CBAHI
المركز السعودي للاعتماد المنشآت الصحية
Saudi Central Board for Accreditation of Healthcare Institutions

King Faisal Specialist Hospital and Research Center - Jeddah (dq/A_FacilityInformations.aspx) [Contact] (../ContactCBAHI.aspx) [✖ Sign Out] (../signout.aspx)

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Survey Report...

HCF: **King Faisal Specialist Hospital and Research Center - Jeddah**
Transaction: **ESR Visit#1**
Surveyors: **Dr. Faisal Ghayb Al-Anzi**
Eng. Nawwar Mohammad Sheikhani
Score: **92.81%**

HR.5 - The hospital has a process for proper credentialing of staff members licensed to provide patient care.

HR.5.1 - The hospital has a written policy describing the process used for the verification of credentials.
Fully Met

HR.5.2 - The hospital gathers, verifies, and evaluates the credentials (license, education, training, certification and experience) of those medical staff, nursing staff, and other health professionals licensed to provide patient care.
Fully Met

HR.5.3 - Credentials are verified from the original source.
Fully Met

HR.5.4 - Job responsibilities and clinical work assignments/ privileges are based on the evaluation of the verified credentials.
Fully Met

HR.5.5 - The hospital ensures the registration of all healthcare professionals with the Saudi Commission for Health Specialties.
Fully Met

HR.5.6 - Staff licensed to provide patient care must always have and maintain a valid license to practice only within their profession.
Fully Met

HR.5.7 - The hospital maintains an updated record of the current professional license, certificate, or registration, when required by laws, regulations, or by the hospital for every medical staff, nursing staff and other healthcare professionals.
Fully Met

HR.5.8 - When verification of credentials is conducted through a third party, the hospital must request for a confirmatory documentation.
Fully Met

HR.5.9 - Verification process applies to all clinical staff categories (full time, part time, visitor, and locum).
Fully Met

MS.7 - Medical staff members have current delineated clinical privileges.

MS.7.1 - Medical staff members are allowed to practice only within the privileges granted by the credentialing and privileging committee.
Fully Met

MS.7.2 - Clinical privileges are reviewed and updated every two years and as needed.
Partially Met • *Clinical privileges are not updated every two years .*

MS.7.3 - The hospital identifies the circumstances under which temporary or emergency privileges are granted.
Fully Met

MS.7.4 - Temporary or emergency privileges are not granted for more than 90 days and are not renewable.
Fully Met

MS.7.5 - When a new privilege is requested by a medical staff member, the relevant credentials are verified and evaluated prior to approval.
Fully Met

PC.25 - Policies and procedures guide the handling, use, and administration of blood and blood products.

PC.25.1 - There are policies and procedures that are developed collaboratively by the blood utilization committee, guiding the handling, use, and administration of blood and blood products.

Fully Met

PC.25.2 - Only physicians order blood and in accordance with a policy clarifying when blood and blood products may be ordered.

Fully Met

PC.25.3 - The physician obtain informed consent for transfusion of blood and blood products. Elements of patient consent include:

PC.25.3.1 Description of the transfusion process.
PC.25.3.2 Identification of the risks and benefits of the transfusion.
PC.25.3.3 Identification of alternatives including the consequences of refusing the treatment.
PC.25.3.4 Giving the opportunity to ask questions.
PC.25.3.5 Giving the right to accept or refuse the transfusion.

Partially Met

- *The Elements of patient consent did not include: Description of the transfusion process. Identification of the risks and benefits of the transfusion. Identification of alternatives including the consequences of refusing the treatment Giving the opportunity to ask questions. Giving the right to accept or refuse the transfusion.*

PC.25.4 - Two staff members verify the patient's identity prior to blood drawing for cross match and prior to the administration of blood.

Fully Met

PC.25.5 - In dire emergencies, patient/family signs consent for "transfusion without NAT testing".

Fully Met

PC.25.6 - Blood is transfused according to accepted transfusion practices from recognized professional organizations.

Fully Met

PC.25.7 - Policies and procedures guide the administration of blood transfusions.

