مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre

Quality Framework Towards Excellence Plan

Accreditation Management Plan (AMP)
2022

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Section 1: Introduction

The Accreditation Management Plan is inline with **vision, mission, values,** of King Faisal Specialist Hospital and Research Centre (KFSH&RC (Gen.Org) and is complimanry to the Quality Framework towards Excllence Plan. The plan is developed by the Quality Management Department and is approved by the Chief Quality Officer.

Section 2: Overview

2.1 Purpos

The Accreditation Management Plan aims to define King Faisal Specialist Hospital and Research Centre's (KFSH&RC) approach to continuously meet or exceed the national and international accreditation standards. It elaborates on the accreditation readiness activities of the hospital and is complementary to the Quality Framework towards Excellence Plan.

2.2 Scope

Accreditation is an effective Quality Management tool that performs an objective, standards-based evaluation of the healthcare provided at KFSH&RC. The accreditation process provides a visible commitment by the hospital to improve the quality of patient care, ensure a safe environment, and continually work to reduce risks to patients, visitors, and staff.

2.3 Objectives

1. 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.
2. Ensure proper assessment of the system, adequate implementation of processes, elimination of problem areas, and boosting the efficiency of the methods following national and international standards.
3. Highlight compliance issues and risks identified and translate the audit plan into executable activities to assure compliance with national and international standards.
4. Provide support for hospital departmental national and international accreditations as requested.
5. Ensure that the hospital policies and procedures meet different hospital accreditations' standards. The policies and procedures shall also be consistent with the quality and patient safety standards to maintain the High-Reliability Organization (HRO) status.
6. Report compliance monitoring of accreditation standards to the relevant department(s), committee(s), and individual(s) promptly. Coordinate or facilitate action plans to resolve identified issues.

7. Promote education and awareness on accreditation standards and hospital policies.
8. Facilitate the participation of hospital staff as assessors, surveyors, and educators for other hospitals with national and international accreditation bodies.
9. Promote the quality and safety of patient care by ensuring clinical documentation completeness and accuracy by conducting regular clinical documentation audits.

2.4 Data Management

Quality Management Department will submit monthly and quarterly reports to senior managers and relevant committees to communicate data related to the various Accreditation Activities.

2.4.1 Quality Indicators

Quality indicators
KPI # 1: % of successfully achieved Accreditations status per hospital site annually (Formula: # of achieved Accreditation Status / Total Accreditation Survey Visits conducted annually * 100)
KPI # 2: % of completion of action plans implementation for identified CBAHI and JCI Accreditation visits reports citations (Formula: # of CBAHI/ JCI Accreditation Visit report citations with implemented corrective actions/ Total # of Accreditation visit citations as per the survey visit report)

Section 3: Governance

3.1 Roles and Responsibilities

The responsibility for the Accreditation Management Plan rests with the Quality Management Department in collaboration with multiple stakeholders, as accreditation activities apply to all hospital departments. Quality Management Department will provide necessary data and work closely with these departments to assure compliance with regulatory standards.

3.1.1 Performance Improvement Council (PIC) (CFO-R: 755, CFO-J: 021 & CFO-M: 1705)

The chairman and the co-chairman is appointed by the Quality and Patient Safety Governance Council. The council is composed of senior management members, providing executive oversight and direction for performance improvement, patient safety, risk management, safety, and accreditation activities. The Director/Head of Quality Management coordinates the PIC meetings every two (2) months. The Chairs of the following committees: Patient Safety and Clinical Risk Management; Accreditation; Hospital Mortality and Morbidity; Medical Quality Management; 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 leader or committee for review and appropriate action(s). QMD coordinates the process until actions are completed.

3.1.2 Accreditation Committee (CFO-R:709, CFO-J:057 & CFO-M:1706)

The Accreditation Committee provides oversight for the hospital's accreditation activities to ensure the continuous application of accreditation standards. Quality Management coordinates the committee meetings monthly or more often as required. Membership is multidisciplinary, with representatives from clinical and non-clinical departments. The chairs of Hospital Safety, Managerial Quality Management, Medical Quality Management, Nursing Quality Management, and Allied Health Quality Management committees are members in this committee.

The Accreditation Committee also provides oversight for the hospital's accreditation activities to ensure that:

- KFSH&RC continually maintains processes and practices that meet or exceed national and international accreditation standards.
- Issues related to compliance with accreditation standards are referred to the appropriate committee(s) outlined in the Quality Framework towards Excellence Plan, department(s), and individual(s) to develop an action plan to resolve the issues.
- Accreditation standards compliance outstanding issues are addressed promptly.

Issues unresolved by the ACC are referred to the PIC for action. Refer to APP: 13449 Escalation of Unresolved Quality and Safety Issues Policies & Procedures

3.1.3 Accreditation Section, QMD (Riyadh, Jeddah, Madinah)

The responsibilities of the Accreditation Section are the following:

- Coordinate preparations for JCI and CBAHI accreditation survey visits.
- Coordinate CBAHI Essential Safety Requirement (ESR) 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 Accreditation Committee meetings.
- Provide regular updates to the Accreditation Committee on JCI and CBAHI standards compliance and continuous readiness activities outcome.
- Facilitate hospital-wide awareness and education by presenting accreditation standards and related policies at general staff, department, unit, and committee meetings.
- Facilitate forming working groups and task forces to resolve identified standards compliance issues.
- Collaborate with departments to ensure that developed or revised policies and procedures align with updated accreditation standards.
- Monitor compliance with policies and standards through focused quality audits, assessment visits, and tracers.
- Facilitate accreditation-related improvement projects in collaboration with departments to achieve the 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.
- Maintain and regularly update the documents of the JCI and CBAHI Evidentiary electronic / manual folders in collaboration with the concerned departments and assigned chapter leaders.

