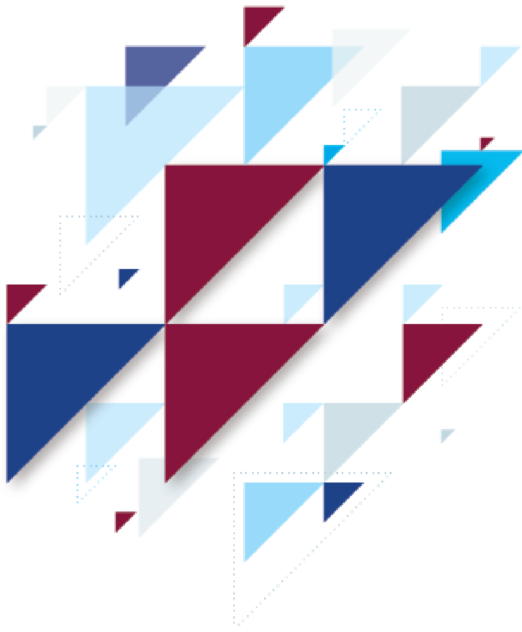

Joint Commission International Accreditation

FINAL ACCREDITATION SURVEY FINDINGS REPORT

King Faisal Specialist Hospital and Research Centre-Jeddah

Jeddah, Saudi Arabia

International Health Care Organization (IHCO) Identification Number: 60000638

Survey Dates:	10 December 2017 - 14 December 2017
Program:	Hospital
Survey Type:	Triennial
Surveyor Team:	Richard L. Sheehan, MS, Administrator, Team Leader Hope M. Juckel-Regan, MA, RN, Nurse Zeeshan Bin Ishtiaque, MD, Physician

OUTCOME:

Based on the findings of the Triennial Hospital survey of 10 December 2017 to 14 December 2017 and the Decision Rules of Joint Commission International (JCI), King Faisal Specialist Hospital and Research Centre-Jeddah has been granted the status of ACCREDITED.

Upon confirmation from the JCR Finance Department indicating that all survey related fees have been paid, you will receive the JCI Hospital certificates and, if necessary, your organization's entry on the JCI website will be updated. You will also have access to The JCI Gold Seal of Approval™, the JCI Accreditation Gold Seal of Approval ™ Guidelines, and the JCI Accreditation Publicity Guide under the "Resources" tab in JCI Direct Connect.

The Joint Commission International Hospital Standards are intended to stimulate continuous, systematic and organization-wide improvement in daily performance and in the outcomes of patient care. It is our expectation that all of the issues identified in the following survey report will have been satisfactorily resolved and full compliance with each identified standard will be demonstrated at the time of your next accreditation survey. Therefore, King Faisal Specialist Hospital and Research Centre-Jeddah is encouraged to immediately place organization-wide focus on the standards with measurable elements scored as "Not Met" and "Partially Met" and to implement the actions necessary to achieve full compliance.

Between surveys, King Faisal Specialist Hospital and Research Centre-Jeddah will be expected to demonstrate compliance with the most current edition of the JCI standards at the time, which includes the JCI accreditation policies and procedures published on the JCI website.

JCI will continue to monitor King Faisal Specialist Hospital and Research Centre-Jeddah for compliance with all of the JCI Hospital standards on an ongoing basis throughout the three-year accreditation cycle. The compliance monitoring activities may include but not be limited to document and record reviews, the review of data monitoring reports, leadership interviews and staff interviews. The monitoring activities may take place on-site or off-site. JCI also reserves the right to conduct an unannounced, onsite evaluation of standards compliance at its discretion.

REQUIRED FOLLOW-UP:

Some of findings identified in this report suggest that if not attended to in a timely manner can evolve into a generalized threat to patient and/or staff health and safety and may over time result in a sentinel event. These health and safety risks would be counter to the improvement efforts your critical care program has accomplished to date, and counter to the spirit of continual improvement in quality and continual reduction of risk that are considered part of the accreditation process. This is of concern to us and we believe should be a priority concern for your organization. For this reason, a Strategic Improvement Plan (SIP) describing the sustainable measures that will be implemented to achieve full compliance is required for the following standard(s) and measurable element(s):

- SQE.9.2, ME #2
- SQE.11, ME #3

This report contains confidential and/or privileged material. Any review or dissemination or other use of, or taking of any action in reliance upon, this information by persons or entities other than the intended recipient is prohibited.

The SIP must be submitted to JCI within the next 45 days or by 1 February 2018 for review and acceptance. Details regarding access to the SIP system will be sent to you by way of a separate notification.

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REPORT OF SURVEY FINDINGS:

Note: The Accreditation Committee may request follow-up for any or all of the standards after the accreditation decision.

