Joint Commission International Accreditation

FINAL ACCREDITATION SURVEY FINDINGS REPORT

Onze Lieve Vrouw Ziekenhuis

Aalst, Belgium

International Health Care Organization (IHCO) Identification Number: 60004663

Survey Dates:	6 June 2016 - 10 June 2016
Program:	Hospital
Survey Type:	Initial
Surveyor Team:	Kenneth S. Waxman, MD, Physician, Team Leader Andrew G. Fallat, MA, Administrator Hope M. Juckel-Regan, MA, RN, Nurse Deborah E. Lee, MBA, RN, Nurse Muayad Al-Hussaini, MD, Physician

OUTCOME:

Based on the findings of the Initial Hospital survey of 6 June 2016 to 10 June 2016 and the Decision Rules of Joint Commission International (JCI), Onze Lieve Vrouw Ziekenhuis 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, Onze Lieve Vrouw Ziekenhuis 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, Onze Lieve Vrouw Ziekenhuis 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 Onze Lieve Vrouw Ziekenhuis 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):

- ACC.4.4, ME #3
- ACC.6, ME #6
- COP.8.5, ME #6
- MMU.5.1, ME #2, ME #4

The SIP must be submitted to JCI within the next 45 days or by 29 July 2016 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.2.1 The hospital develops and implements a process for reporting critical results of diagnostic tests.

Measurable Element #1
The hospital has defined critical values for each type of diagnostic test.
Partially Met
The following were observed:

1. The organization had not completely defined critical values for all types of tests. They had developed a list of critical values for the laboratory. For radiology and cardiology, there was a description of the critical reporting process, but only examples of critical values. There was no list or description of critical values for pathology, pulmonary function testing, nuclear medicine, or electroencephalograms. During the survey, the hospital developed critical value lists for all of the diagnostic services.
2. The organization had not defined critical values for point of care testing. Glucose, hemoglobin, electrolytes, and arterial blood gasses were measured on the inpatient units. Staff who performed these tests did not have definitions of critical results and did not report such results as critical values per hospital policy.

IPSG.2.2 The hospital develops and implements a process for handover communication.

Measurable Element #2
Standardized forms, tools, and methods support a consistent and complete handover process.
Partially Met
The hospitals had standardized methods and tools to support consistent handovers for nurses. In contrast, physician handover was not consistent. There were no standardized forms, tools, or methods for physician handovers.

Measurable Element #3
Data from handover communications are tracked and used to improve approaches to safe handover communication.
Partially Met
The hospital tracked nursing handover associated with intershift reports, but had not tracked data for other nursing handover processes. Physician handover communication had not been tracked.

IPSG.3 **The hospital develops and implements a process to improve the safety of high-alert medications.**

Measurable Element #2
The hospital implements strategies to improve the safety of high-alert medications, which may include specific storage, prescribing, preparation, administration, or monitoring processes.
Partially Met
The hospital had strategies to improve the safety of high alert medications, but did not have a uniform storage process to improve the safety of look-alike/sound-alike medications. For example, on multiple patient care areas, five different doses of enoxaparin (clexane) were stored adjacent to each other, without any warning system or LASA labeling.

IPSG.4.1 **The hospital develops and implements a process for the time-out that is performed in the operating theatre immediately prior to the start of surgery to ensure correct-site, correct-procedure, and correct-patient surgery.**

Measurable Element #1
The full surgical team conducts and documents a time-out procedure in the area in which the surgery/invasive procedure will be performed, just before starting a surgical/invasive procedure.
Partially Met
A complete time out procedure was seen in four of five cases (80% compliance) observed. In one case in the operating room, the operating surgeon did not participate in the whole process of the time out prior to the start of the surgery as he left the room a few seconds after initiating the protocol.

Access to Care and Continuity of Care

ACC.4.3 **The complete discharge summary is prepared for all inpatients.**

Measurable Element #4
The discharge summary contains significant medications, including discharge medications.
Partially Met
In 21 of 27 of closed records (78% compliance) reviewed, the discharge summary documented the medication given during hospitalization.