Fully Met

PC.25.8 - Patients receiving blood are closely monitored.

Fully Met

PC.25.9 - Transfusion reactions are reported and analyzed for preventive and corrective actions.

Fully Met

PC.25.10 - Side effects or complications are immediately reported to the medical staff and blood bank and the transfused unit is sent to the blood bank for further investigations.

Fully Met

PC.26 - Patients at risk for developing venous thromboembolism are identified and managed.

PC.26.1 - Patients are screened for the risk of developing venous thromboembolism.

Fully Met

PC.26.2 - Patients at risk receive prophylaxis according to current evidence-based practice.

Fully Met

QM.17 - The hospital has a process to ensure correct identification of patients.

QM.17.1 - At least two patient identifiers (e.g., patient full name and medical record number) are required whenever taking blood samples, administering medications or blood products, or performing procedures.

Fully Met

QM.17.2 - The hospital has a standardized approach to patient identification (e.g., use of ID bands with standardized information).

Fully Met

QM.17.3 - Patients are actively involved in the process of patient identification.
Fully Met

QM.18 - The hospital has a process to prevent wrong patient, wrong site, and wrong surgery/procedure.

QM.18.1 - There is a process implemented to prevent wrong patient, wrong site, and wrong surgery/procedure during all invasive interventions performed in operating rooms or other locations.
Fully Met

QM.18.2 - The process consists of three phases: verification, site marking, and time out.
Fully Met

QM.18.3 - A pre-procedure verification of the patient information is carried out including the patient's identity, consent, full details of the procedure, laboratory tests and images, and any implant or prosthesis.
Fully Met

QM.18.4 - The surgical/procedural site is marked before conducting the surgery/procedure.
QM.18.4.1 The site is marked especially in bilateral organs and multiple structures (e.g. fingers, toes, and spine).
QM.18.4.2 The site is marked by the individual who will perform the procedure.
QM.18.4.3 The patient is involved in the marking process.
QM.18.4.4 The marking method is consistent throughout the hospital.
QM.18.4.5 The mark is visible after the patient is prepped and draped.
Fully Met

QM.18.5 - A final check (time-out) is conducted before the procedure is initiated.
QM.18.5.1 The time-out is conducted in the location where the procedure will be done, just before starting.
QM.18.5.2 The time-out is initiated by a designated member of the team and involves the members of the team, including the individual performing the procedure, the anesthesia providers, and the nurse(s) involved.
QM.18.5.3 The entire procedure team uses active communication during the time out.
QM.18.5.4 During the time-out, the team members agree on the correct patient identity, the correct procedure to be performed, the correct site, and when applicable, the availability of the correct implant or equipment.
Fully Met

QM.18.6 - The hospital documents its processes for preventing wrong patient, wrong site, and wrong surgery/procedure.
Fully Met

AN.2 - Anesthesia staff members have the appropriate qualifications.

AN.2.1 - Qualified anesthesiologists provide anesthesia services.
Fully Met

AN.2.2 - Qualified anesthesiologist is present inside the operating room throughout the operation.
Fully Met

AN.2.3 - Anesthesia consultant administers and supervises anesthesia for major/specialized operations or high risk patients, including:
AN.2.3.1 Pediatric operations.
AN.2.3.2 Cardio-pulmonary operations.
AN.2.3.3 Neurosurgery operations.
AN.2.3.4 Transplant operations.
Fully Met

AN.2.4 - Anesthesia staff are certified in advanced life support as appropriate to the patient's age.
Fully Met

AN.15 - Qualified staff perform moderate and deep sedation/analgesia.

AN.15.1 - Physicians who perform moderate and deep sedation/analgesia have competency-based privileges granted to perform moderate and deep sedation/analgesia.
Fully Met

AN.15.2 - Clinical staff who participate in caring for patients receiving moderate or deep sedation are certified in advanced life support as appropriate to the age of the patients served.

Fully Met

AN.15.3 - Clinical staff who participate in conducting sedation must successfully complete a proper education/training on moderate and deep sedation.

