

Exit Report

sint-Jozefskliniek Izegem Izegem, Belgium

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Program: Hospital

Survey Type: Initial

Surveyor Team: Mahyar Sadeghi, DDS, MBA, MS, Administrator, Team Leader
Marwa M. Ezz El Din Mostafa, Physician
Pauline Tan, MSc, MPA, RN, Nurse

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 healthcare organizations with the information they need 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

When your organization receives its Final Survey Findings Report, each Measurable Element (ME) scored “Not Met” will be plotted 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 MEs will require a SIP
Moderate/Pattern Moderate/Widespread	Not Met MEs will require a SIP
Moderate/Limited Low/Pattern Low/Widespread	Not Met MEs will not require a SIP
Low/Limited	

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SAFER Matrix

Program Name: Hospital

Likelihood to harm a patient/visitor/staff	ITL			
	High		AOP.02.00 ME 3 COP.04.00 ME 3 IPSG.03.02 ME 2	
	Moderate	AOP.01.05 ME 1 AOP.05.02 ME 5 FMS.04.00 ME 2 FMS.06.01 ME 1 GLD.05.03 ME 1 IPSG.04.00 ME 3 MMU.04.01 ME 5 MMU.07.01 ME 5 PCI.05.00 ME 1 PCI.05.01 ME 2	FMS.03.00 ME 1 HCT.01.05 ME 1 IPSG.03.00 ME 2	
	Low		ASC.01.00 ME 5 FMS.05.00 ME 2 FMS.05.00 ME 5 GLD.05.00 ME 6	IPSG.02.01 ME 2
		Limited	Pattern Scope	Widespread

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Assessment of Patients

AOP.01.05 All patients are reassessed at intervals based on their condition and treatment.

Measurable Element #1

Hospital policy defines, in writing, how often patients are reassessed by various members of the health care team and other circumstances when a reassessment is required, including the following:

- Defined intervals by various members of the care team, including physicians, nurses, and other clinical staff (for example, therapists, social workers)
- When there has been a significant change in patient condition
- When the diagnosis has changed and plan of care needs to be revised
- To determine if the patient is ready for transfer or discharge

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The hospital policy defined that patients must be reassessed by physicians on daily basis. It was observed that patients in the maternity and psychiatric units were reassessed only twice per week.

AOP.02.00 The hospital develops and implements a process to reduce the risk of falls, and patient harm resulting from falls.

Measurable Element #3

The hospital implements a process for the assessment and, when applicable, reassessment of patients who may become at risk for falls due to a change in condition or are already at risk for falls based on the documented assessment.

Not Met

Likelihood to Harm: High

Scope: Pattern

The following were observed:

1. Fall risk assessment was not uniform across the inpatient setting. While the intensive care, geriatric units and emergency department used the fall risk assessment tool comprehensively for patients identified to be at risk, the labor and delivery, post-natal and psychiatric units (deemed as high-risk units) relied on three screening questions that did not address critical risk factors.
2. The hospital policy classified maternity patients as high risk for falls; however, during tracer review of a maternity patient admitted for an emergency cesarean section (CS), the patient was screened for fall risk upon admission and categorized as "no risk" by the midwife. In addition, no postoperative fall reassessments were conducted, hence, no fall prevention interventions were implemented or documented in the patient care plan throughout the patient's five-day hospital stay.
3. In the Acute Psychiatric Inpatient Unit, it was also observed that no fall risk assessment was performed for a patient with acute mental illness who was prescribed psychotropic medication. Despite her significant risk factors, the patient was categorized as low risk for falls based on the three-question screening tool.

AOP.05.02 A radiation and/or diagnostic imaging safety program for patients, staff, and visitors is implemented and is compliant with applicable professional standards, laws, and regulations.

Measurable Element #5

Hazards from magnetic resonance imaging are addressed using industry standards and evidence-based guidelines.