International Patient Safety Goals

IPSG.4.1 **The hospital develops and implements a process for the time-out that is performed immediately prior to the start of the surgical/invasive procedure and the sign-out that is conducted after the procedure.**

Measurable Element #2
Before the patient leaves the area in which the surgical/invasive procedure was performed, a sign-out process is conducted, which includes at least d) through g) in the intent.
Partially Met
In ten out of fourteen (71% compliance) open and closed surgical patient records reviewed there was documented evidence of a sign-out process conducted.

IPSG.5 **The hospital adopts and implements evidence-based hand-hygiene guidelines to reduce the risk of health care–associated infections.**

Measurable Element #1
The hospital has adopted current evidence-based hand-hygiene guidelines.
Partially Met
Although the Hospital had adopted current evidence-based hand hygiene guidelines and documented them in their policy, "Hand Hygiene, MCA-ICHE-J-01-012, effective date 21/08/2016", the policy did not include WHO recommendations regarding use of soap and water and not alcohol-based hand cleaning products for patients diagnosed with *Clostridium Difficile*. The policy was amended during the survey.

Patient and Family Rights

PFR.5.2 **Informed consent is obtained before surgery, anesthesia, procedural sedation, use of blood and blood products, and other high-risk treatments and procedures.**

Measurable Element #2
Consent is obtained before anesthesia and procedural sedation.
Partially Met
In twelve out of fourteen (86% compliance) open and closed surgical patient records, a consent was obtained for anesthesia and procedural sedation.

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Assessment of Patients

AOP.2 **All patients are reassessed at intervals based on their condition and treatment to determine their response to treatment and to plan for continued treatment or discharge.**

Measurable Element #3

A physician reassesses patients at least daily, including weekends, during the acute phase of their care and treatment.

Partially Met

In twelve out of sixteen (75% compliance) open and closed medical and surgical patient records reviewed, there was documented evidence that a physician had reassessed the patient daily, including weekends.

Care of Patients

COP.2.1 **An individualized plan of care is developed and documented for each patient.**

Measurable Element #4

The initial plan of care and any revisions to the plan of care are documented in the patient's medical record.

Partially Met

In ten out of sixteen (63% compliance) open and closed medical and surgical patient records reviewed, there was an initial nursing care plan present.

COP.8.2 **The transplant program includes a multidisciplinary team that consists of people with expertise in the relevant organ-specific transplant programs.**

Measurable Element #4

The transplant program evaluates team members for qualifications, training, and experience at the time each individual is being considered for the transplant team.

Partially Met

The transplant program evaluated doctors, nurses, coordinators, and social workers for qualifications, training, and experience at the time they were being considered for the transplant team; however, team members from infection control, psychological services, and rehabilitative services were not evaluated by the transplant program.

COP.9.3 **Individualized patient care plans guide the care of living donors.**

Measurable Element #3

The living donor candidate receives ongoing psychological support following donation.

Partially Met

The live kidney donor received one psychological consultation following donation; however, there was no documented evidence that ongoing psychological support was provided to living donor candidates following donation.

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Anesthesia and Surgical Care

ASC.2 A qualified individual(s) is responsible for managing the sedation and anesthesia services.

Measurable Element #4

Responsibilities for monitoring and reviewing all sedation and anesthesia services are defined and carried out. (Also see GLD.8, ME 1)

Partially Met

The chief of anesthesia and the department of anesthesia were involved in conducting the sedation course for non-anesthesia personnel; however, they were not involved in monitoring and reviewing sedation services conducted by these non-anesthesia personnel.

Medication Management and Use

MMU.5.2 A system is used to safely dispense medications in the right dose to the right patient at the right time.

Measurable Element #4

After preparation, medications not immediately administered are labeled with the name of the medication, the dosage/concentration, the date prepared, the expiration date, and two patient identifiers (Also see IPSG.1, ME 2)

Partially Met

After preparation, normal saline syringes in the cardiac catheterization suite and a lidocaine syringe in the operation theatre were not labeled.

Prevention and Control of Infections

PCI.5 The hospital designs and implements a comprehensive infection control program that identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.

Measurable Element #3

The hospital has identified those processes associated with infection risk. (Also see AOP.5.3, ME 2; AOP.5.3.1, MEs 1 and 3; MMU.5, MEs 1 and 3)

Partially Met

Processes associated with infection risk included the following:

1. Ripped upholstery on recliner chair in patient room found on Pediatric Intensive Care Unit.
2. In the endoscopy unit, endoscopes were not stored according to the manufacturer's guidelines. The endoscopes were stored in small boxes rather than the endoscope storage cabinet as recommended by the manufacturer's guidelines.
3. In the operating theatre, the use of flash sterilization was discouraged and minimized; however, during review of the records, it was noticed that the flash sterilizer was used to sterilize one physician's referred equipment when he had multiple cases on the same day.

