Joint Commission International Accreditation

FINAL ACCREDITATION SURVEY FINDINGS REPORT

AZ Glorieux

Ronse, Belgium

International Health Care Organization (IHCO) Identification Number: 60005419

Survey Dates:	24 - 28 October 2022
Program:	Hospital
Survey Type:	Triennial
Surveyor Team:	Juan Ferrer, MD, Physician, Team Leader Thomas J. Murray, MHA, LFACHE, Administrator Thomas J. Schaefer, MS, Clinician Danish Y. Khilani, Nurse Rasa V. Kasniunas, RN, MS, Nurse

OUTCOME:

Based on the findings of the Triennial Hospital survey of 24 October 2022 to 28 October 2022 and the Decision Rules of Joint Commission International (JCI), AZ Glorieux 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 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 promote 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, AZ Glorieux 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, AZ Glorieux 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 AZ Glorieux 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 the 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 organization 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):

- PCI.10, ME #1

The SIP must be submitted to JCI within the next 60 days or by 30 Dec 2022 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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Survey Analysis for Evaluating Risk (SAFER)

Joint Commission International (JCI) has implemented the Survey Analysis for Evaluating Risk (SAFER) matrix, which is a comprehensive visual representation of survey findings. This will provide your healthcare organization with the information it needs to prioritize resources and focus strategic improvement plans in areas that are most in need of compliance activities and interventions.

SAFER will help your organization to:

- More easily identify Measurable Elements (ME) with higher risk
- Identify potential for widespread quality initiatives
- Better organize survey findings by level of potential patient, staff, and/or visitor impact

Each Measurable Element (ME) scored "Partially Met" or "Not Met" is placed on the SAFER matrix according to the likelihood the observation could harm a patient(s), staff and/or visitor(s) and the scope at which non-compliance was observed. As the risk level increases, the placement of the standard and ME moves from the bottom left corner (lowest risk level) to the upper right (highest risk level) of the matrix.

The definitions for the likelihood to harm a patient/staff/visitor and scope are as follows:

Likelihood to harm a patient/staff/visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

SAFER Matrix Placement	Strategic Improvement Plan (SIP) Required
High/Limited **High/Pattern** **High/Widespread**	• Not Met and Partially Met MEs will require a SIP
Moderate/Pattern **Moderate/Widespread**	• Only Not Met MEs will require a SIP
Moderate/Limited **Low/Pattern** **Low/Widespread** **Low/Limited**	• Not Met and Partially Met MEs will not require a SIP

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SAFER Matrix
Program Name: Hospital

Likelihood to harm a patient/visitor/staff	Limited	Pattern	Widespread
ITL			
High		PCI.10 ME 1	
Moderate	COP.4 ME 1 GLD.5 ME 2 SQE.8.2 ME 2 MOI.8 ME 4*	AOP.2 ME 2 ASC.7.2 ME 1 PCI.7 ME 1 GLD.7.1 ME 1 FMS.10.1 ME 4 SQE.10 ME 1 MOI.13 ME 1	COP.3.3 ME 2
Low	IPSG.4 ME 2 AOP.6.2 ME 3 AOP.6.2 ME 5 FMS.7.1 ME 1 FMS.7.1 ME 2	FMS.2 ME 2 SQE.5 ME 4 SQE.11 ME 2 MOI.4 ME 3	MOI.7 ME 1

Scope

*Indicates Not Met

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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 **The hospital develops and implements a process for the preoperative verification and surgical/invasive procedure site marking.**

Measurable Element #2

The hospital uses an instantly recognizable and unambiguous mark for identifying the surgical/invasive site that is consistent throughout the hospital.

Partially Met

Likelihood to Harm: Low **Scope: Limited**

The hospital had a process for site marking throughout the hospital; however, site marking was not done for oral surgery procedures, including extractions and implant placement.

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 #2

Patients are reassessed at intervals based on their condition and when there has been a significant change in their condition, plan of care, or individual needs.

Partially Met

Likelihood to Harm: Moderate **Scope: Pattern**

Patients were reassessed for pain twice a shift and after receiving pain medications; however, there was not a standardized process to reassess pain when a patient´s condition changed as for example following surgery or other invasive procedures.

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AOP.6.2 **A radiation and/or diagnostic imaging safety program for patients, staff, and visitors is in place, is followed, and is compliant with applicable professional standards, laws, and regulations.**

Measurable Element #3

Safety protective equipment and devices appropriate to the practices and hazards encountered from radiation and diagnostic imaging are available to staff, patients, and visitors, and in the area in which radiology and diagnostic imaging services are provided.

Partially Met

Likelihood to Harm: Low **Scope: Limited**

The hospital's radiation safety program document was silent to the use of personal radiation detection badges.