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The hospital addressed hazards from magnetic resonance imaging (MRI) using industry standards and evidence-based guidelines; however, there was no ferromagnetic detector available to ensure that patients and staff that might accompany patients did not have non-MRI-compatible objects on or with them.

Anesthesia and Surgical Care

ASC.01.00 The hospital provides sedation and anesthesia services to meet patient needs, and in accordance with professional practice standards and laws and regulations.

Measurable Element #5

This qualified individual(s) is responsible for managing the sedation and anesthesia services, including ensuring the following:

- Sedation and anesthesia services are uniform throughout the hospital.
- Sedation and anesthesia services are available at all times for emergencies.
- The responsibilities for monitoring and reviewing all sedation and anesthesia services are defined and carried out.

Not Met

Likelihood to Harm: Low

Scope: Pattern

No qualified individual was designated to oversee and evaluate sedation services provided outside the Department of Anesthesia.

Care of Patients

COP.04.00 Resuscitation services are available throughout the hospital.

Measurable Element #3

In all areas of the hospital, basic life support is initiated immediately upon recognition of cardiac or respiratory arrest, and advanced life support is initiated in fewer than 5 minutes.

Not Met

Likelihood to Harm: High

Scope: Pattern

The hospital had three resuscitation carts that were used in case of a cardiac or respiratory arrest in any ward or department in the hospital, except in the intensive care unit and the operating theater that had their own carts. The resuscitation committee performed a drill on the arrival of the cart and initiation of advanced cardiac life support in fewer than five minutes, only in the Radiology department. However, they did not have data in other areas like medical, surgical, pediatric wards and the outpatient clinic that they could arrive with the cart and initiate advanced cardiac life support in less than five minutes.

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: Moderate**Scope: Pattern**

The hospital had implemented a safe patient care facility; however, in the inpatient psychiatric unit, the following safety risks were identified:

1. No visitor protocols to check and monitor items brought to the facility that could potentially cause harm to patients and staff.
2. Multiple ligature fixtures including doors, windows' handles, curtain rod, wall metal hangers.
3. Unsecured chairs that could be used for self-harm or to harm others.
4. Windows had breakable glass.
5. Staff had no visibility of patients in their confined rooms; hence they were not able to have line of sight of any risk events by patients.

Additionally, there were no lights on the roof of the hospital buildings to illuminate pathways towards the equipment, which could result in staff fall and injuries. It should be noted that there were no rail guards around the perimeters of the roof.

FMS.04.00 The hospital implements a program to provide a secure environment for patients, families, staff, and visitors.**Measurable Element #2**

The security program identifies all security risk areas and restricted areas and ensures that they are monitored and kept secure.

Not Met**Likelihood to Harm: Moderate****Scope: Limited**

The postnatal unit did not design secure access controls to prevent unauthorized individuals from entering the unit, thus creating a potential risk of infant abduction. In addition, staff did not conduct an infant abduction drill to test the integrity of their security process.

FMS.05.00 The hospital implements a program for the management of hazardous materials and waste.**Measurable Element #2**

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

Not Met

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

The following were observed:

1. The hospital's comprehensive inventory of hazardous materials identified many detailed information about the materials, including the name, and hazard type; however, did not include quantities, and locations of hazardous material.
2. The comprehensive inventory of the hazardous material did not include radioactive, and cytotoxic materials.

Measurable Element #5

The hazardous materials and waste program establishes and implements procedures for the management of spills and exposures, including the use of proper protective equipment and reporting of spills and exposures.

Not Met**Likelihood to Harm: Low****Scope: Pattern**

The hazardous materials and waste program established and implemented procedures for the management of spills and exposures, including the use of proper protective equipment; however, the following were observed:

1. The housekeeping staff used disinfectant and cleaning solutions on the patient care units; however, no eyewash mechanism was available to flush the eyes in case of exposure to chemicals as required by the Material Safety Data Sheet (MSDS).
2. In the waste collection area where considerable amount of chemical wastes were stored, there was no eyewash mechanism to flush the eyes in case of exposure to chemicals as required by the Material Safety Data Sheet (MSDS).
3. The Endoscopy Unit kept a 250ml bottle of water to be used as eye wash in the event of accidental splashing to the eyes. The limited fluid quantity would not be sufficient to assure 15 mins of continuous eye flushing.
4. In the Nuclear Medicine Department, where staff could accidentally be exposed to radioactive material, there was no eyewash mechanism to flush the eyes in case of exposure.

