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THE NATIONAL ACCREDITATION PROCEDURE OF HEALTHCARE ORGANIZATIONS IN LEBANON AS OF 1st JANUARY 2009

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Amendments compared to version 1

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ABBREVIATIONS

The following abbreviations can be used:

- HCO: Healthcare Organization
- SA: Self-Assessment
- NCHA: National Committee of Hospital Accreditation
- TCHA: Technical Committee of Hospital Accreditation
- EPP: Evaluation of Professional Practices

This document aims to describe accurately the accreditation process of healthcare organizations in Lebanon as of 1st January 2009. Indeed, at that date, all public and private health facilities in Lebanon would have benefited from the first and even a second accreditation process.

For many years health authorities have sought to enhance the performance of hospital services without directly intervening in professional practices, but controlling them on both economic and financial levels. The resistance raised by these attempts has not changed the organization of work. The idea of regulation by the professionals themselves is needed. The quality assessment appears as the tool likely to bring a solution, to provoke an "awakening" that addresses current deficiencies in optimizing the cost/benefit rate according to a professional as well as a social approach leading to the user's satisfaction.

Reflection on improving quality is about the development of standards, their application with evidence and measures. Accreditation of hospitals in Lebanon is part of this perspective. The procedure encourages hospitals to examine both their functions (organizational aspect, professional and clinical practices) and users' satisfaction with respect to benefits provided for the continuous improvement of their performance.

The educational dimension of this accreditation is important: it aims to foster a progress dynamic, according to an objective assessment of compliance with standards recognized by professionals.

Accreditation may help hospitals develop towards a decisional practice that is more consistent with their internal and external environments. It allows them to move gradually from a reactive attitude to a decision-making behaviour largely based on anticipation.

Furthermore, accreditation will help alleviate unnecessary tensions in order to deal with realities with more rationality. This reference method limits the internal political game involving as many participants as possible in the decision-making process and providing them with a common methodology.

Accreditation is also a powerful factor of integration between the different dimensions be it technical, scientific or socioeconomic embodied by the three organization pillars namely the nursing, the medical and the administrative bodies. The emphasis is often placed on the assessment of medical service rendered to the patient.

The new Lebanese system of accreditation of healthcare organizations differs from the previous one by the following:

- Integration of two additional chapters in the Accreditation Manual:
    - Patient safety
    - Evaluation of professional practices
- Creation of a Technical Committee for Hospital Accreditation auxiliary to the Ministry of Health (see 3.2)
- Accrediting audit bodies responsible for the conduct of accreditation audits, otherwise known as accreditation visits
- Obliging all health organizations to conduct a self-assessment preceding the accreditation visit
- The possibility for health organizations to comment on the contents of the report or challenge the decisions of the National Committee of Hospital Accreditation.

I. ACCREDITATION: DEFINITION AND OBJECTIVES

The International Society for Quality in Health Care (ISQua) defines accreditation as:

- "A self-assessment and external peer assessment process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system."
- "A public recognition by a national accreditation organization of the compliance with the accreditation standards set by a healthcare organization, a compliance that has been proven through an independent and external peer assessment of the performance level of this organization regarding the standards."

This includes a review and an analysis of the quality system of an accreditation program in a way to guarantee its adequacy to the requirements and effectiveness of its performance.

The objectives of accreditation are as follows:

- Assessing the healthcare quality and safety;
- Assessing the ability of healthcare organizations to improve work conditions, care services and overall care of the patient;
- Formulating clear recommendations;
- External recognition of the hospitals' care quality as well as the public's confidence.

The approach adopted in the accreditation of healthcare organizations in Lebanon includes quality assurance, continuous improvement of quality, as well as risk management:

- Quality assurance helps to create a relationship of trust between healthcare providers and patients, by providing written evidence that the organization has the means to control the risk of malfunction.

