Joint Commission International Accreditation

FINAL ACCREDITATION SURVEY FINDINGS REPORT

Sint Andriesziekenhuis Tielt

Tielt, Belgium

International Health Care Organization (IHCO) Identification Number: 60006721

Survey Dates:	8 January 2018 - 12 January 2018
Program:	Hospital
Survey Type:	Initial
Surveyor Team:	Enrico Baldantoni, MD, Physician, Team Leader Paulo Neno, MD, Administrator Diane M. Sanders, RN, MN, Nurse

OUTCOME:

Based on the findings of the Initial Hospital survey of 8 January 2018 to 12 January 2018 and the Decision Rules of Joint Commission International (JCI), Sint Andriesziekenhuis Tielt 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 will 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 stimulate 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, Sint Andriesziekenhuis Tielt 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, Sint Andriesziekenhuis Tielt 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 Sint Andriesziekenhuis Tielt 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 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 critical care program 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):

- GLD.11.2, ME #3

The SIP must be submitted to JCI within the next 45 days or by 26 February 2018 for review and acceptance. Details regarding access to the SIP system will be sent to you by way of a separate notification.

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.4.1 The hospital develops and 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 #3
When surgical/invasive procedures are performed, including medical and dental procedures done in settings other than the operating theatre, the hospital uses uniform processes to ensure safe surgery.
Partially Met
The organization's policy SATNET-683-355 required the use of an arrow as the site mark for interventional procedures; however, this was not implemented in the Radiology Department. Additionally, the time-out process was not standardized.

Anesthesia and Surgical Care

ASC.4 A qualified individual conducts a preanesthesia assessment and preinduction assessment.

Measurable Element #3
The two assessments are performed by an individual(s) qualified to do so and documented in the patient medical record.
Partially Met
Zero of six closed records of patients who received anesthesia had a separate pre-induction assessment documented. The overall compliance to the requirement of documenting two-separate assessment was 50%.

ASC.7 Each patient's surgical care is planned and documented based on the results of the assessment.

Measurable Element #1
The assessment information used to develop and to support the planned invasive procedure is documented in the patient's medical record by the responsible physician before the procedure is performed. (Also see AOP.5.4, ME 3 and AOP.6.4, ME 3)
Partially Met
Five of 10 (50% compliance) open and closed records of patients undergoing an invasive procedure documented an assessment by the responsible physician prior to the procedure.

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. (Also see ACC.3, ME 4)
Partially Met
Five of six (83% compliance) surgical reports contained the seven required elements a) though g) from the intent statement. The organization had implemented a surgical report that contained all elements of the intent statement for major surgical procedures; however, the comprehensive surgical report was not used for minor surgical procedures.

Medication Management and Use

MMU.3 Medications are properly and safely stored.

Measurable Element #1
Medications are stored under conditions suitable for product stability, including medications stored on individual patient care units and ambulances (as applicable).
Partially Met
Manufacturers recommended that medications stored at room temperature had to be kept in a range between 15 and 25 degrees centigrade; however, the renovated area of the hospital had a Building Maintenance System (BMS) that included temperature control, while the rest of the areas (approximately 50% of the bed capacity) neither monitored nor documented the root temperature of areas where medications were kept. Additionally, emergency medications to be used by the emergency response service were kept inside the ambulance. During the survey, the use of temperature logs in areas not covered by the BMS was implemented.

Measurable Element #2
Controlled substances are accurately accounted for according to applicable laws and regulations. (Also see MMU.1, ME 5)
Partially Met
Throughout the hospital, the practice observed and confirmed by pharmacy, to discard remaining doses of controlled substances, was to dispose of the ampoule/vial or the syringe containing the residual drug in the medication waste bin. This practice had a potential for diversion and abuse.

MMU.7 Medication effects on patients are monitored.

Measurable Element #3
The hospital has a process for recording in the patient medical record, adverse effects related to medication use and reporting adverse effects to the hospital. (Also see QPS.8)
Partially Met
Individual physicians reported adverse drug reactions (ADRs) to an external authority; however, there was no system in place to report ADRs to the hospital.

Quality Improvement and Patient Safety

QPS.1 **A qualified individual(s) guides the implementation of the hospital's program for quality improvement and patient safety and manages the activities needed to carry out an effective program of continuous quality improvement and patient safety within the hospital.**

Measurable Element #5

The quality program is responsible for the regular communication of quality issues to all staff. (Also see GLD.4.1, ME 3)

Partially Met

The organization did not have a process in place for periodic communication of pertinent quality issues to the facility management staff, as part of the quality program.