Fully Met

IPC.4 - There is a designated multidisciplinary committee that provides oversight of the infection prevention and control program.

IPC.4.1 - The infection prevention and control committee is chaired by the hospital director or the medical director.

Fully Met

IPC.4.2 - The membership of the infection prevention and control committee includes representatives from the medical staff, nursing staff, microbiology, operating room, central sterilization service, pharmaceutical care, dietary services, housekeeping, infection prevention and control staff, and other departments as needed.

Fully Met

IPC.4.3 - The infection prevention and control committee meets on a regular basis (at least quarterly).

Fully Met

IPC.4.4 - Functions of the infection prevention and control committee include, but are not limited to, the following:

IPC.4.4.1 Review of the hospital infection prevention and control policies and procedures.
IPC.4.4.2 Review of the reports of healthcare-associated infections surveillance submitted regularly by the infection prevention and control team and suggestion of appropriate actions.
IPC.4.4.3 Revision of the yearly plan submitted by infection prevention and control team and suggestion of additions/changes if necessary.
IPC.4.4.4 Evaluates and revises on a continuous basis the procedures & the mechanisms developed by the infection prevention & control team to serve established standards and goals.
IPC.4.4.5 Brings to the attention of the infection prevention & control team new infection control issues arising in different departments of the hospital & suggests solutions.
IPC.4.4.6 Each member of the committee acts as an advocate of infection prevention & control in his department, trying to promote its principles, and ensures application of its rules.

Fully Met

IPC.15 - Facility design and available supplies support isolation practices.

IPC.15.1 - There is at least one negative pressure airborne isolation room in the emergency room and one in patient care areas (one negative pressure room for every 25-30 beds in general hospitals).

Fully Met

IPC.15.2 - The infection prevention and control team decides the need for more airborne isolation rooms depending on the volume of patients in need for airborne isolation admitted to the hospital.

Partially Met

- *No evidence of documentation indicate that the infection prevention and control team decides the need for more airborne isolation rooms depending on the volume of patients in need for airborne isolation admitted to the hospital.*

IPC.15.3 - The ventilation system serving airborne isolation facilities provides pressure patterns that prevent airborne pathogens from being distributed to other areas of the hospital.

IPC.15.3.1 Rooms designed for airborne isolation patients are under negative pressure.
IPC.15.3.2 Air is exhausted to the outside and is not re-circulated unless it is filtered through High-Efficiency Particulate Air (HEPA) Filter.
IPC.15.3.3 The negative pressure for the isolation room should be validated on daily basis when patient is isolated (admitted in the room). Weekly validation is done when the room has no patients. A minimum of 12 air changes per hour should be maintained by testing and documentation as per manufacturer's recommendation/hospital's policy

Fully Met

IPC.15.4 - The entry of the isolation room is through a work area or ante-room that serves as a site for hand washing, gowning and storage of protective clothing (gloves, aprons, masks).

Not Met

- *The entry of the isolation room is not through a work area or ante-room that serves as a site for hand washing, gowning and storage of protective clothing (gloves, aprons, masks).*

IPC.15.5 - Toilet, shower, or tub and hand washing facilities are provided for each isolation room.

Fully Met

IPC.15.6 - Transmission-based precaution cards (isolation signs) are consistent with the patient diagnosis and are posted in Arabic and English and indicate the type of precautions required.

IPC.15.6.1 Transmission-based precaution cards (isolation signs) are color coded for isolation of different categories (e.g., contact: green, airborne: blue, droplet: pink or red).

IPC.15.6.2 Transmission-based precaution cards (isolation signs) should contain short statements and supported with the required figures.

IPC.15.6.3 Isolation instructions must highlight the transmission-based precaution cards (isolation signs) needed while transporting the patients under transmission-based precautions to other department (e.g., radiology).

Fully Met

IPC.15.7 - Respirator (high filtration) masks (N-95, N-99) are used by staff during direct care of patients on airborne precautions and are available on all units likely to admit patients on airborne precautions.

