to reflect improvement, but an updated overall evaluation score is not provided because the original score equals or exceeds 94.

**Updated Performance.** This column on a performance report shows the most recent performance of the health care organization and includes updates that have occurred since the full survey (see Current Status.)