ACC.4.4 **The records of outpatients requiring complex care or with complex diagnoses contain profiles of the medical care and are made available to health care practitioners providing care to those patients.**

Measurable Element #3
The hospital uses a process that will ensure the outpatient profile is available in an easy to retrieve and review format.
Not Met
The hospital did not have a process to easily retrieve or review an outpatient profile. The profile was not contained in a single document, but rather had to be reconstructed from multiple

sources. A complete profile could be obtained by reviewing information from three different types of documents:

1. A computerized form listing patient problems.
2. A second form listing previous clinic visits.
3. A review of clinic notes to determine current medications and changes in the care plans.

ACC.6 **The process for referring, transferring, or discharging patients, both inpatients and outpatients, includes planning to meet patients' transportation needs.**

Measurable Element #6

There is a process in place to monitor the quality and safety of transportation provided or arranged by the hospital, including a complaint process.

Not Met

There was no process in place to monitor the quality and safety of transportation provided or arranged by the hospital, including a complaint process.

Patient and Family Rights

PFR.5.1 **Patient informed consent is obtained through a process defined by the hospital and carried out by trained staff in a manner and language the patient can understand.**

Measurable Element #5

There is a uniform recording of informed consent.

Partially Met

The recording of informed consent was not uniform. Hospital policy permitted two different informed consent processes, written and verbal. Written consents were documented on forms, which varied in their requirements. Some written consents required both patient and physician signatures, but the consent for colonoscopy required only the patient signature. The process of verbal consents was accepted for multiple procedures including major operations, chemotherapy, radiation therapy, and angiography. Verbal consent documentation required only a physician entry in the electronic medical record with no patient signature.

Assessment of Patients

AOP.1 **All patients cared for by the hospital have their health care needs identified through an assessment process that has been defined by the hospital.**

Measurable Element #1

The minimum content of assessments for inpatients is defined for each clinical discipline that performs assessments and specifies the required elements of the history and physical examination.

Partially Met

The hospital policy "Assessment of Inpatients" defined the minimum content of inpatient assessments conducted by physicians and nurses, but did not define the minimum content of assessments for dieticians or physical therapists.

Measurable Element #2
The minimum content of assessments for outpatients is defined for each clinical discipline that performs assessments and specifies the required elements of the history and physical examination.
Partially Met
The hospital policy "Assessment of Outpatients" did not define the minimum content of assessment for dieticians, physical therapists, or nurses. The policy defined the required elements of the history for physicians, but not the required elements of the physical examination.

Care of Patients

COP.3 The care of high-risk patients and the provision of high-risk services are guided by professional practice guidelines, laws, and regulations.

Measurable Element #2
When high-risk services are provided by the hospital, leadership establishes and implements guidelines and procedures for those services and for the care of high-risk patients, for at least a) through i) of the intent. (Also see MOI.10.1, ME 4)
Partially Met
The organization had not implemented guidelines and procedures to assure that children who were assessed and who were at risk of abuse would be identified and appropriately protected. Two medical records from the emergency department were reviewed, both of which provided examples of children at potential risk who were not screened and/or protected.

COP.3.1 Clinical staff are trained to recognize and respond to changes in a patient's condition.

Measurable Element #1
The hospital develops and implements a systematic process for staff recognition of and response to a patient whose condition appears to be worsening.
Partially Met
The organization had implemented a process for recognition of and response to patients whose condition appeared to be worsening for adults but had not implemented a process for pediatric patients and adult rehabilitation patients at the Ninove Hospital.

COP.3.2 Resuscitation services are available throughout the hospital.

Measurable Element #2
Medical technology 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
Resuscitation medications and technology were not standardized and were not always available for use. The following were observed:
1. Medications for advanced life support were not standardized. Emergency medications were stored in a variety of carts and back packs, differing between areas of the hospital and

between hospitals. Each of these different emergency medication storage containers contained different types and amounts of medications and different labeling systems.
2. Defibrillators were not standardized. There were a variety of defibrillators of different manufacturers and models on different units.
3. In an operating room in the outpatient operation area, the emergency resuscitation supplies were not present in the expected area, and emergent airway equipment was not immediately available.

COP.8.5 The transplant program obtains informed consent specific to organ transplantation from the transplant candidate.

Measurable Element #3

In addition to the information provided to any surgical patient as part of the informed consent process, the transplant program informs the prospective transplant candidate of organ donor risk factors that could affect the success of the graft or the candidate's health as a recipient, including, but not limited to, a) through d) of the intent.