Fully Met

IPC.15.8 - Respirator (high filtration) masks (N95, N-99) can be reused by the same patient care giver as per the period specified by the manufacturer.

Fully Met

MM.5 - The hospital has a system for the safety of high-alert medications.

MM.5.1 - There is a written multidisciplinary plan for managing high-alert medications and hazardous pharmaceutical chemicals. It includes identification, location, labeling, storage, dispensing, and administration of high-alert medications.

Fully Met

MM.5.2 - The hospital identifies an annually updated list of high-alert medications and hazardous pharmaceutical chemicals based on its own data and national and international recognized organizations (e.g., Institute of Safe Medication Practice, World Health Organization). The list contains, but is not limited to, the following:

MM.5.2.1 Controlled and narcotics medications.

MM.5.2.2 Neuromuscular blockers.

MM.5.2.3 Chemotherapeutic agents.

MM.5.2.4 Concentrated electrolytes (e.g., hypertonic sodium chloride, concentrated potassium salts).

MM.5.2.5 Antithrombotic medications (e.g., heparin, warfarin).

MM.5.2.6 Insulins.

MM.5.2.7 Anesthetic medications (e.g., propofol, ketamine).

MM.5.2.8 Investigational (research) drugs, as applicable.

MM.5.2.9 Other medications as identified by the hospital.

Fully Met

MM.5.3 - The hospital plan for managing high-alert medications and hazardous pharmaceutical chemicals is implemented. This includes, but is not limited to, the following:

MM.5.3.1 Improving access to information about high-alert medications.

MM.5.3.2 Limiting access to high-alert medications.

MM.5.3.3 Using auxiliary labels or computerized alerts if available.

MM.5.3.4 Standardizing the ordering, transcribing, preparation, dispensing, administration, and monitoring of high-alert medications.

MM.5.3.5 Employing independent double checks.

Fully Met

MM.5.4 - The hospital develops and implements standard concentrations for all medications administered by intravenous infusion.

Fully Met

MM.6 - The hospital has a system for the safety of look-alike and sound-alike (LASA) medications.

MM.6.1 - There is a multidisciplinary policy and procedure on handling look- alike/sound-alike (LASA) medications.

Fully Met

MM.6.2 - The hospital reviews and revises annually its list of confusing drug names, which include LASA medication name pairs that the hospital stores, dispenses, and administers.

Fully Met

MM.6.3 - The hospital takes actions to prevent errors involving LASA medications including the following, as applicable:

MM.6.3.1 Providing education on LASA medications to healthcare professionals at orientation and as part of continuing education.
MM.6.3.2 Using both the brand and generic names for prescribing LASA medications.
MM.6.3.3 Writing the diagnosis/ indication of the LASA medication on the prescription.
MM.6.3.4 Changing the appearance of look-alike product package.
MM.6.3.5 Reading carefully the label each time a medication is accessed, and/or prior to administration.
MM.6.3.6 Minimizing the use of verbal and telephone orders.
MM.6.3.7 Checking the purpose/indication of the medication on the prescription prior to dispensing and administering.
MM.6.3.8 Placing LASA medications in locations separate from each other or in non-alphabetical order.

Fully Met

MM.41 - The hospital has a process for monitoring, identifying, and reporting significant medication errors, including near misses, hazardous conditions, and at-risk behaviors that have the potential to cause patient harm.

MM.41.1 - There is a multidisciplinary policy and procedure on handling medication errors, near misses, and hazardous situations (e.g., confusion over look-alike/sound-alike drugs or similar packaging).

Fully Met

MM.41.2 - The policy has a clear and acceptable definition of significant medication error, near misses, and hazardous situations.

Fully Met

MM.41.3 - The treating physician is notified of the medication error at the appropriate time.

Fully Met

MM.41.4 - Medication error reporting is completed within the specified time frame after discovery of the error.

Fully Met

MM.41.5 - The hospital has a standard format for reporting medication errors.

Fully Met

MM.41.6 - Staff are educated on the process and importance of medication error reporting.