Measurable Element #5

Hazards from magnetic resonance imaging are addressed using industry standards and evidence-based guidelines (for example, identification of safety zones, access restrictions, signage, availability of non-ferromagnetic equipment, and so on).

Partially Met

Likelihood to Harm: Low **Scope: Limited**

The hospital's radiation safety document was silent to the identification of safety zones in the magnetic resonance imaging area.

Care of Patients

COP.3.3 **Resuscitation services are available throughout the hospital.**

Measurable Element #2

Medical equipment for resuscitation and medications for basic and advanced life support are standardized and available for use based on the needs of the population served.

Partially Met

Likelihood to Harm: Moderate **Scope: Widespread**

Laryngoscopes in the emergency adult bags on patient units were inconsistently tested for functioning light.

COP.4 **The hospital establishes and implements a program for the safe use of lasers and other optical radiation devices used for performing procedures and treatments.**

Measurable Element #1

The hospital's program for the safe use of lasers and optical radiation devices is based on industry standards and professional guidelines and complies with applicable laws and regulations.

Partially Met

Likelihood to Harm: Moderate **Scope: Limited**

The hospital's program for the safe use of lasers did not include optical radiation devices.

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Anesthesia and Surgical Care

ASC.7.2 **Information about the surgical procedure is documented in the patient's medical record to facilitate continuing care.**

Measurable Element #1

Surgical reports, templates, or operative progress notes include at least a) through g) from the intent.

Partially Met

Likelihood to Harm: Moderate **Scope: Pattern**

In seven out of 11 (63% compliance) surgical reports reviewed, blood loss was documented.

Prevention and Control of Infections

PCI.7 **The infection prevention and control program identifies and implements standards from recognized infection prevention and control programs to address cleaning and disinfection of the environment and environmental surfaces.**

Measurable Element #1

The hospital selects cleaning and disinfection standards and procedures from recognized infection prevention and control programs to maintain environmental cleanliness.

Partially Met

Likelihood to Harm: Moderate **Scope: Pattern**

The following were observed for cleaning and disinfection practices:

1. In the Operating Room, cleaning and disinfection between patients was incomplete.
2. Appropriate controls were not in place to ensure separation of clean/sterile and dirty supplies in the Operating Room.
3. In the Mixed Day Unit, clean and dirty supplies were stored in the same area.

PCI.10 **The hospital reduces the risk of infection in the facility through the use of mechanical and engineering controls.**

Measurable Element #1

The hospital operates and maintains negative and positive pressure ventilation systems in accordance with local and national laws and regulations and professional standards.

Partially Met

Likelihood to Harm: High **Scope: Pattern**

The hospital had the capability of maintaining negative and positive pressure ventilation systems; however, in the Operating Room area it was observed that five of seven Operating Rooms and the Central Sterile Supply storage area had pressure differentials that were not in compliance with national and European standards.

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Governance, Leadership, and Direction

GLD.5 **The chief executive and hospital leadership prioritize which hospitalwide processes will be measured, which hospitalwide improvement and patient safety activities will be implemented, and how success of these hospitalwide efforts will be measured.**

Measurable Element #2

The chief executive and hospital leadership ensure that, when present, clinical research and health professional education programs are represented in the priorities.

Partially Met

Likelihood to Harm: Moderate **Scope: Limited**

Clinical research studies were approved by the hospital ethics committee; however, there was no additional reporting to the ethics committee relating to the outcome of research activities, and incidents related to them were not reported to or integrated into the hospital's quality and patient safety program.

GLD.7.1 **Hospital leadership seeks and uses data and information on the safety of the supply chain to protect patients and staff from unstable, contaminated, defective, and counterfeit supplies.**

Measurable Element #1

Hospital leadership outlines the steps in the supply chains for supplies defined as at most risk.

Partially Met

Likelihood to Harm: Moderate **Scope: Pattern**

The hospital had outlined the steps in the supply chain for at most risk medications; however, during the look-back period they had not outlined the steps in the supply chain for any supplies defined as at most risk.

Facility Management and Safety

FMS.2 **A qualified individual oversees the facility management and safety structure to reduce and control risks in the care environment.**

Measurable Element #2

The qualified individual is responsible for elements a) through f) of the intent.

Partially Met

Likelihood to Harm: Low **Scope: Pattern**

The hospital had reviewed the documentation of their management and safety programs on a three year cycle and not on an annual basis as required by item f) of the intent.

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FMS.7.1 **The hospital's program for the management of hazardous materials and waste includes the inventory, handling, storage, and use of hazardous materials.**

Measurable Element #1

The hazardous materials and waste program identifies the type, quantities, and locations of hazardous materials and has a complete inventory, which is updated at least annually, to reflect changes in the hazardous materials used and stored in the organization.