Partially Met

The transplant program did not inform prospective recipients of the donor history or the age of the organ, as required by elements a) and c) in the intent. During the survey, the organization revised the consent to include these elements.

Measurable Element #6

In addition to the information provided to any surgical patient as part of the informed consent process, the transplant program informs the prospective transplant candidate of alternative treatments.

Not Met

There was no evidence that the transplant program informed prospective transplant patients of alternative treatments. The program did not have a process to inform the patient about alternative treatment, nor did informed consent forms include information regarding alternative treatment. During the survey, the organization revised the consent form to include language regarding alternative treatments.

Anesthesia and Surgical Care

ASC.3.2 Procedural sedation is administered and monitored according to professional practice guidelines.

Measurable Element #1

There is a presedation assessment performed and documented that includes at least a) through e) to evaluate risk and appropriateness of procedural sedation for the patient. (Also see AOP.1, MEs 1 and 2)

Partially Met

Presedation assessments were not performed for procedures performed under moderate or deep sedation in the endoscopy suite. For procedures performed in angiography or the cardiac catheterization laboratory, presedation assessments were performed.

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.

Partially Met

The following were observed regarding storage of medications:

1. The hospital had defined the upper limit for safe medication storage as 25 degrees Celsius. During tracers on many inpatient units on both the Aalst and Asse campuses, it was observed that thermometer readings near medication storage areas exceeded 25 degrees. Review of temperature monitoring logs on these units demonstrated multiple readings over 25 degrees, but no corrective actions had been taken.
2. There was no temperature monitoring in the medication storage area in the Asse emergency department.
3. There was no humidity monitoring in numerous medication storage areas across the organization.

Measurable Element #3

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

Partially Met

The following was observed regarding labeling of medications:

1. In the Aalst operating room, a basin on the operating field with a clear solution was not labeled. During the same procedure, an unlabeled syringe said to contain heparin was mixed with the clear solution.
2. After preparation, chemotherapy was not labeled with expiration date or time.
3. After preparation, radiopharmaceutical syringes were not labeled.

Measurable Element #5

Medications are protected from loss or theft throughout the hospital.

Partially Met

The following were observed regarding risk of loss or theft of medications:

1. The pharmacy was not staffed during the night and weekend. Security staff had card reader access to the pharmacy, but there was no system in place to monitor whether the pharmacy had unauthorized entries during un-staffed hours. A system was created during the survey to identify and monitor pharmacy access at all times.

2. In a patient care area in the Asse emergency department, a large medication storage cabinet containing high risk medications was unlocked.

MMU.4.1 The hospital defines the elements of a complete order or prescription.

Measurable Element #2
The hospital develops and implements a process to manage medication orders that are incomplete, illegible, or unclear.
Partially Met
The hospital had developed a process to manage incomplete or illegible physician medication orders, which required nurses to notify physicians to rewrite the orders; however, on review of open and closed medical records, numerous examples were observed of incomplete medication orders which had not been corrected.

MMU.5.1 Medication prescriptions or orders are reviewed for appropriateness.

Measurable Element #2
Apart from exceptions identified in the intent, each prescription or order is reviewed for appropriateness prior to dispensing and administration and includes elements a) through g) in the intent. Thus, each prescription or order is evaluated for appropriateness.
Not Met
The organization did not have a process to review each prescription or order for appropriateness.

Measurable Element #4
Individuals permitted to review orders or prescriptions are judged competent to do so and are provided resources to support the review process.
Not Met
There was no process to determine competencies of individuals to perform appropriateness reviews.

MMU.7 Medication effects on patients are monitored.

Measurable Element #2
Medication adverse effects on patients are monitored and documented.
Partially Met
The hospital had developed a reporting system for medication adverse effects, but this process had not been effectively implemented. Zero medication adverse events had been reported.

Quality Improvement and Patient Safety

QPS.8 **Data are always analyzed when undesirable trends and variation are evident from the data.**

Measurable Element #6

Adverse events or patterns of adverse events during moderate or deep sedation and anesthesia use are analyzed. (Also see ASC.3.2 and ASC.5)

Partially Met

The organization had a process to analyze adverse events during anesthesia in the operating room, but had not begun a process to monitor whether adverse events occurred during sedation performed outside of the operating room.