Prevention and Control of Infections

PCI.7 **The hospital reduces the risk of infections associated with medical/surgical equipment, devices, and supplies by ensuring adequate cleaning, disinfection, sterilization, and storage; and implements a process for managing expired supplies.**

Measurable Element #1

The hospital follows professional practice guidelines for sterilization techniques that best fit the type of situations for sterilization and devices and supplies being sterilized. (Also see PCI.5, MEs 3 and 4)

Partially Met

Throughout the hospital, hinged instruments were sterilized and stored in the closed position, thus preventing adequate sterilization at the articulating surfaces, as recommended by best references such as the Association for the Advancement of Medical Instrumentation, American National Standards Institute (AAMI/ANSI).

PCI.7.2 **The hospital reduces the risk of infections through proper disposal of waste.**

Measurable Element #3

Operation of the mortuary and postmortem area is managed to minimize infection transmission risk.

Partially Met

In the Morgue's mortuary chamber, the following were observed:

1. No monitoring/recording of temperature.
2. Textile curtains that could have reduced the effectiveness of the cleaning and disinfection processes.

Both non-conformities were corrected during the survey.

PCI.7.4 The hospital reduces the risk of infections associated with the operations of food services.

Measurable Element #3
Kitchen sanitation measures are implemented to prevent the risk of cross contamination.
Partially Met
In the kitchen, the following were observed:
1. Clean towels stored in the dirty crockery and flatware cleaning area.
2. Cooking supplies placed on a used grill.
3. No functional separation between clean and dirty areas where pots and pans were cleaned and stored.

Governance, Leadership, and Direction

GLD.6.1 Hospital leadership ensures that contracts and other arrangements are included as part of the hospital's quality improvement and patient safety program.

Measurable Element #1
All contracts stipulate the quality data that are to be reported to the hospital, the reporting frequency and mechanism, and how the hospital will respond when quality requirements or expectations are not met. (Also see AOP.5.10, ME 1 and AOP.6.8, ME 1)
Partially Met
The hospital defined quality measures to monitor contracts; however, there was no evidence of such monitoring for the external reference Clinical Laboratory and the contracted Ambulance Service.

GLD.11.2 Department/service leaders select and implement clinical practice guidelines, and related clinical pathways and/or clinical protocols, to guide clinical care.

Measurable Element #3
Department/service leaders implement clinical guidelines and any associated clinical pathways or clinical protocols for each identified priority area as relevant to the department/service.
Not Met
The organization had selected the following clinical pathways: hysterectomy, gastric by-pass, total knee replacement, angioplasty and suicide prevention. Two of five (40% compliance) were implemented and relative data were collected. These were related to gastric bypass and total knee replacement.

Facility Management and Safety

FMS.4 The hospital plans and implements a program to provide a safe physical facility through inspection and planning to reduce risks.

Measurable Element #1
The hospital has a program to provide a safe physical facility. (Also see AOP.5.3, ME 1 and SOP.6.3, ME 1)

Partially Met

The following were observed:

1. In the Kitchen, multiple emergency shut-off switches, fire extinguishers, and the fire cabinet were obstructed by carts. Additionally, the walk-in freezer could not be opened from the inside due to ice accumulation. This was immediately corrected.
2. In the Psychiatry Ward, fire extinguishers were easily removable from the wall, fire cabinets with fire hoses and attached nozzles were unlocked, and the bed in the isolation room allowed access to a strong point of fixation.

FMS.4.1 The hospital plans and implements a program to provide a secure environment for patients, families, staff, and visitors.

Measurable Element #3

All security risk areas and restricted areas are identified, documented, monitored, and kept secure. (Also see MMU.3, ME 4; MMU.3.1; and MMU.3.2)

Partially Met

The following were observed:

1. The Information Technology (IT) server room, identified as a high-risk area, was located in a remote site with no video surveillance. This was corrected during the survey.
2. In the Pediatric Department, the activation of the fire notification button released all exit doors to facilitate a safe exit; however, this could have also determined unauthorized access/egress to/from this high-risk area.

FMS.5 The hospital has a program for the inventory, handling, storage, and use of hazardous materials and waste.

Measurable Element #2

The program establishes and implements safe handling, storage, and use of hazardous materials and waste. (Also see AOP.5.6, ME 3; AOP.6.6, ME 2; and MMU.3.1, ME 2)

Partially Met

1. In the gas storage area, the following were observed:
   - Gas cylinders not labeled with the identification of the type of gas and the current quantity.
   - Two unsecured cylinders.
   - The gate blocked by a parked vehicle.
2. Throughout the hospital, sharp containers were unsecured on countertops and carts.

All situations were corrected during the survey.

Measurable Element #3

The program establishes and implements the proper protective equipment and procedures required during use. (Also see AOP.5.3, ME 3 and AOP.6.3, ME 4)

Partially Met

The following were observed:

1. In the central housekeeping room, where chemicals were mixed, neither a functional eye-wash mechanism was available, nor eye protection as recommended by the material safety data sheet (MSDS) of the manufacturer of the cleaning solutions.
2. In the Operating Theater, staff was observed using chemicals, such as cleaning agents and formaldehyde, without wearing appropriate personal protective equipment.

FMS.5.1 The hospital has a program for the control and disposal of hazardous materials and waste.

