مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre
Gen. Org. مؤسسة عامة

Accreditation Plan

PURPOSE

The purpose of the organization-wide Accreditation Plan is to define King Faisal Specialist Hospital and Research Centre's (KFSH&RC) (Gen. Org.) approach to continuously meet and/or exceed the national and international accreditation standards. The Accreditation Plan provides an elaboration on the accreditation readiness activities of the Hospital and it is complementary to the Quality and Safety Management Plan (QSMP).

INTRODUCTION

Accreditation is an effective Quality Management tool that provides the means of performing an objective standards-based evaluation of the healthcare provided at KFSH&RC (Gen. Org.). The accreditation process provides a visible commitment by the Organization to improve the quality of patient care, ensure a safe environment, and continually work to reduce risks to patients, visitors and staff. Quality Management Department (QMD) develops the plan that is then reviewed by the Accreditation Committee members before submission for approval.

GOAL

The goal of this plan is to describe the mechanisms to achieve continuous compliance with national and international accreditation standards. The plan shall promote continuous Quality Improvement and Patient Safety throughout the Hospital as an element to achieve becoming High Reliability Organization (HRO).

OBJECTIVES

- Facilitate and ensure alignment and compliance with the updated Joint Commission International (JCI) and Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) accreditation standards.
- Ensures proper assessment of a system, adequate implementation of processes, elimination of problem areas, and boosting the efficiency of the methods following national and international standards.
- Highlight compliance issues and risks identified translate the audit plan into executable and quality activities to assure compliance with national and international standards.
- Provide support for hospital departmental national and international accreditations (Appendix A) as requested.
- Ensure that the hospital policies and procedures meet different hospital accreditations' standards. The policies and procedures shall be also consistent with the quality and patient safety standards to maintain the status of the High Reliability Organization (HRO).
- Report compliance monitoring of accreditation standards to the relevant department(s), committee(s), and individual(s) promptly. Coordinate and/or facilitate action plans to resolve identified issues.
- Promote education and awareness on accreditation standards and hospital policies.
- Facilitate the participation of hospital staff as assessors, surveyors and educators for other hospitals with national and international accreditation bodies.
- Enrich quality of patient care by ensuring clinical documentation accuracy and improve safety measures by conducting clinical documentation audits.

Accreditation Plan

NOVEL ACCREDITATION APPLICATION

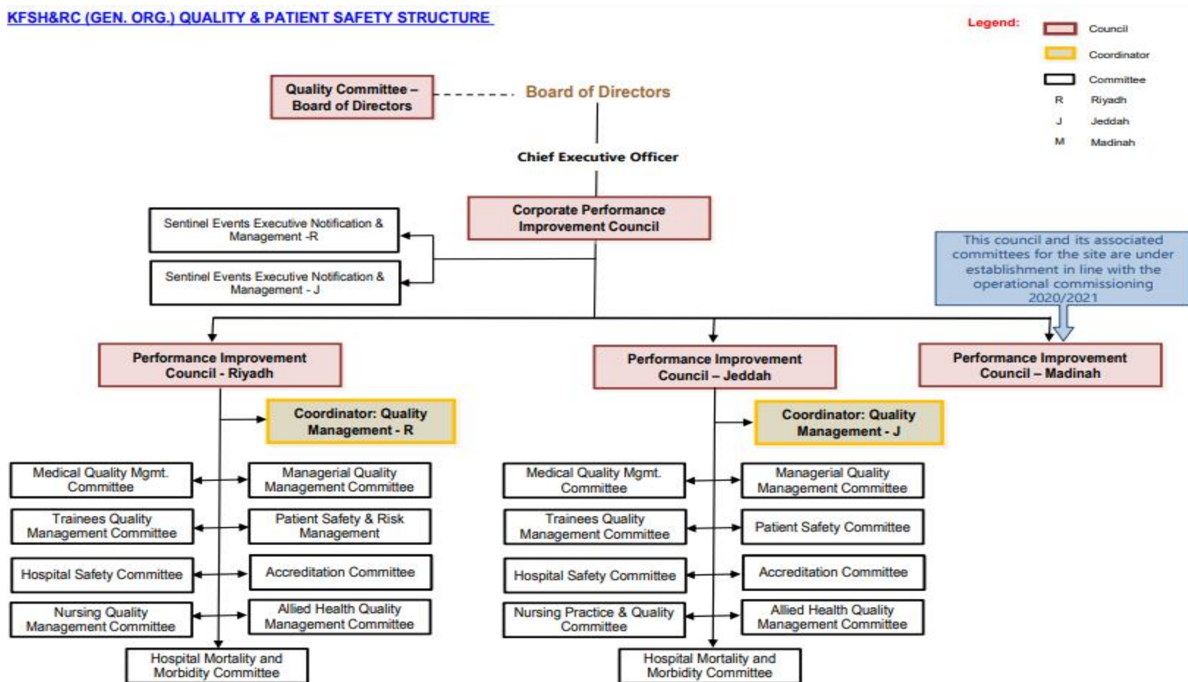
Departmental/Sectional/Divisional/Services who would like to apply for novel accreditation other than the Hospital's current accreditations are to complete the "Request for Novel Accreditation" form in (Appendix B).