Prevention and Control of Infections

PCI.7 **The hospital identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.**

Measurable Element #1

The hospital has identified those processes associated with infection risk. (Also see MMU.5, ME 1)

Partially Met

Processes were observed which were associated with increased infection risk:

1. Throughout the hospital, it was observed that in dirty utility rooms there was mixing of clean and dirty supplies and equipment.
2. Dialysis fluid was stored in a storeroom off site of the Dialysis Patient Care Unit at the Ninove Site. When the sterile fluid bags were needed for patient treatments, the bags were carried through a large waste storage area, increasing the potential infection risk.
3. The waste area at the Asse Hospital contained contaminated waste which was not separated from other stored materials.
4. Storage areas for sterile supplies were not monitored for humidity throughout the hospitals, including in the storage areas in the operating suites, in central sterilization, and on multiple inpatient units.
5. The operating room in the Asse Hospital had a single corridor where clean and contaminated processes could not be separated. Sterile supplies were stored on open shelving in this hallway.
6. No soap for hand washing was available in the patient bathroom in the Pediatric Day Care Center.
7. No checklist or evidence of toy cleaning was present in the Pediatric Ward at Aalst.
8. Bed pans were washed by hand in the Pediatric Ward in Asse Hospital, without procedures in place to assure adequate cleaning.

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

Measurable Element #1
The hospital stores food and nutrition products using sanitation, temperature, light, moisture, ventilation, and security in a manner that reduces the risk of infection.
Partially Met
The organization did not have a process to assure that food was safely stored in refrigerators in patient rooms. These refrigerators were intended for water storage and labeled accordingly, but it was observed that patients frequently stored personal food. Food stored in these refrigerators was not inspected, nor was it labeled or dated. The hospital did not monitor these refrigerators for temperature, thus creating a risk of spoilage and infection.

PCI.9 Gloves, masks, eye protection, other protective equipment, soap, and disinfectants are available and used correctly when required.

Measurable Element #1
The hospital identifies situations in which personal protective equipment is required and ensures that it is available at any site of care at which it could be needed.
Partially Met
The disinfectants, REOCID and CLINELL spray, were used across the organization without the personal protective equipment recommended by the manufacturer. Staff only used gloves, but the Material Safety Data Sheets required masks, goggles, and gowns.

Governance, Leadership, and Direction

GLD.1.1 The operational responsibilities and accountabilities of the governing entity are described in a written document(s).

Measurable Element #5
Those responsible for governance appoint, and annually evaluate, the hospital's chief executive(s) using established criteria and process.
Partially Met
The most recent annual evaluation of the hospital's Chief Executive Officer consisted of a short paragraph message from the Board Chairman to the Chief Executive Officer rather than thorough evaluations done in prior years that used established criteria.

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.

Partially Met
The hospital received quality information from cleaning, its largest service contractor, in form of routine reporting of the contractor's own quality inspections as well as confirmation of staff training by instructors who met the hospital's criteria for approval. The obligation to provide these reports were not contained in the contract that was adopted three years ago. Negotiations to date with potential vendors to a new three year contract had begun and included the obligation to place these data requirements into future agreements.

GLD.14 Health professional education, when provided within the hospital, is guided by the educational parameters defined by the sponsoring academic program and the hospital's leadership.

Measurable Element #5
The hospital understands and provides the required level of supervision for each type and level of student and trainee.
Partially Met
The hospital provided supervision, but did not have a process to understand the required level of supervision for each postgraduate trainee.

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.
Partially Met
The following safety risks were observed:
1. Throughout the organization, patient emergency call lights adjacent to the patient room toilets could not be reached if a patient fell.
2. The visitor bathroom on the Rehabilitation Patient Care Unit at the Ninove Site had no emergency call light.
3. There were no emergency call alarms in the patient bathroom and only one emergency alarm in Pediatric Day Care Unit.
4. There was no process to check the emergency oxygen supply in the Pediatric Treatment room.
5. Disinfectants to clean bed pans were stored in an unlocked cupboard where children had access on the Pediatric Ward Asse Hospital.
6. Twenty-six of 32 wheel chair brakes (81% compliance) worked properly.

FMS.5.1 The hospital has a program for the control and disposal of hazardous materials and waste.
Measurable Element #2
The program establishes and implements procedures for the management of spills and exposures, including the use of proper protective equipment.