Section 4: Implementation

4.1 Accreditation Standard

4.1.1 National Accreditation and International Accreditation

KFSH&RC is compliant with accreditation standards of JCI and CBAHI.

4.1.2 Novel Accreitation

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

Quality Management - Accreditation Section Provides support and awareness to the requested Department/Section/Division/Service to improve the process of the Novel Accreditation. Additionally, the section ensures that the proposed Novel accreditation aligns with the hospital's strategic objective. Besides, the section will streamline the process, plan budget allocation, facilitate the survey visit requirements, and coordinate the policy formation. See **(Appendix B)** for the Novel Accreditation Flowchart.

Department's Chairman or Head shall submit the 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.

4.2 Monitoring Compliance through Tracers

4.2.1 Individual Patient Tracers

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 tracer sessions. The tracer team will review the patient medical record with the involved healthcare providers. The process for patient selection shall be as follows:

- Selection is based on KFSH&RC top ten (10) high-risk diagnoses/procedures. In addition, patients who have developed complications or adverse occurrences such as infections or drug interactions are chosen to trace the care provided.
- The patient selected should be close to discharge or have been long enough in the hospital 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

4.2.2 System Traces

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

4.2.3 Focused Tracers

QMD staff will coordinate the focused tracers as needed. Focused tracers shall be multidisciplinary, educational, and conducted by QMD to monitor and promote compliance with accreditation standards and key KFSH&RC policies (e.g., procedural sedation, infection control, high alert medications, and staff file reviews). The policies may be identified by QMD or any other Quality committee as per the Quality Management Structure outlined in Quality Framework towards Excellence Plan.

4.3 Monitoring compliance through Quality and Safety Rounds

QMD staff will conduct/coordinate a variety of Quality Rounds in collaboration with the multidisciplinary team for clinical and non-clinical areas regularly and as required with the following objectives:

- Identify hazards and risks and maintain safe conditions for patients, visitors, employees, dependents, and Hospital property.
- Monitor compliance with the accreditation standard
- Educate Health Care Providers and other support services staff on standards.
- Establish teamwork to act on the identified issues.
- Provide recommendations for improvement for area managers in an official report.

4.4 Monitoring Compliance through Mock Survey Visits

QMD staff will coordinate Medical, Nursing, Laboratory, Facility, Infection Control, Pharmacy, and Leadership Accreditation Mock Surveys/Assessments to monitor the compliance with Accreditation standards of JCI, CBAHI, or other accreditations and educate Health Care Providers (HCP's) about the expectations of the standards' requirements.

4.5 Monitoring Compliance through Medical Records Audits

QMD staff will oversee the conduction of closed and open medical records reviews. In addition, they 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 audits for medical departments using standardized audit tools, and the results will be reported quarterly to the relevant departments and staff. Physicians will perform the audits, and Quality Management will audit a random sample of selected, audited charts to ensure data validation and accuracy of the auditing process.

Nursing Affairs: QMD staff will audit or oversee the audits for all nursing units using standardized audit tools, and the results will be reported quarterly to the relevant departments and staff. Nurses will perform the audits, and Quality Management will audit a random sample of selected, audited charts 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 Quality Management will audit a random sample of selected, audited charts to ensure data validation and accuracy.

4.6 Communication Plan

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

- Good practices shall be recognized and immediately commended.
- Reports shall be sent electronically on time 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 the issues identified are resolved.
- Unresolved issues shall be provided to the PIC quarterly.

4.7 Confidentiality and Conflicts of Interest

Quality data and information are confidentially maintained following the Employee Relation Manual (ERM) guidelines, Effective 09 Ramadan 1436 (June 2017). The ERM states on 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 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.

Section 5: Revision and Evaluation

QMG evaluates the plan and revise it annually or earlier if deemed necessary.

Section 6: Appendices

Appendix A: Novel Accreditation Application Form

KING FAISAL SPECIALIST HOSPITAL AND RESEARCH CENTRE
(General Organization)

REQUEST FOR NOVEL ACCREDITATION

REQUESTOR	Name of the Group /Division/ Department /Section applying for Accreditation		
	Name of the Accreditation Program *(Attach Accreditation Standards and Accreditation Manual if applicable)*		
	Specify Accreditation objectives including benefits to KFSH&RC(Gen.Org)		
	Accreditation cycles *(The length between two (2) consecutive survey visits)*		
	Specify required support from the Accreditation Committee: *(type and details)*	☐ Education	
		☐ Facilitation	
		☐ Coordination	
		☐ Interpretation of standards	
		☐ Preparation for the survey visit	
		☐ Participation in the survey visit	
		☐ Consultation for Post- Survey findings action plans	
	Accreditation Expenses, including the accreditation fee and survey visit expenses *(Estimated Cost)*		
	Name of Executive Director (ED) or Equivalent		
	Signature:		
	Date:		
ACCREDITATION COMMITTEE	Recommendations		
	Name of Committee Chairman		
	Signature:		
	Date:		

Form 30040-21 (09-34)

Appendix B: Novel Accreditation Flowchart

Novel Accreditation Certification Application Process