Fully Met

MM.41.7 - There is active reporting of medication errors, near misses, and hazardous situations.

Fully Met

MM.41.8 - The hospital conducts intensive root-cause analysis for all significant or potentially significant medication errors.

Fully Met

MM.41.9 - Medication errors, near misses, and hazardous situations are documented in the patient's medical record.

Fully Met

MM.41.10 - The hospital utilizes reported data to improve the medication use process, prevent medication errors, and improve patient safety.

Fully Met

MM.41.11 - Healthcare professionals are provided with feedback on reported medication errors, near misses, and hazardous situations.

Fully Met

MM.41.12 - The hospital reports sentinel events related to serious medication errors to the relevant authorities.

Fully Met

LB.51 - The blood bank develops a process to prevent disease transmission by blood/platelet transfusion.

LB.51.1 - There are policies and procedures mandating that a sample of blood obtained from the donor during blood/ blood component collection is subjected to the following infectious diseases testing:

LB.51.1.1 HBsAg.
LB.51.1.2 Anti-HBc.
LB.51.1.3 Anti-HCV.
LB.51.1.4 Anti-HIV-1/2.
LB.51.1.5 Anti-HTLV-I/II.
LB.51.1.6 HIV-1 RNA.
LB.51.1.7 HCV RNA.
LB.51.1.8 HBV DNA.
LB.51.1.9 Serological test for syphilis.
LB.51.1.10 Other additional or supplemental tests as mandated by relevant health authorities.

Fully Met

LB.51.2 - The blood bank has a process to limit and detect bacterial contamination in platelet components. The process:

LB.51.2.1 Describes the blood bank approach to limit bacterial contamination and the investigations of positive cases.
LB.51.2.2 Ensures the employed detection method is sensitive enough to detect significant bacterial contamination.

Fully Met

FMS.9 - The hospital ensures that all its occupants are safe from radiation hazards.

FMS.9.1 - The hospital has a radiation safety policy and procedure and it is implemented.

Fully Met

FMS.9.2 - All radio-active materials are clearly labeled and safely and securely stored.

Fully Met

FMS.9.3 - The hospital has the relevant valid license(s) from King Abdulaziz City for Science and Technology.

Fully Met

FMS.9.4 - Staff handling nuclear materials are qualified and certified by King Abdul-Aziz City for Science and Technology.

Fully Met

FMS.9.5 - There is a valid shielding certificate of the x-ray room(s) including regular test to ensure permissible radiation levels.

Fully Met

FMS.9.6 - Lead aprons and gonad/thyroid shields are available to cover patients and staff needs and are annually tested according to a hospital-wide inventory.

Fully Met

FMS.9.7 - Personal radiation dosimeters (TLD cards) are available, tested every 3 months, and actions taken when test results exceed permissible levels.

Fully Met

FMS.21 - The hospital has an effective fire alarm system.

FMS.21.1 - There is a fire alarm system that is functioning and regularly inspected as per civil defense guidelines.

Fully Met

FMS.21.2 - The fire alarm system testing results are documented.

Fully Met

FMS.21.3 - The fire alarm system has preventive maintenance.

Fully Met

FMS.21.4 - The elevators are connected to the fire alarm system.

Partially Met • *No supportive document was present. The hospital should have distribution drawings as the standard requests.*

FMS.22 - The hospital has a fire suppression system available in the required area(s).

FMS.22.1 - The hospital has a functional sprinkler system.

Fully Met

FMS.22.2 - The hospital has clean agent suppression system.

Fully Met

FMS.22.3 - The hospital has wet chemical system.

Fully Met

FMS.22.4 - The hospital has stand pipes and hose system.

Fully Met

FMS.23 - There are fire exits that are properly located in the hospital.

FMS.23.1 - Fire exits are available and are properly located in the hospital.

Fully Met

FMS.23.2 - Fire exits are not locked.

Fully Met

FMS.23.3 - Fire exits are not obstructed.

Fully Met

FMS.23.4 - Fire exits have panic hard ware.