Measurable Element #4

The hospital disposes of hazardous materials and wastes safely or contracts with sources that ensure the proper disposal of hazardous materials and waste in dedicated hazardous waste sites or as determined by national laws and regulations. (Also see AOP.5.7, ME 5; PCI.7.2, ME 1; and PCI.7.3, ME 3)

Partially Met

In the waste management area, the following were observed:

1. The area was unsecured.
2. Containers of liquid chemical waste, including glutalhaldehyde, were unlabeled.
3. Staff members were unable to describe the process for cleaning and sanitizing the area.
4. Food waste bags were potentially accessible to rodents and other pests.
5. A large medication waste container was left opened and unattended.

Additionally, wooden pallets, difficult to clean and disinfect, were in use in the biological waste storage room.

FMS.7 The hospital establishes and implements a program for the prevention, early detection, suppression, abatement, and safe exit from the facility in response to fires and nonfire emergencies.

Measurable Element #5

The program includes the abatement of fire and containment of smoke.

Partially Met

In the waste management area, where residual flammable chemicals were disposed of, no fire extinguishers were available. This was corrected during the survey.

FMS.9.1 Utility systems are inspected, maintained, and improved.

Measurable Element #1

Utility systems and components are inspected based on hospital-developed criteria.

Partially Met

The utility systems plan and related periodic inspections failed to identify the potential risk of having a backup power generator located in a remote, and unprotected area.

FMS.9.2.1 The hospital tests its emergency water and electrical systems and documents the results.

Measurable Element #1
The hospital tests alternative sources of water at least quarterly or more frequently if required by local laws and regulations or conditions of the source of water.
Partially Met
The organization had identified an alternative contracted source of water, in addition to a local reservoir. The contracted service had not been tested yet.

FMS.11.1 Staff members are trained and knowledgeable about their roles in the hospital's programs for fire safety, security, hazardous materials, and emergencies.

Measurable Element #1
Staff members can describe and/or demonstrate their roles in response to a fire. (Also see FMS.7.1, ME 2)
Partially Met
The fire safety system was recently redesigned, replacing the existing alarm with a new activation and response system. Nursing staff members could not consistently describe their role in response to a fire emergency using the new system.

Staff Qualifications and Education

SQE.1.1 Each staff member's responsibilities are defined in a current job description.

Measurable Element #2
Those individuals identified in a) through d) in the intent, when present in the hospital, have job descriptions appropriate to their activities and responsibilities or have been privileged if noted as an alternative. (Also see AOP.3, ME 1; PCI.1, ME 3; and SQE.5, ME 3)
Partially Met
Seven of eight (88% compliance) nursing job descriptions were appropriate to their identified activities and responsibilities. Head Nurses of each ward were expected to provide patient care as needed; however, their job descriptions contained managerial responsibilities and did not contain any clinical patient care responsibilities.

SQE.3 The hospital uses a defined process to ensure that clinical staff knowledge and skills are consistent with patient needs.

Measurable Element #5
There is at least one documented evaluation of each clinical staff member working under a job description each year or more frequently as defined by the hospital. (Also see SQE.11, ME 1))
Partially Met
Seven of eight (88% compliance) nursing files contained a documented annual evaluation.

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 monitoring and evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member compared to other department/service medical staff members. (Also see QPS.4, ME 2)
Partially Met
The organization had adopted a set of qualitative criteria, with a yes/no answer, related to professional growth and behaviors. Compliance to hand hygiene and completeness of medical records were applied for all physicians as "clinical" measures. Internal comparisons between individual medical staff members were limited to the latter measure.

Measurable Element #3
The clinical results of data and information available on medical staff members are reviewed with objective and evidence-based information, as available, for external benchmarking.
Partially Met
Five of eight (62% compliance) files reviewed, documented one reference with evidence-based information for external benchmarking.

Management of Information

MOI.2 **Information privacy, confidentiality, and security—including data integrity—are maintained.**

Measurable Element #1
The hospital has a written process that protects the confidentiality, security, and integrity of data and information. (Also see COP.2.2, ME 6, SQE.5, ME 1; and MOI.3, MEs 2 and 3)
Partially Met
The following were observed:
1. The organization's policy SATNET-683-461 on confidentiality and security of data did not address how to protect patient confidential information placed on medication containers, such as labels of vials and bottles.
2. In the waste storage area, a large container of medications vials/bottles with attached labels with confidential information was accessible.

MOI.11.1 **Every patient medical record entry identifies its author and when the entry was made in the medical record.**

Measurable Element #3
The time of each patient medical entry can be identified. (Also see IPSG.2.2)
Partially Met
The organization was in a transition phase between paper and electronic patient records. The

time of entry was inconsistently implemented in multiple handwritten notes, which included: informed consent, time-out, sign-out, pre-induction assessment, discharge from the recovery area after anesthesia/sedation, and time of antibiotic prophylaxis administration.