- Continuous improvement of quality is based on the analysis of the processes in order to improve quality. This method is participatory and involves the contribution of all professionals involved in the studied processes. This is a true management tool. In this approach, there is no a priori reference, as the professionals define improvement actions and indicators necessary to monitor and maintain the desired level of quality.

- Risk management is based on the identification, prevention and control of risks incurred by patients and their families, as well as by the organization's staff.

Any organization seeking accreditation is committed to developing a quality system, allowing health professionals to provide the best level of service possible to the patient through:

- Identifying and acting on key issues regarding patient safety;
- Self-assessing and improving the key aspects of the services in accordance with the accreditation standards;
- Introducing corrections for the identified deficiencies;
- Calling independent and external auditors to assess the quality of services;
- Exploiting the recommendations to achieve continuous improvement.

Accordingly, an "accredited" healthcare organization reflects the following:

- Establishment of a risk management process covering all activity sectors for optimal safety of the patient-user;
- Establishment of a comprehensive quality system that aims to identify gaps in care / services provision and to correct them;
- Optimum compliance with the national accreditation standards.

We can say that a hospital is "accredited" if the arrangement and organization of resources and activities constitute a process that results in medical care and services of satisfactory quality.

Furthermore, accreditation contributes to the contracting between hospitals, the Ministry of Public Health, and financing funds while having an impact on the settlement level that considers the organization's accreditation level.

II. ORGANIZATIONS INVOLVED IN ACCREDITATION

In the Accreditation Manual, is considered a hospital any healthcare organization - whatever its name - dedicated to providing medical care through inpatient or outpatient services, be it private, public or social security-related, regardless of its complexity, whether for-profit or non-profit, open to the entire community or limited to a sector of the community.

The manual covers both polyvalent and specialized organizations, for acute hospital care, regardless of the generic name we have given them. This definition calls for a precise explanation of the terms used:

- Designation of the organization: hospital, medical centre, polyclinic, clinic or any other equivalent term;
- polyvalent organization: it provides care in four basic services - medicine, general surgery, paediatrics, obstetrics and gynaecology, calling on either specialists or generalists;
- Specialized organization: it refers to a short stay facility for a clinical specialty;
- Acute care organization: it is devoted to the short term disease treatment, irrespective of its acute or chronic nature; are excluded all diseases requiring accommodation for extended periods to patients suffering from disabilities or permanent impairment and seeking a permanent residence with medical assistance;
- Inpatient organization: it provides medical care in the organization, with or without outpatient care, although the two phases of medical care can be performed in different buildings; the inpatient care should be one of the main objectives of the organization and not simply a secondary service (i.e. beds for recovering patients in outpatient care, beds for observation, or "day hospital" for outpatient treatment).

The accreditation system allows each organization to apply for one of the following categories:

- University healthcare organization
- Non-university healthcare organization with tertiary care services
- General healthcare organization
- Specialized healthcare organization

This ensures that no organization is penalized due to absence of activities, since the level of accreditation is now reporting only activities that are approved and deployed at the involved organization. Accordingly, parts of the manual will not be enforceable in the organizations that basically do not offer the related activities.

When the healthcare organization has several hospital sites, the legal representative of the organization is responsible for determining whether the entire legal structure requires one single procedure or multiple procedures related to different implementations according to a splitting logic respecting the patient care patterns.

Therefore, to be eligible to participate in the accreditation program, an organization must:

- Be a hospital for acute care;

- Be functional for at least twelve (12) months before the accreditation visit;
- Ensure availability of services necessary to achieve the mission of the organization. These services can be provided either directly by the organization or outsourced.

In the case of organizations that have been accredited or certified by international organizations, this initiative will be taken into account but does not exempt the organization from implementing the accreditation process.

The long-stay organizations are not involved in the present accreditation process.

III. ACCREDITATION BODIES

3. 1. National Committee of Hospital Accreditation (NCHA)

The Decree Law 9826 of 22nd June 1962 amended by Legislative Decree 139/83 of 16.9.1983 states in Article 7 that "a committee for assessment, classification and accreditation of hospitals is created at the Ministry of Health". This committee is required to establish the National Committee of Hospital Accreditation. A set of governing documents has to be put in place including the rules of this body, allowing the organization and the structuring of the new accreditation process.

