



Final Accreditation Survey Findings Report

AZ Glorieux

Ronse, Belgium

International Health Care Organization (IHCO) Identification Number: 60005419

Survey Dates: 7 - 10 October 2025

Program: Hospital

Survey Type: Triennial

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OUTCOME:

Based on the findings of the Triennial Hospital of 7 October 2025 to 10 October 2025 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" to implement the actions necessary to achieve full compliance.

Between surveys, the AZ Glorieux will be expected to demonstrate compliance with the most current edition of the JCI accreditation standards at the time, which includes the JCI accreditation policies and procedures published on the JCI website.

REQUIRED TOUCHPOINTS:

As part of JCI Continuous Engagement, AZ Glorieux will be expected to complete five (5) mandatory touchpoint sessions as outlined in the JCI standards, policies, and procedures. These sessions will be conducted in 6-month intervals and will be conducted via MS Teams or Zoom. The touchpoint session dates will be provided by JCI approximately three (3) to four (4) months after the organization's last day of full survey and will be scheduled successively thereafter on a schedule determined by JCI with input from the Organization. Each session will be with an assigned JCI surveyor. Prior to each touchpoint, the JCI surveyor will arrange the agenda with the survey coordinator designated on your electronic application.

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):

- AOP.03.06, ME #4

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- COP.03.00, ME #2
- PCC.04.01, ME #2

The SIP must be submitted to JCI within the next 60 days or by 20 Dec 2025 for review and acceptance. Details regarding access to the SIP system will be sent to you by way of a separate notification.

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 “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	<ul style="list-style-type: none"> • Not Met MEs will require a SIP
Moderate/Pattern Moderate/Widespread	<ul style="list-style-type: none"> • Not Met MEs will require a SIP
Moderate/Limited Low/Pattern Low/Widespread	<ul style="list-style-type: none"> • Not Met MEs will not require a SIP
Low/Limited	

**SAFER Matrix
Program Name: Hospital**

Likelihood to harm a patient/visitor/staff	ITL			
	High			
	Moderate	ASC.03.00 ME 1 ASC.03.02 ME 3 IPSP.04.01 ME 1 QPS.03.04 ME 3	AOP.03.06 ME 4 PCC.04.01 ME 2	COP.03.00 ME 2
	Low	MMU.03.00 ME 4 MMU.06.00 ME 4 PCI.05.00 ME 7 SQE.03.02 ME 3	ASC.04.02 ME 1 FMS.03.00 ME 1 HCT.01.04 ME 1 IPSP.02.00 ME 1 IPSP.04.00 ME 2 MMU.03.00 ME 2	FMS.06.00 ME 1 PCI.03.00 ME 2
		Limited	Pattern Scope	Widespread

REPORT OF SURVEY FINDINGS:

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

Assessment of Patients

AOP.03.06 Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are established and implemented.

Measurable Element #4

Procedures are established and implemented for the receipt and tracking of specimens.

Not Met

Likelihood to Harm: Moderate

Scope: Pattern

The following were observed:

1. The hospital had not developed procedures that ensured a chain of custody for histopathology specimens that were referred to an outsourced lab. The tracking of reports returning from the outsourced laboratory had not been defined.
2. In the Operating Rooms and in the Same Day Hospital, specimens were not tracked from the Operating Rooms to the Pathology Department. No one signed a document to verify that the specimen arrived at the Pathology Department.

Anesthesia and Surgical Care

ASC.03.00 A qualified individual conducts a preanesthesia assessment and preinduction assessment.

Measurable Element #1

A preanesthesia assessment is performed that includes at least the following elements when evaluating risk and appropriateness of anesthesia for the patient:

- Identify airway problems that may influence the type of anesthesia used.
- Evaluate at-risk patients for appropriateness of anesthesia.
- Select the anesthesia and plan anesthesia care.
- Safely administer an anesthetic based on patient assessment, identified risks, and type of procedure.
- Interpret findings from patient monitoring during anesthesia and recovery.
- Provide information for the use of analgesia following surgery.

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The Mallampati Score was not documented prior to epidural anesthesia for a patient undergoing Cesarean-section. Staff stated that a Mallampati was only performed for patients who have general anesthesia.

ASC.03.02 Each patient's physiological status during anesthesia and surgery is monitored according to professional practice guidelines and documented in the patient's medical record.

Measurable Element #3

The results of monitoring are documented in the patient's medical record.

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The anesthesia team conducted sedation for patients undergoing imaging procedures; however, no documentation of the pre-sedation assessment, assessments conducted during sedation or of the recovery assessment and management was recorded. Staff stated the lack of documentation occurred because there were no computers available in the imaging rooms for use by the anesthesia team.

ASC.04.02 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 the following elements:

- Preoperative diagnosis and planned procedure
- Postoperative diagnosis
- Name of operative surgeon and assistants
- Procedures performed and description of each procedure findings
- Perioperative complications
- Tubes and/or drains placed intraoperatively
- Surgical specimens sent for examination
- Amount of blood loss and amount of transfused blood
- Date, time, and signature of responsible physician

Not Met

Likelihood to Harm: Low

Scope: Pattern

In open and closed medical records, the surgical reports did not consistently document the complications, specimens or estimated blood loss.