Quality Management - Accreditation Section Provide support, awareness to the requested Departmental/Sectional/Divisional/Services to Improve the process of Novel Accreditation, streamline the process, plan budget allocation, application, preparation and policy formation and reduce variation among hospital departments and ensure that all the proposal of the Novel accreditation is aligned with hospital strategic objective.
See Appendix C for Novel Accreditation Flowchart.
Department's Chairman or Head shall submit completed form in official correspondence to the Chairman of the Accreditation Committee. Quality Management shall be copied in the correspondence to follow-up on the request.

RESPONSIBILITY

The Board of Directors Chairman approves the Hospital Quality and Safety Plan and oversees its implementation through the Hospital Quality and Safety structure. QMD is responsible for coordinating the implementation of the plan with each senior manager throughout the Organization. The Hospital Quality & Patient Safety structure is outlined in Figure 1:

Figure 1



Accreditation Plan

PERFORMANCE IMPROVEMENT COUNCIL (PIC) (CFO-R: 755 & CFO-J: 021)

The General Manager or Director of Healthcare Delivery of the site chairs the PIC that is composed of members from the senior managers. The Council provides executive oversight and direction for performance improvement, patient safety, risk management, safety, and accreditation activities. The Director of Quality Management coordinates the PIC meetings every two (2) months. The Chairs of the following committees: Patient Safety and Risk Management; Hospital Safety; Accreditation; Hospital Mortality and Morbidity; Nursing Quality Management; Managerial Quality Management and Allied Health Quality Management attend the PIC and their updates are part of the council agenda. The PIC chairman forwards the issues raised from the quality and safety committees to the applicable senior manager or committee for review and appropriate action(s). QMD coordinates the process until actions are completed.

ACCREDITATION COMMITTEE (ACC) (CFO-R: 709 & CFO-J: 057) RIYADH, JEDDAH & MADINAH

ACC provides oversight for the organization accreditation activities to ensure the continuous application of accreditation standards. Quality Management coordinates the committee meetings on a monthly/quarterly basis or more often as required. Membership is multidisciplinary with representatives from clinical and non-clinical departments. The chairmen of Hospital Safety, Managerial Quality Management, Medical Quality Management, Nursing Quality Management, and Allied Health Quality Management committees are members of the ACC.

The Accreditation Committee also provides oversight for the organization accreditation activities to ensure that:

- KFSH&RC (Gen. Org.) maintains processes and practices that meet or exceed national and international accreditation standards on a continual basis.
- Issues related to compliance with accreditation standards are referred to the appropriate committee(s) (Figure 1), department(s), and individual(s) to develop an action plan to resolve the issues.
- Accreditation standards compliance outstanding issues are addressed in a timely manner.
- Issues unresolved by the ACC are referred to the PIC for action.

ACCREDITATION SECTION, QMD (RIYADH, JEDDAH & MADINAH).

The responsibilities of the Accreditation Section are the following:

- Coordinate preparations for JCI and CBAHI survey visits.
- Coordinate CBAHI Essential Safety Requirement (ESR) annual assessment visit.
- Coordinate CBAHI MERS-COV & Covid -19 annual assessment visit.
- Coordinate completion and submission of CBAHI Mid-Term- Self Assessment mandated between two consecutive survey visits.
- Provide support to Departmental/Sectional/Divisional/Service(s) Accreditations as requested.
- Conduct regular meetings with Departmental/Sectional/Divisional/Service(s) Accreditations' coordinators and follow up to reflect the most updated information of each Accreditation on Data Bank through service HUB application when applicable.

Coordinate the ACC meetings.