FMS.06.01 The hospital maintains fire safety equipment and fire safety building features.**Measurable Element #1**

The fire safety program includes equipment/systems for the early detection and alarm notification of fire and smoke.

Not Met

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

In the hospital's diesel generator area where considerable amount of diesel fuel was stored as well as the covered roof section of block D of the hospital where some electrical panels and equipment were located, there were no equipment/systems for the early detection and alarm notification of fire and smoke.

Governance, Leadership, and Direction

GLD.05.00 Hospital leaders are accountable for the review, selection, and monitoring of clinical and nonclinical contracts and inspect compliance with contracted services as needed.

Measurable Element #6

Quality data reported under contracts are integrated into the hospital's quality monitoring program.

Not Met

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

The contracted services quality and performance data were not consistently reported under contracts and were not integrated into the hospital's quality monitoring program.

GLD.05.03 Hospital leaders establish a supply chain strategy that includes protection of patients and staff from unstable, contaminated, defective, and counterfeit supplies.

Measurable Element #1

Hospital leaders establish a written supply chain strategy that does the following:

- Defines the steps in the supply chain.
- Identifies risk within the steps of the supply chain.
- Defines supplies at most risk.
- Outlines recommendations on mitigating risks that will ensure continuity of safe and highquality patient care services.

Not Met

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

The hospital had not established a written supply chain strategy that did the following:

- Defines the steps in the supply chain.
- Identifies risk within the steps of the supply chain.
- Defines supplies at most risk.
- Outlines recommendations on mitigating risks that will ensure continuity of safe and high-quality patient care services.

Health Care Technology

HCT.01.05 The hospital develops and maintains processes and procedures for cybersecurity and cyber risk management.

Measurable Element #1

The hospital maintains, and tests at least annually, a written incident response program that includes the following:

- Identifying the probable impact a cyberattack on data systems will have on all aspects of care and operations
- Identifying strategies for the provision of ongoing safe and high-quality care and services

Not Met

Likelihood to Harm: Moderate

Scope: Pattern

The following were observed:

1. The hospital's cyber-incident response plan identified the probable impact that a cyberattack on data systems will have on clinical and administrative aspects related to clinical care; however, the program did not include response to cyberattack that impacted hospital's operations data systems.
2. The hospital tested the response program to a cyberattack that impacted clinical care; however, the test did not include the probable impact a cyberattack on operations data systems.

International Patient Safety Goals

IPSG.02.01 The hospital implements a standardized process for handover communication.

Measurable Element #2

The hospital uses standardized forms, tools, or methods that support a consistent and complete handover process that includes the opportunity for all staff involved to clarify information and ask questions.

Not Met

Likelihood to Harm: Low

Scope: Widespread

The hospital was unable to demonstrate a consistent and complete handover process when transferring patients between different levels of care, departments or healthcare teams. Staff mentioned that the hospital was already in the process of initiating the design and implementation of a handover tool between the emergency department and inpatient wards as a start, with the view to roll out the tool to the other units after the pilot was successful.

IPSG.03.00 The hospital implements a process to improve the safety of high-alert medications.

Measurable Element #2

The hospital implements a risk mitigation strategy for reducing the risk of harm from high-alert medications that is uniform throughout the hospital and, in addition, includes tailored strategies for specific medications when necessary.

Not Met

Likelihood to Harm: Moderate

Scope: Pattern

The following were observed:

1. Inconsistent labeling of high alert medications was observed in several departments, for example the emergency department and the operating theater.
2. Concentrated electrolytes were labeled with the same label used for high alert medications (Green label with exclamation mark), no specific label to identify it as concentrated electrolytes.