Not Met • *Fire exits have no panic hard ware. The hospital should install panic hard ware for all fire exits.*

FMS.23.5 - Fire exits are fire resistant.

Partially Met • *Fire rating was not proven.*

FMS.23.6 - Fire exits are clearly marked with illuminated exit sign.

Fully Met

FMS.24 - The hospital and its occupants are safe from fire and smoke.

FMS.24.1 - The hospital implements a strict "No Smoking" policy.

Fully Met

FMS.24.2 - There are no obstructions to exits, fire extinguishers, fire alarm boxes, emergency blankets, safety showers, and eye wash stations.

Fully Met

FMS.24.3 - Emergency lighting is adequate for safe evacuation of the hospital.

Fully Met

FMS.24.4 - Storage areas are properly and safely organized:

FMS.24.4.1 Shelves and racks are sturdy and in good condition.
FMS.24.4.2 No items stored directly on the floor (a minimum of ten centimeters is left to manage spills).
FMS.24.4.3 Items should be stacked on a flat base.
FMS.24.4.4 Heavier objects are close to the floor and lighter/smaller objects are higher.
FMS.24.4.5 Items are not stacked so high to block sprinklers or come in contact with overhead lights or pipes (a minimum distance of fifty centimeters from ceiling level).

Fully Met

FMS.24.5 - Fire rated doors are available according to the hospital zones with no separation between walls and ceiling to prevent smoke spread between rooms and areas.

Fully Met

FMS.32 - The hospital ensures proper maintenance of the medical gas system.

FMS.32.1 - The medical gas system is regularly tested for:

FMS.32.1.1 Pressure.
FMS.32.1.2 Leaks.
FMS.32.1.3 Functionality of valves, alarms, pressure gauge, and switches.

Partially Met
- *The medical gas system is not tested for functionality of valves, alarms, pressure gauge and switches.*

FMS.32.2 - There is a policy and procedure that ensures effective use of medical gas system. Areas covered include, but are not limited to, the following:

FMS.32.2.1 The procedures to follow for taking any part of the system offline.
FMS.32.2.2 Commissioning and testing new branching or modifications.
FMS.32.2.3 The procedure for ordering and filling liquid oxygen.
FMS.32.2.4 Documenting all repairs/alterations/tests/filling logs/consumption.

Fully Met

FMS.32.3 - Compressed medical air is regularly tested for humidity and purity.

Not Met
- *Compressed medical air is not regularly tested for humidity and purity. The hospital should conduct annual testing for humidity and purity.*

FMS.32.4 - The central medical gas station is in a safe and secure place.

Fully Met

FMS.32.5 - The outlets of medical gases in patient care areas are clearly marked with the type of gas and have different connections according to the gas type.

Fully Met

FMS.32.6 - All medical gas pipes are clearly marked and labeled for the contents and direction of gas flow.

Partially Met
- *All medical gas pipes are clearly marked and labeled for the contents and direction of gas flow. However, the marking, labeling and gas flow should be at 1.5 to 2 meter interval to avoid human error and cross connection.*

FMS.32.7 - In case of gas pipe repairs or new extensions, outlets are tested for the type of gas to ensure the correct type is delivered through the new pipe. Results of testing are recorded and maintained with engineering and the unit manager.

Not Met
- *No supportive document was present.*

FMS.32.8 - The hospital keeps standby oxygen and medical air cylinders enough for forty eight hours of average consumption.

Fully Met

FMS.32.9 - The gas cylinders are regularly tested for gas type, amount, and any leaks.

Fully Met

FMS.32.10 - Emergency shut off valves are available in all units and are clearly marked with areas/rooms affected.

Fully Met

FMS.32.11 - The hospital dedicates the responsibility of the closure of shut off valves to well-trained individual(s) available in the unit concerned.

Fully Met

FMS.32.12 - The hospital has adequate medical gases outlets in the patient care areas as appropriate and these outlets are to be error proof medical gas outlets- preferred to be in accordance with DIN standards related to gases piping, outlets and valves.

Fully Met

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