The mandate of the committee is to promote, in both public and private hospitals, the development of healthcare assessment, as well as to implement the accreditation process in these organizations.

The committee's members are appointed by decision of the Minister of Health.

For each member of the committee, a deputy is appointed under the same conditions. The deputy is not entitled to be on the committee except in the absence or incapacity of the incumbent.

The National Committee of Hospital Accreditation is chaired by the Director General of the Ministry of Health.

Are designated as members of the National Committee of Hospital Accreditation:

- 2 representatives of the Union of Private Hospitals;
- 2 representatives of the Order of Physicians;
- 1 representative of the Military Medical Services;
- 1 representative of the National Fund of Social Security;
- 1 representative from each faculty of medicine in Lebanon;
- 1 qualified person in the field of hospital management;
- The director of care at the Ministry of Public Health;
- The head of hospital services in the Ministry of Public Health – rapporteur.

The NCHA is responsible for the following:

- Define the strategic directions of the accreditation process;
- Ensure the good coordination of the accreditation implementation;
- Set deadlines for the implementation of accreditation visits;
- Validate the hospital accreditation procedures;
- Validate and disseminate hospital accreditation standards and benchmarks, diffuse them by ministerial decree in the Official Gazette;

- Approve the audit reports of the accredited organizations and submitted by the Technical Committee;
- Define the levels of accreditation of each hospital;
- Suggest financial incentives linked to the accreditation outcome.

The NCHA has the prerogative to seek the help and assistance of a third party in order to be backed to carry out its missions, particularly for developing and updating standards.

The NCHA meets at least four times a year based on convening of its chairman.

The NCHA adopts the organization and performance that best contribute to satisfy the needs of its assigned functions under the best conditions.

3. 2. Technical Committee of Hospital Accreditation (TCHA)

The TCHA is an impartial entity, which has the competence and reliability required to ensure the technical expertise as regards the approval of the audit bodies and the accreditation of hospitals expected to get a permit under the national accreditation program for healthcare organizations in Lebanon. It has the structure and human resources necessary to ensure the control and supervision of all steps and actions related to the development, continuity and sustainability of the program.

The committee is composed of five qualified foreign people whose names are proposed by the High Authority of Health and appointed for 3 years by ministerial decision.

The committee relies on external audits conducted by authorized bodies as provided in "Terms of approval and operation of the audit bodies for the accreditation of health organizations in Lebanon" as well as on all available tools and resources related to the national accreditation program. It works in full coordination with the NCHA.

The committee shall be convened by its chairman. It can hold emergency meetings if the president deems necessary. The committee prepares an annual report of its activities approved by the steering committee of the agreement signed between the Lebanese Ministry of Public Health and the High Authority of Health.

The committee is responsible for the following tasks:

- Analyze application files for the approval of the audit bodies
- Select audit bodies and propose the approval to the Ministry of Health
- Analyze the audit reports prepared by the audit bodies
- Submit the accreditation reports to the Ministry of Health of Lebanon
- Control the accredited audit bodies and submit a report to the Ministry of Health

IV. ACCREDITATION TERM

Except in cases where a problem of property or human security is highlighted by the auditors during the accreditation visit and in accordance with Legislative Decree 136 of 16.9.1983, the term of accreditation shall be two years.

Any organization having followed the process in accordance with the rules established in this document hence benefits from a two-year accreditation, irrespective of its level of accreditation (see § X) as well as from an additional period of one year in order to be able to implement corrective actions and finalize the process of quality improvement.

The organization is in charge of reviving the accreditation process during this additional year. Thus, the time between two accreditation procedures is maximum three years.

V. COMMITMENT TO THE PROCEDURE

As of 1st January 2009, the procedures' planning is initiated directly by the Ministry of Public Health of Lebanon, at the request of the health organizations.