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Governance, Leadership, and Direction

GLD.3 **Hospital leadership is identified and is collectively responsible for defining the hospital's mission and creating the programs and policies needed to fulfill the mission.**

Measurable Element #3

Hospital leadership is responsible for creating the policies and procedures necessary to carry out the mission.

Partially Met

The following hospital policies were not consistent with the current practice:

1. Communication of Verbal/Telephone Orders and Test Results, MCA-J-ADM-01-008, effective date 10/23/17
2. Handover Process: Handover Between Nurses, NA-J-ADM-01-031, effective date 09/01/2015
3. The hospital policy number MCA-J-ADM-07-008 on "Correct site, correct procedure, correct patient surgery" did not mention how presence of all required documents, blood products, medical equipment, and implantable devices would be verified as part of preoperative verification process. Likewise, as part of time-out process, the hospital policy required that all team members were required to confirm their agreement with "name of the patient" as the correct patient identity and did not mention "name of the patient and hospital medical record number" as the patient identifiers during time-out process.

GLD.11.2 **Department/service leaders select and implement clinical practice guidelines, and related clinical pathways and/or clinical protocols, to guide clinical care.**

Measurable Element #4

Department/service leaders demonstrate how the use of clinical practice guidelines, clinical pathways, and/or clinical protocols has reduced variation in processes and outcomes

Partially Met

Department/service leaders were able to demonstrate how the use of clinical practice guidelines, pathways, and clinical protocols had resulted in reduced variation in outcomes; however, they were not able to demonstrate reduced variation in processes.

Facility Management and Safety

FMS.5 **The hospital has a program for the inventory, handling, storage, and use of hazardous materials and waste.**

Measurable Element #2

The program establishes and implements safe handling, storage, and use of hazardous materials and waste. (Also see AOP.5.6, ME 3; AOP.6.6, ME 2; and MMU.3.1, ME 2)

Partially Met

Formalin was stored in a large container in the operation theatre. The Formalin was transferred to smaller specimen containers without the use of a chemical fume hood as required by the material safety data sheet.

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Staff Qualifications and Education

SQE.3 The hospital uses a defined process to ensure that clinical staff knowledge and skills are consistent with patient needs.

Measurable Element #5

There is at least one documented evaluation of each clinical staff member working under a job description each year or more frequently as defined by the hospital. (Also see SQE.11, ME 1))

Partially Met

In five out of eight (63% compliance) nursing and other clinical staff's personnel records reviewed there was documented evidence of a current annual evaluation.

SQE.9.2 There is a uniform, transparent decision process for the initial appointment of medical staff members.

Measurable Element #2

Appointments are not made until at least licensure/registration has been verified from the primary source, and the medical staff member then provides patient care services under supervision until all credentials required by laws and regulations have been verified from the original source, up to a maximum of 90 days. (Also see SQE.3)

Not Met

The hospital had a process whereby doctors were appointed as locum consultants before they were offered a full-time position on the medical staff. As locum consultants, they had the privileges of working independently without any supervision. The credentials of the medical staff appointed as locum consultants were not verified from the primary source before they started providing care to the patients.

Measurable Element #3

The method of supervision, frequency of supervision, and accountable supervisors are documented in the credential file of the individual. (Also see SQE.5)

Partially Met

The method of supervision and frequency of supervision were documented; however, accountable supervisors were not documented in the credential files of the individuals.

SQE.11 The hospital uses an ongoing standardized process to evaluate the quality and safety of the patient care provided by each medical staff member.

Measurable Element #2

The monitoring and evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member compared to other department/service medical staff members. (Also see QPS.4, ME 2)

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Partially Met

The monitoring and evaluation process identified areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff members through the CARE (Clinical, Administrative, Research, Education) model. The conduct of the physicians was also evaluated subjectively by their respective supervisors; however, neither areas of achievement nor potential improvement related to the behaviors, professional growth, and clinical results were compared to other medical staff members.

Measurable Element #3

The clinical results of data and information available on medical staff members are reviewed with objective and evidence-based information, as available, for external benchmarking.

Not Met

The clinical results of data and information available on medical staff members were not reviewed with objective and evidence-based information for external benchmarking.

Management of Information

MOI.4 The hospital uses standardized diagnosis and procedure codes and ensures the standardized use of approved symbols and abbreviations across the hospital.

Measurable Element #3

If the hospital allows abbreviations, the hospital implements the uniform use of approved abbreviations and each abbreviation has only one meaning.

Partially Met

Unapproved abbreviations such as COT, BD, and GI were used. Likewise, some abbreviations had more than one meaning. For example:

1. PSC: “Posterior Sclerotic Cataract” and “Pain Scale Chronicity”
2. VS: “Vital Signs” and “Versus”
3. Ortho: “Orthodontics” and “Orthopedics”

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