Care of Patients

COP.03.00 Clinical staff are trained to recognize and respond to changes in a patient's condition.

Measurable Element #2

The hospital implements documented age-specific early warning criteria describing early signs of a change or deterioration in a patient's condition.

Not Met

Likelihood to Harm: Moderate

Scope: Widespread

The following were observed:

1. The hospital had implemented a National Early Warning Score (NEWS) policy to identify the early signs of patient deterioration. The NEWS process was not yet fully implemented. Two patients traced in the Inpatient Geriatric Unit had NEWS which required every 30 minutes to every one hour reassessment and notification to the physician; however, evidence of the additional assessments required was not present in the patient's electronic medical record. Leaders stated that although the NEWS policy was implemented in 2017 the process had never been fully functional.
2. The labor and delivery team assessed patients using the General Adult Early Warning Scoring System (EWS) rather than an Obstetrical Early Warning Scoring System (MEOWS) tool. This could result in missed signs of early deterioration unique to the obstetric patient population.
3. There was no early warning score system introduced in the Neonatal Intensive Care Unit (NICU).

Facility Management and Safety

FMS.03.00 The hospital implements a program to provide a safe physical facility.

Measurable Element #1

The hospital develops and implements a written program to provide a safe physical facility.

Not Met

Likelihood to Harm: Low

Scope: Pattern

Across the organization there were no alarm calls in any bathrooms in outpatient areas. Numerous elderly and disabled patients used these services with no means to call for help if they were to fall. The hospital had undertaken a risk assessment for all inpatient services; however, they had not included Outpatient Services.

FMS.06.00 **The hospital establishes and implements a program for fire safety that complies with national and local codes, laws, and regulations.**

Measurable Element #1

The hospital develops and implements a written program for fire safety to protect all occupants of the hospital's facilities from fire and smoke emergencies.

Not Met

Likelihood to Harm: Low

Scope: Widespread

The organization had a written program for fire safety; however, the program did not include a critical part of the plan that defined the fire assembly point or a safe outdoor location where people gather after a building evacuation to allow for a headcount and communication with emergency services. This was corrected prior to the end of the survey.

Health Care Technology

HCT.01.04 **The hospital develops, maintains, and tests a program for response to planned and unplanned downtime of data systems.**

Measurable Element #1

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

Not Met

Likelihood to Harm: Low

Scope: Pattern

The hospital had not conducted a test of their unplanned downtime program.

International Patient Safety Goals

IPSG.02.00 **The hospital implements a process for reporting critical results of diagnostic tests.**

Measurable Element #1

The hospital defines, in writing, critical test results that may represent urgent or emergent life-threatening values for diagnostic tests.

Not Met

Likelihood to Harm: Low

Scope: Pattern

The following were observed:

1. The hospital had not defined critical test results for: continuous cardiocography (CTG) and histopathology.
2. The hospital had not defined in writing, critical test results for electrocardiograms in the adult, pediatric or neonatal populations or critical values for the sleep laboratory.

IPSG.04.00 The hospital 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.

Not Met

Likelihood to Harm: Low

Scope: Pattern

The following were observed:

1. The organization's policy regarding surgical site marking (Document GLOR-39-726 version 11.00) allows the ophthalmologist to use a 'dot' as the surgical site mark rather than an arrow that is used by all other physicians per the policy, which allowed for inconsistency in site marking. In addition, the policy is silent on how to document the surgical site if the patient refuses surgical site marking, such as using a diagram in the chart as an alternative. The organization's policy just states that the refusal will be documented in the patient record.
2. In the maxillofacial surgery service, a process of site marking was in the development phase and not yet fully introduced.

IPSG.04.01 The hospital 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 #1

The full team actively participates in a time-out process, which includes the following elements in the area in which the surgical/invasive procedure will be performed, immediately before starting the procedure, and this is documented:

- Correct patient identity
- Correct procedure to be done
- Correct surgical/invasive procedure site

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The following were observed:

1. The record of a patient receiving epidural analgesia for labor did not include documentation of the time-out. Staff stated that time-out was not conducted prior to insertion of an epidural catheter for the administration of epidural analgesia for labor.
2. In the Emergency Department (ED) during an invasive procedure such as placement of a chest tube in a stable patient, a time-out and site marking was not consistently performed.

Medication Management and Use

MMU.03.00 Medications are properly and safely stored.

Measurable Element #4

Medications and chemicals used to prepare medications are accurately labeled with contents, expiration dates, and applicable warnings.

Not Met

Likelihood to Harm: Low

Scope: Limited

In the Operating Rooms, when a spinal anesthetic was administered where there is usually one syringe with an anesthetic to anesthetize the skin and one syringe containing the medication to be placed in the intrathecal space, neither were labeled as to their content.

Measurable Element #2

The hospital stores all medications, including biologicals and controlled (scheduled) medications, in a secured area to prevent diversion, and locked, as applicable, in accordance with laws and regulations. These medications are accurately accounted for according to applicable laws and regulations.