The planning procedures should respect the sequential order of the organizations in the previous procedure as well as a period of maximum three years following the previous visit.

The legal representative of the organization shall submit the record of commitment to the NCHA at the earliest one year before the six-month period of the set visit, along with the information related to:

- The approved body he/she has adopted for the conduct of his/her accreditation visit;
- The desired period to perform the audit.

Subsequently the technical committee plans the restitution process of the accreditation with the NCHA and determines the timetable for the committee's decision.

The proposed accreditation model is based on a continuous cycle of up to three years. The planning and organization of the process are conducted in a way to meet this deadline.

5. 1. Presentation of the organization

To be committed to the accreditation process requires from the part of the organization to transmit a simplified record to the Ministry of Health, in support of the commitment letter of the legal representative, and after consulting the governing body. The record shall comprise the following:

- The identification and planning form (VIP);
- The strategic plan of the organization;
- Changes since the last procedure, as regards the legal aspects and the patient care patterns;
- A description of the progress of its quality process;
- The track of recommendations made during the previous accreditation visit;
- The approved body selected by the organization for its accreditation visit (see "Terms of approval and operation of the audit bodies for the accreditation of health organizations in Lebanon");
- The timetable for the end of the self-assessment and intervention.

Upon receipt of this record, the Ministry of Public Health analyses the application and carries out the registration.

5. 2. Accreditation Contract

On the basis of information collected in the identification and planning form, the Ministry of Public Health develops the accreditation contract, which is then sent for signature by the organization about six months before the visit.

The contract specifies the commitments of the national committee of hospital accreditation, the technical committee, the hospital and its approved body chosen for the proper conduct of the accreditation process.

These commitments include the following:

- The process scope: the organization(s) and legal entities involved in the process;
- The chosen period of the visit (month and year);
- The contract signed between the organization and the approved body chosen by the organization;
- Requirements for document production: these include all self-assessment collection grids. They also include timelines and quality of produced information, transparency of the relationship with the approved body (according to the specifications and regulations). The exact dates of the visit shall be known, in consultation with the approved body and the organization, no later than two months before the visit. The data related to the visit including the dates, the number of days and the number of auditors shall be specified by the approved body and the organization, no later than two months before the visit. Following any change, the organization and the audit body specify and explain the reasons for any modifications or amendments of the visit. In case of default or non-compliance with the organization's rules of methodology, the TCHA may take a dissatisfaction decision vis-à-vis the procedure;
- At the time of the accreditation visit, the approved body shall report any situation involving the process quality and / or the patients' or staff's safety;
- Reciprocal commitments of good conduct regarding confidentiality, transparency and timeliness;
- Approval of the financial contribution.

The accreditation process includes four key components:

- Preparation and implementation of the self-assessment process by the hospital;
- An audit to validate the results of the self-assessment conducted by an approved body;
- Submission of the audit report and definition of the accreditation level;
- Continuous improvement of quality.

VI. THE CHOICE OF THE AUDIT BODY

Following the selection of an approved audit organization, the healthcare organization signs a contract under the rules of the current procedure and in accordance with Appendix VIII of the document "Terms of approval and operation of the audit bodies for the accreditation of health organizations in Lebanon".

And in order to monitor the planning process of audits, a copy of the contract is sent to CTAH by the approved body.

The audit bodies are selected and approved in accordance with the specifications provided in "Terms of approval and operation of the audit bodies for the accreditation of health organizations in Lebanon". This document specifies the rules of intervention and control of

the approved bodies for a period of three years, as well as the rules of selection, intervention and evaluation of the auditors.

VII. ACCREDITATION AND QUALITY PROCESS

One of the objectives of accreditation is to recognize the efficiency and dynamism of a perennial quality process within the health organizations. It is therefore appropriate that officials initiate and support a genuine approach to quality improvement based on the Accreditation Manual.