- Reports to the ACC and senior managers on JCI and CBAHI standards in regard to updates, continuous readiness activities, and survey methodologies.
- Facilitate organization-wide awareness and education by presenting accreditation standards and related policies at general staff, department, unit and committee meetings.

- Facilitate the formation of working groups and taskforces to resolve identified standards compliance issues.
- Collaborate with departments to ensure that developed or revised policies and procedures are in line with updated accreditation standards.
- Monitor compliance with policies and standards through focused quality audits, assessment visits and tracers.
- Assigning a Risk level toward the findings reported in the quality audits using JCI-Risk Assessment Matrix- Survey Analysis for Evaluating Risk SAFER) Matrix) Appendix D
- Report findings by using the matrix is intended to help organizations to:
- Easily identify findings with higher risk
- Identify potential for widespread quality initiatives
- Better organize survey findings by level of potential patient impact
- Have, one comprehensive visual representation of survey findings
- Report issues related to compliance with accreditation standards in a timely manner to the appropriate committee(s), department(s), and individual(s).
- Facilitate the conduction of accreditation-related improvement projects in collaboration with departments to achieve JCI Strategic Improvement Plan (SIP), CBAHI Correction Action Plan (CAP) and other accreditation bodies' improvement projects.
- Ensure with relevant QMD sections the development of indicators and audits to monitor compliance with accreditations standards.
- Work to ensure implementation of the recommendations and correction of the citations provided by JCI or CBAHI surveyors by relevant departments.
- Regularly maintain and update the documents of the JCI and CBAHI Evidentiary Binders in collaboration with the concerned departments and assigned chapter leaders.

ACCREDITATION STANDARDS COMPLIANCE MONITORING

Quality Management staff coordinate the following functions to assure continuous monitoring and compliance with accreditation standards using standardized assessment or audit tools.

INDIVIDUAL PATIENT TRACERS

Individual Tracers shall be multidisciplinary and educational. The Accreditation Section/QMD staff will coordinate the tracers. Healthcare providers involved in the patient's care and some members of the Quality Management Committees are invited to the trace sessions. The tracer team will review the patient medical record with the involved health care providers. The process for patient selection shall be as follows:

- Selection is based on KFSH&RC (Gen. Org.) top ten (10) high-risk diagnoses/procedures. Patients who have developed complications or adverse occurrences such as infections or drug interactions are chosen as well to trace the care provided.
- The patient selected should be close to discharge or have been long enough in the hospital to be able to evaluate different transitions of care aspects of the patient care provided.
- The multidisciplinary discussion will be guided by priority focus areas identified in the accreditation standards or hospital policies.

Accreditation Plan

SYSTEM TRACERS

QMD staff will coordinate the system tracers as needed. Infection Control, Medication, Data Management, Facility and Quality and Patient Safety and Supply Chain Management system tracers will be coordinated to evaluate any issues related to those systems to address them in a timely manner.

FOCUSED TRACERS

QMD staff will coordinate the focused Tracers as needed. Focused tracers shall be multidisciplinary, educational and conducted by QMD with the aim of monitoring and promoting compliance with accreditation standards and key KFSH&RC (Gen. Org.) policies (e.g. procedural sedation, infection control, high alert medications, staff file reviews etc.). The policies may be identified by QMD and/or by any of the other Quality Committees as per the Quality Management Structure (Figure 1).

ENVIRONMENT OF CARE (QUALITY AND SAFETY ROUNDS)

The environment where care, treatment, or services are being provided can be a crucial factor in achieving good outcomes. QMD staff coordinates the Environment of Care Rounds in collaboration with the multidisciplinary team for clinical and non-clinical areas regularly and as required.

ENVIRONMENT OF CARE ROUNDS GOAL

- Identify hazards and risks and maintain safe conditions for patients, visitors, employees, dependents and Hospital property.
- Monitor compliance with the accreditations Facility Management and Safety Standards (FMS).
- Educate Health Care Providers (HCP's) and other support services staff on how to maintain a safe Environment of Care.
- Establish teamwork to act on the identified issues.
- Provide recommendations for improvement for area managers in an official report.

CBAHI MOCK SURVEY VISITS

QMD staff will coordinate Medical, Nursing, Laboratory, Facility, Infection Control, Pharmacy and Leadership CBAHI Mock Survey/Assessment to monitor the compliance with CBAHI standards and educate Health Care Providers (HCP) about the expectations and the standards' requirements.