Partially Met

The following risks related to spills or exposure to hazardous materials were observed:

1. In the operating suite, hazardous materials, including bottles of formaldehyde, were stored without the availability of a spill kit. Furthermore, during interviews, staff members had not been trained on management of potential spills or exposures.
2. In the Aalst endoscopy suite, there was no procedure in place in the case of exposure to the potentially toxic chemicals utilized in the endoscope cleaner.
3. In the chemotherapy preparation areas in Aalst and Asse, staff had not been trained on procedures to utilize in case of exposure to a cytotoxic agent.

FMS.6 **The hospital develops, maintains, and tests an emergency management program to respond to emergencies, epidemics, and natural or other disasters that have the potential of occurring within their community.**

Measurable Element #3

The hospital establishes and implements a disaster program that identifies its response to likely disasters, including items a) through g) in the intent.

Partially Met

The hospital's disaster program included six of the seven items in the intent. Missing was item g) the process to manage emergencies when personal responsibilities of staff conflict with the hospital's responsibility for providing patient care.

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 #4

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

Partially Met

The following risks related to fire abatement were observed:

1. In the Aalst operating suite, staff were unable to access and shut off the oxygen flow in case of fire.
2. The absence of automatic fire abatement in the parking garage under Asse Hospital created significant risk to the building and all occupants.
3. The gas shut-off valves to the Operating Theater in Asse Hospital were not easily accessible due to a temporary wall constructed during renovation.

Measurable Element #5

The program includes the safe exit from the facility when fire and nonfire emergencies occur.

Partially Met

Safe exit from the facility was compromised by many examples of inadequate signs and hazardous walkways. The following examples were observed:

1. Absence of signage indicating exiting from the roof at Level 5 of W block.
2. Steep steps leading directly from the entrance of the building down to the floor.
3. Absence of signs indicating appropriate direction to secure assembly points outside the hospital.

FMS.7.1 **The hospital regularly tests its fire and smoke safety program, including any devices related to early detection and suppression, and documents the results.**

Measurable Element #1
All staff participate in at least one fire and smoke safety program test per year. (Also see FMS.11 – FMS.11.2)
Partially Met
The hospital documented that 62% of staff participated in the fire safety test program in the year prior to the survey.

FMS.8 **The hospital establishes and implements a program for inspecting, testing, and maintaining medical technology and documenting the results.**

Measurable Element #2
There is an inventory of all medical technology.
Partially Met
There was not a single inventory of all medical technology. Various departments, such as radiology, nuclear medicine, radiation therapy, and laboratory maintained their own department with no processes currently coordinated with the medical engineering department. An action plan was in place to coordinate all hospital medical technology under the direction of a qualified individual.

Measurable Element #3
Medical technology is inspected and tested when new and according to age, use, and manufacturers' recommendations thereafter.
Partially Met
The hospital contracted with outside vendors for much of its equipment. The record of inspection and testing of equipment by the outside vendor was not available on site. When record was made available, it documented the vendor's conclusion that the device satisfied various national and international standards, without documenting any supportable data. Therefore, it was not possible to determine the appropriateness of the testing.

Staff Qualifications and Education

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 #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
The physician annual review was subjective. The hospital collected data on physician clinical results, but had not yet developed a process to incorporate these metrics into the annual review process for external benchmarking.

Management of Information

MOI.11 The hospital identifies those authorized to make entries in the patient clinical record.

Measurable Element #3
There is a process that addresses how entries in the patient record are corrected or overwritten.
Partially Met
Throughout the organization, hand written medical records contained entries that were corrected or overwritten by methods that were not approved by hospital policy. Incorrect corrections were also observed in narcotic logs.

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

Measurable Element #3
The time of each patient clinical entry can be identified.
Partially Met
Most electronic medical record entries included times; however, handwritten entries often did not include times. Examples of untimed entries included physician medication orders, written consent forms, time-out documentation, and many nursing and physician progress notes.

MOI.12 As part of its monitoring and performance improvement activities, the hospital regularly assesses patient clinical record content and the completeness of patient clinical records.

Measurable Element #2
The review is conducted by physicians, nurses, and others authorized to make entries in patient records or to manage patient records.
Partially Met
Physicians and nurses reviewed records, but others authorized to make entries, such as dieticians, physical and occupational therapists, pharmacists, and social workers did not participate in a review process.