7.1. Leadership and Coordination

The accreditation process constitutes a major commitment for the hospital. Therefore, in order to ensure the success of the process and continuously improve both the quality and safety, it is necessary to develop key structures and provide adequate supports.

Although the strategy chosen by each organization may differ, some important fundamentals should be respected to provide appropriate leadership and management as well as sound coordination of the accreditation process. These include:

- Commitment of the Management
- Establishment of a Steering Committee of Accreditation
- Identification of an accreditation coordinator

7. 1. 1. Commitment of the Management

It is important that the Management encourages the accreditation activities of the organization and stays actively involved in all the stages of the process.
It should communicate the key reasons behind the commitment to the accreditation and the benefits that the organization hopes to achieve through this process.
These above incentives should be taken in order to create the most conducive conditions to the participation of the key people in the process.

7. 1. 2. The Steering Committee of Accreditation

If the organization does not basically have a committee of "quality", it is then necessary to create a steering committee of accreditation in order to monitor the process. This committee should be inter-hierarchical and multidisciplinary. It can be established specifically for this purpose or it may arise from existing organizational bodies, such as the executive committee, the committee of quality management, etc.

The functions of the steering committee are defined as follows:

- Establish the objectives of accreditation;
- Define the overall plan of the procedure implementation;
- Provide the appropriate training / education and the necessary support to the organization;
- Promote the accreditation process in the organization;
- Determine the composition of the self-assessment teams;
- Coordinate all levels of the hierarchy;
- Monitor the activities of the accreditation coordinator;
- Follow up the recommendations following the accreditation visit.

7. 1. 3. The Accreditation Coordinator

The logic of the accreditation process requires that the organization designates a person as "accreditation coordinator" to manage accreditation activities and establish the link between the organization and the accreditation authority.

Its missions are determined as follows:

- Develop a plan to prepare for the accreditation process;
- Contribute to the definition of the objectives of accreditation;
- Assess the training needs of the teams and coordinate the training program;
- Lead the team during the self-assessment;
- Provide teams with the necessary tools, such as the Accreditation Manual and curriculum guides, to conduct the self-assessment;
- Ensure effective communication and collaboration throughout the process;
- Ensure that self-assessment grids are completed and submitted on time;
- Organize and allocate the necessary logistical support during the accreditation visit;
- Collect and index all documents available in the organization;
- Prepare self-assessment teams for the meetings with the auditors during the visit;
- Communicate with the approved audit body.

This role is naturally dedicated to the Coordinator of quality in case the latter does already exist within the organization. Otherwise, a staff member may be solely committed to the task of an accreditation coordinator. An accreditation coordinator should have the necessary skills in management especially in quality management, project management, and document management, as well as a good knowledge of the accreditation process. He/she should be supported by an appropriate logistic organization.

7.2. Implementation Schedule

The proposed accreditation model is based on a continuous cycle of three years. The healthcare organizations must then integrate all phases of the accreditation process every three years as part of their approach to quality improvement. The phases include the following:

- Preparation,
- Self-assessment
- Visit
- Continuous assessment

Furthermore, and in order to ensure a proper management of the accreditation process, a "roadmap" should define all activities and the major steps of the process to be completed within a set time schedule. A generic "implementation schedule" may be presented according to the following table:

Month	Action
– 12	Registration in the accreditation process Formation of the self-assessment teams
– 12 to – 6	Choice of the approved body
from – 9 to – 3 (depending on the organization's size)	Implementation of the self-assessment
- 6	Signature of the contract between the organization and the Technical Committee of Hospital Accreditation
- 3	Dispatch of the self-assessment results to the approved body
- 2	Development of the visit schedule by the approved body
- 2	Appointment of the audit team by the approved body
0	Accreditation visit
+ 1	Delivery of the audit report to the Technical Committee of Hospital Accreditation and to the organization
+ 2	Formulation of prospective comments or objections by the organization
+ 5	Dispatch of the accreditation report to the organization and prospective publication on the Internet
+ 12 *	Continuous assessment – follow-up report (if applicable)
+ 18 *	Continuous assessment – follow-up visit (if applicable)
+ 24	Registration in the coming accreditation process

*** These dates are only effective if the accreditation report anticipates a follow-up report or visit. They are also indicative, as the duration is determined according to the situation found during the audit.**

VIII. SELF-ASSESSMENT

Self-assessment constitutes an innovation in the accreditation process compared to the prior procedure and an essential step to the good conduct of accreditation.