MEDICAL RECORDS AUDITS

QMD staff will oversee the conduction of closed and open medical records reviews and will review and update the audit tools (Clinical Indicators) yearly or every accreditation cycle (3 years) as required per JCI and CBAHI updated accreditation standards manuals as outlined below:

- **Medical Departments:** QMD staff will audit or oversee the conduction of the audits for medical departments using standardized audit tools and the results will be reported on a quarterly basis to the relevant departments and staff. Physicians will perform the audits and a random sample of selected audited charts will be audited by Quality Management to ensure data validation and accuracy of the auditing process.
- **Nursing Affairs:** QMD staff will audit or oversee the conduction of the audits for all nursing units using standardized audit tools and the results will be reported on a quarterly basis to the relevant departments and staff. Nurses will perform the audits and a random sample of selected audited charts will be audited by Quality Management to ensure data validation and accuracy of the auditing process.
- **Allied Health Departments:** QMD staff will audit or oversee the conduction of audits for Allied Health Departments using standardized audit tools and the results are sent biannually to

relevant departments. Allied Health staff will perform the audits and random sample of selected audited charts will be audited by Quality Management to ensure data validation and accuracy of the auditing process.

ACCREDITATION STANDARDS MONITORING REPORTS

Tracers, Environment of Care (Quality and Safety Rounds) and CBAHI Mock survey /assessment visits findings will be shared with the Area Manager.

- Good practices shall be recognized and immediately commended.
- Reports shall be sent electronically in a timely manner to the managers of the relevant departments.
- Issues identified shall be presented by QMD to the Accreditation Committee members in the monthly/quarterly meetings.
- Recommended actions on the issues identified shall be produced during the Accreditation Committee meetings.
- The Accreditation Committee shall delegate the responsibility for actions to the appropriate team/ department/committee/individual with a timeline for completion.
- Periodic updates shall be provided to the Accreditation Committee until issues identified are resolved.
- Unresolved issues shall be provided to the PIC on a quarterly basis.

CONFIDENTIALITY

Quality data and information are confidentially maintained in accordance with the guidelines in the Employee Relation Manual (ERM), Effective 09 Ramadan 1436 (June 2017). The ERM states in page #2 of "employee conduct, responsibilities, and disciplinary procedures - Chapter V-2" item 2.11: "Refrain from disclosure or dissemination of information in any manner, concerning job related matters and/or Hospital operations, without prior authorization." and APP- 42 "Confidentiality Policy", effective 24 Dhu Al Qada 1438 (16 August 2017) and Confidentiality Statement GD: 095-1432.

QMD data is password secured in a specific server. The Director or Head of Quality Management or his /her designee determines access to this server.

Accreditation Plan

ACCREDITATION PLAN EVALUATION AND REVISION

The Accreditation Committee will evaluate the plan based on the committee's annual report and revise it annually or earlier if deemed necessary.

APPENDIX A: INTERNATIONAL AND NATIONAL ACCREDITATIONS

KFSH&RC (Gen. Org.) – Riyadh International & National Clinical Areas Accreditations	
Accreditation	**Owner**
Joint Commission International (JCI) Accreditation – Academic Medical Center (AMC)	Hospital Wide
Saudi Central Board for Accreditation of Health Care Institution (CBAHI)	Hospital Wide
Emergency Management Accreditation Program (EMAP)	Hospital Wide
Joint Accreditation Committee International – ISCT and EBMT (JACIE)	Oncology & DPLM
College of American Pathologists (CAP)	Department of Pathology and Laboratory Medicine
American Association of Blood Bank (AABB)	
American Society of Hematology/ Immunology (ASHI)	
Non Clinical Testing in Toxicology (ISO 17025) International Organization for standardization	
American Society for reproductive Medicine (ASRM)	
ISO 9001:2000 Lab – Quality Management System Requirements	
The Royal College of Pathologists of Australia(RCPA)	
American Nurses Credentialing Center (ANCC) – Magnet Designation	Nursing Affairs
Chest Pain Centre Accreditation (CPC)	Department of Emergency Medicine (DEM) and Heart Centre
Accreditation For Cardiovascular Excellence (ACE) - Electrophysiology	Heart Centre
Accreditation For Cardiovascular Excellence (ACE) - Cardiac Catheterization and Percutaneous Coronary Intervention	Heart Centre
Accreditation For Cardiovascular Excellence (ACE) - Pediatric Congenital Cardiac Catheterization Laboratory	Heart Centre
European Accreditation of Cardiovascular Imaging Laboratory (EACVI)	Heart Centre - (Echo Lab)
Baby Friendly Hospital Accreditation	Women Health Division
CT Scan and Ultra-Sound Accreditation in American College of Radiology (ACR)	Radiology Department
Nuclear medicine and Positron Emission Tomography service accreditation by American college of Radiology	
American Nurses Credentialing Centre (ANCC) Magnet Designation	Nursing Affairs
Manufacturing License for Radio-pharmaceuticals	Cyclotron Department
ISO 9001:2015 Quality Management System	
Radioactive Product Manufacture and Handling	
KFSH&RC (Gen. Org.) – Riyadh International Education and Information System Accreditations	
Accreditation	**Owner**
International Accreditation of Hospital and Health System Pharmacy Services	