IPSG.03.02 The hospital implements a process to manage the safe use of concentrated electrolytes.

Measurable Element #2

The hospital only stores vials of concentrated electrolytes outside of the pharmacy for emergency situations or specific purposes, and these are clearly identified in hospital policy.

Not Met

Likelihood to Harm: High

Scope: Pattern

Concentrated electrolytes including potassium chloride were stored in their undiluted form across several departments, despite not being required for emergency situations or specific purposes. For example it was stored in the Pediatric, gastroenterology, Cardiac and outpatient chemotherapy departments.

IPSG.04.00 The hospital implements a process for the preoperative verification and

surgical/invasive procedure site marking.**Measurable Element #3**

The surgical/invasive site marking process includes the following:

- Marking completed by the person performing the procedure
- Patient involved in the marking process
- Alternative site-marking process for cases in which marking may result in harm
- Alternative site-identification process for patients who refuse site marking
- Alternative site-marking techniques for situations in which routine site marking is not possible (for example, laser, stereotactic radiosurgery, dental)

Not Met**Likelihood to Harm: Moderate****Scope: Limited**

The following were observed:

1. In the outpatient Maxillofacial clinic, the surgeon who performed invasive procedures did not complete a site marking. He only confirmed the site of the procedure against the referral note and with the patient.
2. The hospital's policy did not identify an alternative site marking for neonates. This was further confirmed in the operating theater, where the nurse confirmed that in case of neonates (3 months old and above), the surgeon only confirmed the site with the parents, before the surgery.

Medication Management and Use

MMU.04.01 The hospital identifies safe prescribing, ordering, and transcribing practices and defines the elements of a complete order or prescription.

Measurable Element #5

The hospital implements a written policy that includes the following types of medication orders:

- As needed (PRN) orders
- Standing orders
- Automatic stop orders
- Titrating orders
- Taper orders
- Range orders
- Signed and held orders
- Orders for compounded drugs or drug mixtures not commercially available
- Orders for medication-related devices (for example, nebulizers, catheters)
- Orders for investigational medications, if applicable
- Orders for herbal products, if applicable
- Orders for medications at discharge or transfer

Not Met

Likelihood to Harm: Moderate

Scope: Limited

Titration orders for medications was observed not to be specific as to the frequency of adjustment and/or dose amount for adjustments. For example, Noradrenaline 8mg/4ml to achieve MAP above 65 with no specific titrating doses or frequency for adjustment.

MMU.07.01 The hospital implements a process for identifying, reporting, managing, and tracking all medication errors and near miss events (or close calls).

Measurable Element #5

The hospital uses the analysis of medication errors and near miss events to improve medication use processes.

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The hospital collected data on medication errors and near misses. However, the data was not segregated to identify how many medication errors and how many near misses were reported. Furthermore, the collected data was not further analyzed to improve medication use processes.

Prevention and Control of Infections

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 #1

The hospital implements practices to reduce the risk of infection from handling and disposal of infectious waste, blood and blood components, body fluids, and body tissues.

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The hospital had implemented a process to collect and store medical waste; however, the plastic bags containing medical waste in the waste collection and storage area were kept unprotected on the floor and stacked on top of each other, thus posing an increased risk of infection transmission if the medical waste bags break open.

PCI.05.01 The hospital reduces the risk of infections associated with exposure to blood, body

fluids, and other potentially infectious materials.

Measurable Element #2

The hospital implements practices to reduce the risk of exposure to blood and body fluids.

Not Met

Likelihood to Harm: Moderate

Scope: Limited

Staff working in the Central Sterile Supply Department dirty processing section and the Endoscopy Unit scope washing area wore disposable gowns that did not fully cover the operators' exposed arms to offer effective protection against splashes from chemical detergents or contaminated fluids.

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