Self-assessment enables the organization to examine its daily activities and assess them against the accreditation standards. It aims to position the organization to fulfil the requirements of the Accreditation Manual and examine the evolution of the situation.

It also helps identify compliance matters, but also areas for improvement.

8.1 Self-Assessment Teams

The self-assessment implementation requires that specialized teams be formed. The composition of the assessment teams should reflect a multidisciplinary support within the organization.

Furthermore, teams' composition should rather rely on each member's skills than their related positions.

And in order to guarantee the fullest level of homogenization, it is recommended to conduct a preliminary reflection on the teams' composition. Therefore, since the auditors' mission is to directly meet with the self-assessment groups, thus it is not advisable to create one self-assessment group per chapter of standards, but rather to think in terms of networks of support and activity sectors.

Organizations should establish at least five self-assessment groups, excluding the EPP, based on the following areas:

- Patient care management
- Medico- technical sectors
- Logistical and technical sectors
- Management
- Patient safety

Therefore, the self-assessment teams through their composition should reflect both the services provided by the organization and the structure of the Accreditation Manual. It is important to note that the self-assessment team is supposed to reflect the overall requirements of standards and not a service or department. Thus, the self-assessment team of the human resources management must reflect the standards of the human resources throughout the whole organization and not just within the very department/service of human resources. A self-assessment team of healthcare/services should take into account the patient's/user's record throughout the provided support all over the organization and not only in a given service or unit.

Each team may consist of an average of 6 to 15 members. The number of teams depends on the number of healthcare/services provided by the organization.

In the small size organizations, it is possible to choose a single multidisciplinary self-assessment team for the entire organization.

In some organizations, it may be necessary to establish working groups. Thus, a self-assessment group related to the patients' care for example can create a working group for "medical care", another group for "surgical care", another for "paediatrics"... The compilation

of all working groups' conclusions helps prepare the self-assessment report related to the patients' care management.

Regarding the Evaluation of Professional Practices (EPP), a self-assessment group is established for each assessment action (see the EPP system of reference).

In most cases, these actions include several occupational categories. Therefore, it is useful to involve all agents involved in the issue.

The self-assessment team defines the method, the sample size, collects data, analyzes and communicates results, recommends and monitors actions for improvement.

8.2 Self-Assessment Implementation

Self-assessment is performed by the involved teams over an average period of six months that would be adjusted according to the organization's size. During this period, the self-assessment teams meet regularly. A record of these meetings is kept (attendance sheets).

Experience has shown that the frequency of the meetings vary between once a week for an hour or two, to once a month for half a day.
In all cases, it is necessary to meet the key steps during the self-assessment. These include:

- Training;
- Discussion;
- Agreement on the principle of compliance and improvement opportunities;
- Compilation of compliance evidence;
- Identification of available support materials;
- Ratings according to the assessment scale.

8. 2. 1. Training

Before starting the self-assessment work, members should know:

- The objectives and conduct of the accreditation process;
- The objectives of self-assessment;
- Their missions in the context of self-assessment;
- The structure and overall content of the Accreditation Manual, and not only the part related to their own team, in order to have a good understanding of the requirements in the various activity sectors.

8. 2. 2. Discussion

Discussions and debates within the self-assessment teams are at the heart of the added value of the overall accreditation process. Through the encouragement of open discussions, teams must answer key questions such as:

- What activities do we achieve in relation to each criterion?
- What do we do exactly?
- What could we improve?
- Are we already doing something about it?
- What should we bring as evidence to validate what we do?
- Who else could we seek to obtain a clearer idea about our performance, staff, partners, clients?