Accreditation Plan

The ASHP Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Residency Program	Pharmaceutical Care Division
The ASHP Accreditation Standard for Postgraduate Year Two (PGY2) Oncology Residency Program	
The ASHP Accreditation Standard for Postgraduate Year Two (PGY2) Solid Organ Transplant Residency Program	
Accreditation Council for Pharmacy Education (ACPE)	
American Academy of Continuing Medicine Education (AACME)	Academic and Training Affairs (ATA)
American Society for Kidney Transplant " certified and Accredited for fellowship training program" (AST)	Health Informatics Technology Affairs (HITA)
HIMSS Analytics Outpatient Electronic Medical Record Adoption Model (O-EMRAM) - Stage 7	
HIMSS Analytics Adoption Model for Analytics Maturity (AMAM) – Stage 6	
ISO/IEC 27001 Information Security Management System (ISMS)	
Qiyas - Government Digital transformation	
HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) - Stage 6	

KFSH&RC (Gen. Org.) – Jeddah International Clinical Areas Accreditations	
Accreditation	**Owner**
Joint Commission International (JCI) Accreditation	Hospital Wide
A colleague of American Pathologists (CAP)	Pathology and Laboratory Medicine
American Society for Histocompatibility and Immunogenic (ASHI)	Pathology and Laboratory Medicine
American Association for Blood Banks (AABB)	Pathology and Laboratory Medicine
American Nurses Credentialing Centre (ANCC) Magnet Designation	Nursing Affairs
Hazard Analysis and Critical Control Point (HACCP)	Food Services
KFSH&RC (Gen. Org.) – Jeddah International Clinical Areas Accreditations	
Accreditation	**Owner**
Joint Accreditation Committee International – ISCT and EBMT (JACIE)	Oncology & DPLM
The Institution Accreditation Commission For Health Specialist	Academic and Training Affairs (ATA)
Emergency Care Research Institute(ECRI)	Clinical Engineering