Not Met

Likelihood to Harm: Low

Scope: Pattern

The following were observed where an increased risk of medication diversion could occur:

1. In the Pediatric Outpatient Clinic, vaccinations were stored in a refrigerator that could not be secured.
2. In the Lessines Medical Center, medications were kept in a drawer that was not secured.
3. In the ED, narcotics were securely stored prior to administration; however, excess narcotic medication that needed to be discarded was put in a yellow plastic bag designated as the hazardous medical waste container, thus setting up the possibility of diversion of the narcotic. In addition, the discarded amount of narcotic was not documented by any staff, or usually two staff members.

MMU.06.00 Medication administration is safely performed by qualified individuals.

Measurable Element #4

Medications are administered as prescribed on a timely basis, and each dose is recorded in the patient's medical record.

Not Met

Likelihood to Harm: Low

Scope: Limited

In the Maxillofacial Clinic where tooth extractions were performed, the local anesthetic medication name was recorded in the patient's medical record; however, the dose was not documented. The name and dose of the medication administered was on a separate sheet of paper that was sent to and kept in the Pharmacy, not in the patient's medical record.

Patient-Centered Care

PCC.04.01 Each patient's educational needs and learning ability are assessed and documented in their medical record.

Measurable Element #2

Education provided to patients and families is documented in the patient's medical record.

Not Met

Likelihood to Harm: Moderate

Scope: Pattern

Although initial educational needs for outpatients were documented in the patient's record, ongoing patient education needs were not captured in the patient's written plan of care. Education provided to meet the patient's ongoing individual needs and assessment of the patient's understanding of the education was not documented for patients receiving care in the four dialysis centers or for patients having home hemodialysis or peritoneal dialysis.

Prevention and Control of Infections

PCI.03.00 The hospital reduces the risk of infections associated with medical/surgical equipment, devices, and supplies by proper cleaning, disinfection, sterilization, and storage.

Measurable Element #2

The hospital implements proper infection prevention and control practices when performing high-level disinfection and sterilization of critical medical equipment, devices, and supplies that address the following:

- Use of approved chemical sterilants and high-level disinfectants in accordance with the product label and the device manufacturer's instructions
- Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical or biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection
- Resolution of conflicts or discrepancies between medical device manufacturers' instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment
- Criteria and the process for the use of immediate-use steam sterilization
- Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use

Not Met

Likelihood to Harm: Low

Scope: Widespread

In the Maternity Services the sterile instruments from Central Sterile Supply Department (CSSD) were observed closed and the hinged instruments clamped. It was confirmed later that this was a hospitalwide practice. These processes were not in accordance with recognized guidelines such as Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), and Association of periOperative Registered Nurses (AORN).

PCI.05.00 The hospital implements processes for proper disposal of waste, proper management of human tissues, and safe handling and disposal of sharps and needles.

Measurable Element #7

The hospital has a written policy to direct chain of custody for all bodies and body parts handled by pathology, mortuary, and other postmortem areas.

Not Met

Likelihood to Harm: Low

Scope: Limited

The hospital had not developed a written policy to direct chain of custody for all bodies and body parts.

Quality Improvement and Patient Safety

QPS.03.04 The hospital identifies undesirable trends and variation, and always conducts an intensive analysis, or a comprehensive systematic analysis, when these are evident from its data collection.

Measurable Element #3

The hospital performs data collection and analysis for all of the following, at minimum, when applicable:

- All confirmed transfusion reactions
- All serious drug reactions or drug-related patient safety events as defined by the hospital or laws and regulations
- All medication errors and near misses, as defined by the hospital
- All major patient safety events or errors related to surgical procedures
- All major discrepancies between preoperative and postoperative diagnoses; for example, a preoperative diagnosis of intestinal obstruction and a postoperative diagnosis of ruptured abdominal aortic aneurysm (AAA)
- Patient safety events or patterns of events during procedural sedation regardless of administration route
- Patient safety events or patterns of events during anesthesia regardless of administration route
- Patient safety events or errors related to patient identification
- Patient safety events or errors related to pathology samples, such as biopsy or other tissue specimens

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The hospital performed data collection and analysis for the required elements of the standards; however, the following were not included:

1. Matching of surgical procedure planned with the surgical procedure conducted was performed, however concordance between preoperative diagnosis and postoperative diagnosis was not performed.
2. Collection of data and analysis of sedation and anesthesia related events was limited to tracking use of reversal agents. An agreed upon definition of a sedation/anesthesia related event had not been created, and tracking methodology to identify events had not been implemented.

Staff Qualifications and Education

SQE.03.02 **The hospital has a standardized process for nursing staff participation in the hospital's continuous quality improvement activities, including evaluating individual performance when indicated.**

Measurable Element #3

Information from the review process is documented in the nurse's personnel record or in a separate credential record, consistent with hospital policy.

Not Met

Likelihood to Harm: Low

Scope: Limited

It was observed the system to have quality improvement outcome data recorded in nursing staff personnel files as part of the review process had not yet been introduced.