For each reference, the criteria are specific elements to help define what types of evidence are required to verify compliance. These criteria, as well as examples and illustrations

presented in the guidelines associated with references, are a starting point for the teams during their discussions.

8. 2. 3. Agreement on the principle of compliance and improvement opportunities

During discussions, the team must try to identify to what extent the organization's activities comply with the requirements of the manual. If they do not comply, the team must identify what type of action should be taken to achieve compliance. It is necessary that each team agree on these points and that its conclusions be documented.

8. 2. 4. Compilation of compliance evidence

Following the assessment conducted by the teams on the degree of compliance in respect of each criterion of the Accreditation Manual, it is necessary to identify what evidence may be provided to substantiate these findings. The evidence will be reviewed during the accreditation visit to allow auditors to validate the findings of the self-assessment teams. By identifying evidence of compliance, the self-assessment team should examine what can be provided in connection with the structures, processes and outcomes. In case of identification of an opportunity for improvement, evidence of progression such as a plan to improve quality must be highlighted.

8. 2. 5. Self-assessment and evaluation of professional practices

In the new version of the Lebanese accreditation referential system, many criteria that are included in some systems of reference are in connection with the evaluation of professional practices, whether in organizational policy, care environment, key areas of medical care, or patient safety.

In order to ensure a sufficient degree of commitment at the various stages of the evaluation of professional practices, a minimum number of projects is required for each of these criteria. This number varies depending on the size of the organization and the number of supports, according to the following table:

<table>
<tr><td></td><td>From 1 to 50 beds of full or day hospitalization</td><td>From 51 to 150 beds of full or day hospitalization</td><td>More than 150 beds of full or day hospitalization</td></tr>
<tr><td>EP 4</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>EP5</td><td rowspan="2">1 (elective)</td><td>1</td><td>2</td></tr>
<tr><td>EP6</td><td>1</td><td>2</td></tr>
<tr><td>EP7</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>TOTAL</td><td>3</td><td>6</td><td>10</td></tr>
</table>

As regards specialized organizations, EPP often focus on the clinical specialty of the organization.

8.3 Self-Assessment Report

The Accreditation Manual comprises chapters including references, divided into criteria. Thus, the chapter "Anesthetics (NA)" includes 13 references. The reference represents the basis of self-assessment.

8. 3. 1. Input grids

Input grids are available on the website of the Ministry of Public Health of Lebanon to allow the organization's professionals to shape the self-assessment report (Appendix II presents the self-assessment grid of the QS chapter).

The self-assessment grid proposes to list the "elements of proof" that will allow the organization to provide the necessary factual evidence to prove the objectivity of the results.

As regards the EPP, the number of projects that are subject to self-assessment grids is limited to the number of required projects.

Objectivity and fairness of the results represent a criterion of satisfaction to the procedure. This implies that all answers and prospective comments are based on validated facts.

8. 3. 2. Rating of references (excluding EPP)

All references are subject to a rating performed by the members of the self-assessment group.

All criteria must be completed according to their degree of implementation and control in the organization with three possible answers:

- Yes, totally
- No, not at all
- Partially.

A health organization that is not affected by a criterion is then identified with "not applicable" in the self-assessment grid.

Professionals must also comment on each criterion in an objective way in order to enable auditors to understand the exact situation in relation to the system of reference.

The rating depends on the answers related to each criterion and must be established according to the following generic scale:

- A: the organization meets fully and continuously all the criteria constituting the reference
- B: the organization meets generally or most of the time the criteria constituting the reference
- C: the organization meets only partially or rarely the criteria constituting the reference
- D: the organization does not meet at all and in no way the criteria constituting the reference
- NA: not applicable reference

This rating allows:

- Teams to measure the achieved quality level;
- Auditors to prepare their visit plan;
- To promote exchanges between professionals of the organization during the self-assessment and with the auditors during the visit.