APPENDIX B: NOVEL ACCREDITATION APPLICATION FORM

King Faisal Specialist Hospital & Research Centre (Gen.Org.) Accreditation Plan

Accreditation Plan

<table>
<tr><th colspan="2">REQUEST FOR NOVEL ACCREDITATION</th></tr>
<tr><td>Name of the Group/Division/Department/Section applying for Accreditation</td><td></td></tr>
<tr><td>Name of the Accreditation Program
(Attach Accreditation Standards and Accreditation Manual if applicable)</td><td></td></tr>
<tr><td>Specify Accreditation objectives including benefits to KFSH&RC (Gen. Org.)</td><td></td></tr>
<tr><td>Accreditation cycles
(The length between two (2) consecutive survey visits)</td><td></td></tr>
<tr><td>Specify required support (type and details) from the Accreditation Committee:
1. Education
2. Facilitation
3. Coordination
4. Interpretation of standards
5. Preparation for the survey visit
6. Participation in the survey visit
7. Consultation for Post- Survey findings action plans</td><td></td></tr>
<tr><td>Accreditation Expenses, including the accreditation fee and survey visit expenses (Estimated Coast)</td><td></td></tr>
<tr><td>Finding of the self-assessments (Challenges)</td><td></td></tr>
<tr><td>Recommendations from the Accreditation Committee</td><td></td></tr>
<tr><td>Accreditation Committee Chairman Signature</td><td></td></tr>
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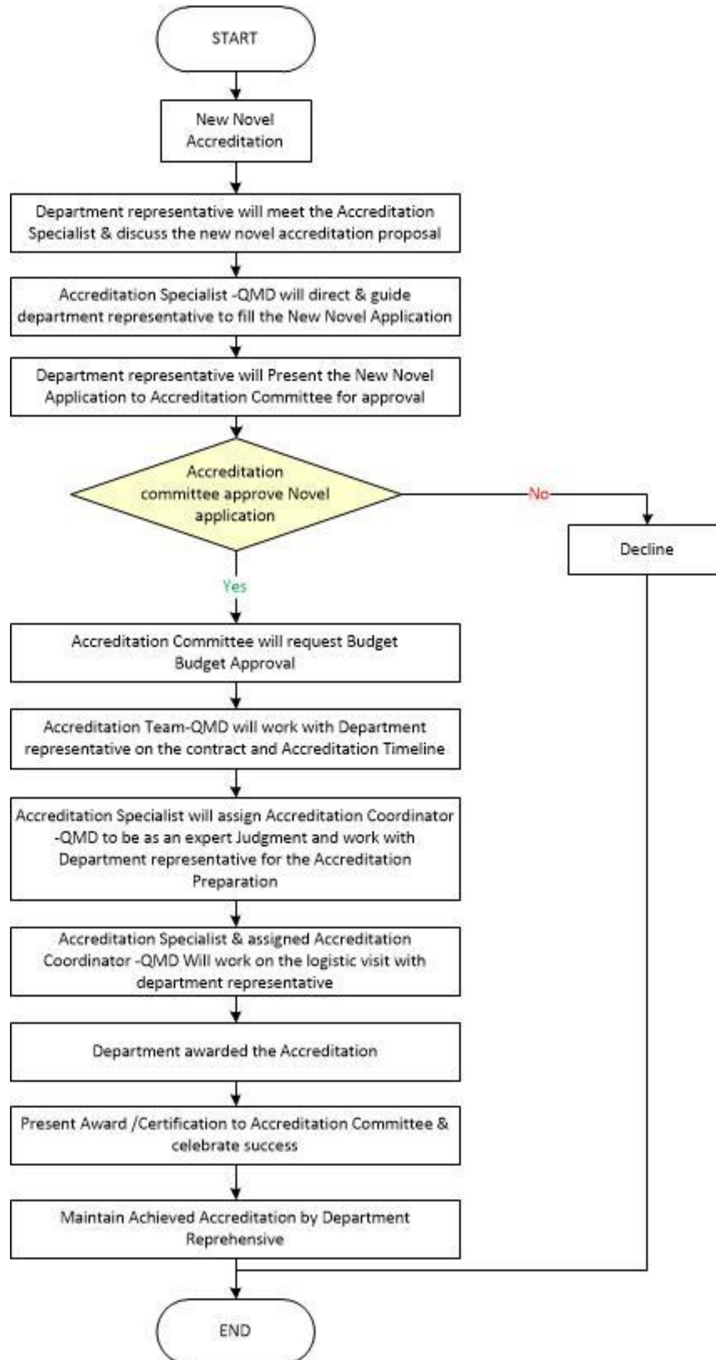
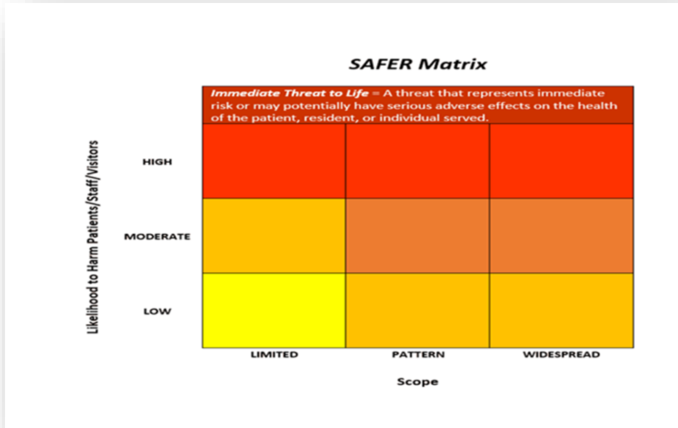
Accreditation Plan

APPENDIX C: NOVEL ACCREDITATION FLOWCHART



Accreditation Plan

APPENDIX D: JCI-Risk Assessment Matrix- Survey Analysis for Evaluating Risk (SAFER) Matrix