Partially Met

Likelihood to Harm: Low **Scope: Limited**

The hospital's inventory of hazardous materials and waste did not include genotoxic/cytotoxic and radioactive material. In the ICU and Hemodialysis Unit, hazardous materials exceeded the quantity of the inventory list.

Measurable Element #2

The hazardous materials and waste program establishes and implements procedures for safe handling, storage, and use of hazardous materials.

Partially Met

Likelihood to Harm: Low **Scope: Limited**

The hospital did not provide adequate signage to identify rooms in which flammable materials were stored. Areas included the hazardous materials storage rooms in the Chemistry and Anatomical Pathology Laboratories.

FMS.10.1 **The utility systems program includes inspection, testing, and maintenance to ensure that utilities operate effectively and efficiently to meet the needs of patients, staff, and visitors.**

Measurable Element #4

The hospital labels utility system controls to facilitate partial or complete emergency shutdowns.

Partially Met

Likelihood to Harm: Moderate **Scope: Pattern**

Medical gas shutoff valves in the Operating Room complex were not labeled and unclear as to which valves controlled the flow of gases.

Staff Qualifications and Education

SQE.5 **There is documented personnel information for each staff member.**

Measurable Element #4

Personnel files contain a record of orientation to the hospital and the staff member's specific role and in-service education attended by the staff member.

Partially Met

Likelihood to Harm: Low **Scope: Pattern**

Hospital had a general orientation for new clinical and non-clinical staff members; however, unit specific orientation was not documented in staff files.

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SQE.8.2 **The hospital provides a staff health and safety program that addresses staff physical and mental health and safe working conditions.**

Measurable Element #2

The staff health and safety program includes at least a) through f) in the intent.

Partially Met

Likelihood to Harm: Moderate **Scope: Limited**

Inadequate ventilation system in the Psychiatric Unit's smoke room posed a harmful exposure to patients, staff and visitors.

SQE.10 **The hospital has a standardized, objective, evidence-based procedure to authorize medical staff members to admit and to treat patients and/or to provide other clinical services consistent with their qualifications.**

Measurable Element #1

The privilege delineation process used by the hospital meets criteria a) through e) found in the intent.

Partially Met

Likelihood to Harm: Moderate **Scope: Pattern**

The organization had a process for delineating medical staff privileges that met all the criteria other than element e (can be demonstrated as to how the procedure is used effectively), as was evident for the following:

1. Privileges were made accessible by electronic copy to individuals and locations where medical staff provided services, although nursing leadership in those areas could not demonstrate how to access the information.
2. The organization could not demonstrate how the privileging process was effectively used to restrict the potential of providing services beyond their granted privileges.

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 ongoing professional practice evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member, and the results are reviewed with objective and evidence-based information as available. These results are compared to other department/service medical staff members.

Partially Met

Likelihood to Harm: Low **Scope: Pattern**

Professional practice evaluation for medical staff identified areas of achievement related to behaviors and clinical results, although important dimensions of professional growth were not considered. Examples were patient care, interpersonal and communication skills, professionalism or patient safety system practices.

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Management of Information

MOI.4 **The hospital uses standardized diagnosis and procedure codes and ensures the uniform 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

Likelihood to Harm: Low **Scope: Pattern**

Unapproved abbreviations observed in clinical records included, but were not limited to, MDO, PTZ, CD, SG, KO, OZ.

MOI.7 **Documents, including policies, procedures, and programs, are managed in a consistent and uniform manner.**

Measurable Element #1

There is a written guidance document that defines the requirements for developing and maintaining policies, procedures, and programs, including at least items a) through h) in the intent.

Partially Met

Likelihood to Harm: Low **Scope: Widespread**

The hospital had not developed a method on how changes to a document could be identified (item d in the intent).

MOI.8 **The hospital initiates and maintains a standardized, accurate medical record for every patient assessed or treated and determines the record's content, format, and location of entries.**

Measurable Element #4

The hospital has a process to monitor compliance with the guidelines on the proper use of copy-and-paste, auto-fill, auto-correct, and templates and implements corrective action as needed.

Not Met

Likelihood to Harm: Moderate **Scope: Limited**

The hospital had not developed a process to monitor compliance with the guidelines on the proper use of copy-and-paste.

MOI.13 **The hospital develops, maintains, and tests a program for response to planned and unplanned downtime of data systems.**

Measurable Element #1

The hospital develops and maintains, and tests at least annually, a program for response to planned and unplanned downtime of data systems.

Partially Met

Likelihood to Harm: Moderate **Scope: Pattern**

The hospital conducted an annual test of its response to a planned data system downtime event; however, the hospital had not conducted a test of its response to an unplanned downtime event.

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