Safer Analysis for Evaluating Risk® – (SAFER)™ Operational Definitions

LIKELIHOOD TO HARM

Category	Definition	Further Guidance
LOW	Harm could happen, but would be rare	– Undermines safety/quality or contributes to an unsafe environment, but very unlikely to directly contribute to harm. – It would be rare for any actual patient harm to occur as a result of the deficiency.
MODERATE	Harm could happen occasionally	– Could cause harm directly, but more likely to cause harm as a contributing factor in the presence of special circumstances or additional failures. – If the deficiency continues, it would be possible that harm could occur but only in certain situations and/or patients.
HIGH	Harm could happen at any time	– Could directly lead to harm without the need for other significant circumstances or failures. – If the deficiency continues, it would be likely that harm could happen at any time to any patient (or did happen)

SCOPE

Category	Definition	Further Guidance
LIMITED	Unique occurrence that is not representative of routine/regular practice, and has the potential to impact only one or a very limited number of patients, visitors, staff	– An outlier. – Scope is isolated when one or a very limited number of patients are affected and/or one or a very limited number of staff are involved, and/or the deficiency occurs in a very limited number of locations.
PATTERN	Multiple occurrences of the deficiency, or a single occurrence that has the potential to impact more than a limited number of patients, visitors, staff	– Process Variation. – Scope is pattern when more than a very limited number of patients are affected, and/or more than a very limited number of staff are involved, and/ or the situation has occurred in several locations, and/or the same patient(s) have been affected by repeated occurrences of the same deficient practice.
WIDESPREAD	Deficiency is pervasive in the facility, or represents systemic failure, or has the potential to impact most/all patients, visitors, staff	– Process Failure. – Scope is widespread when the deficiency affects most/all patients, is pervasive in the facility or represents systemic failure. Widespread scope refers to the entire organization, not just a subset of patients or one unit.

Accreditation Plan

APPENDIX E: Abbreviations

QMD Quality Management Department

CQO Chief Quality Officer

CMO Chief Medical Officer

JCI Joint Commission International

HRO High Reliability Organization

CBAHI Central Board for Accreditation of Healthcare Institutions

SIP Strategic Improvement Plan

CAP Corrective Action Plan

PIC Performance Improvement Council

GD General Distribution

APP Administrative Policy and Procedure

CFO Committee Formulation Order

ERM Employee Relation Manual

HCP Health Care Provider

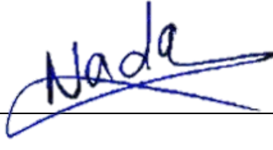
FMS Facility Management and Safety

ACC Accreditation Committee

Accreditation Plan

ACCREDITATION PLAN APPROVAL

Reviewed by:



Date: 7 January 2021

Nada Alharbi
Director, Quality Management Department - Riyadh
KFSH&RC (Gen. Org.)

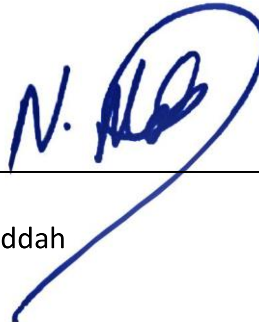
Date: 7 January 2021

Shorouq Zakariya
Director, Quality Management Department - Jeddah
KFSH&RC (Gen. Org.)

Date: 10 January 2021

Fadwa Abu Mostafa
Head, Quality Management - Madinah
KFSH&RC (Gen. Org.)

Recommended by:

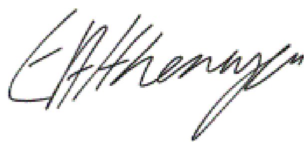


Date: 20 January 2021

Dr. Nasser Mahdi
General Manager - Jeddah
KFSH&RC (Gen. Org.)

Date: 20 January 2021

Dr. Nezar Khalifah
General Manager - Madinah
KFSH&RC (Gen. Org.)



Date: 21 January 2021

Dr. Eyad Althenayan
Chief Quality Officer, Quality Management
KFSH&RC (Gen. Org.)

Accreditation Plan

ACCREDITATION PLAN APPROVAL

Recommended by: ______________________ **Date:** 24 January 2021

Dr. Mohammed Alotaibi
Deputy Chief Executive Officer–Healthcare Delivery
KFSH&RC (Gen. Org.)

Approved by: ______________________ **Date:** 24 January 2021

Dr. Yaseen Mallawi
Acting Chief Executive Officer – Healthcare Delivery
KFSH&RC (Gen. Org.)