8. 3. 3. EPP reference rating

Regarding the referential system of the evaluation of professional practices (EPP), the rating is not performed by criterion but by project or action presented according to the following rules:

A rating: EPP action reaching the development and / or the implementation of an action plan for improvement

B rating: action reaching a less advanced stage (process analysis, diagnosis in progress)

C rating: identified but not initiated action

D rating: unidentified action

8. 3. 4. Summary of the reference

The summary helps value the positive aspects related to the reference and identify improvement actions.

It shall not exceed five lines.

- **Positive aspects**: aspects very well achieved by the organization.
- **Improvement actions**: malfunctions, failures, non-conformances and problems are not subject to sanctions but are opportunities for improvement that should be highlighted.

The purpose of the assessment is to identify areas for improvement, as well as to establish priorities and a timetable for implementation.

8. 3. 5. Validation of the self-assessment report

At the end of the self-assessment process, the organization must provide the approved body identified for accreditation audit with the self-assessment report, validated by the Director.

This report includes the following elements for each chapter of the Accreditation Manual:

- Composition of the self-assessment team;
- Summary of the self-assessment process:
    - Highlights
    - Opportunities for improvement
    - Improvement priorities identified in a plan of quality improvement
    - Conclusions of the self-assessment process and the ratings assigned to each criterion
    - Signature of the self-assessment team leader

IX. ACCREDITATION VISIT

9. 1. Objectives of the Visit

The visit aims to support and make more effective the policy of continuous quality improvement of health organizations. It is in no way an external control.

The visit, one of which objectives is to test the ability of professionals to conduct a self-assessment, focuses on the overall activities of the health organization within the scope of the accreditation process.

It is based on a series of steps to help auditors measure the quality level achieved in all areas covered by the accreditation process and appreciate the developed dynamic quality. It builds on the results of the self-assessment performed by the organization.

Through the participation of all activity sectors and occupational categories, self-assessment helps analyze thoroughly and comprehensively the organization's activity. The first role of the auditors is to assess the self-assessment process and the adopted methodology:

- Has it affected all sectors of activity?
- Has it really involved all actors?
- Has it been conducted in a multidisciplinary way?
- Have the various occupational categories participated well?
- Have the answers been sufficiently comprehensive, objective, documented?

Through the results of the self-assessment, the organization has to prove the satisfaction to a given chapter or criteria. The auditing team will try to cross information in order to validate the detailed findings made during the self-assessment.

The self-assessment results provide the auditors with a thorough overview of the activities of the organization. The quality of the visit depends mainly on the procedures of achievement and the objective content of the self-assessment.

In other words, the visit allows auditors to evaluate:

- The organization's policy and the commitment of organizational leaders;
- The impact of the organization's internal management in terms of quality;
- Analysis tools and practices implemented for quality and safety;
- Assessment of results and achieved improvements.

The visit encompasses the following steps:

- Preparation with the approved body selected by the organization;
- Transmission of the self-assessment report to the auditors before the visit;
- A meeting at the beginning of the visit to review the progress achieved regarding the findings of the previous accreditation procedure with the steering committee;
- Visit of the various activity sectors of the health organization following a patient-related or thematic process to better assess the satisfaction against the criteria and the achieved level of quality. In a second step auditors will meet with the self-assessment groups to discuss the discrepancies between the self-assessment results and the newly noted findings;
- Assessment of the medical service rendered to the patient through the evaluation of professional practices (EPP) and patient safety. This will lead auditors to achieve patient pathways by type of care. During these visits, the auditors also observe the work organization and the interfaces between the clinical activity sectors and the sectors in charge of the support activities;
- Visits of medical-technical, logistical and technical facilities most likely managed by external providers, in order to apprehend the reality of interfaces with the organization's activity sectors in those areas.

It is noteworthy that the auditors do not meet all the professionals of the organization and do not visit all activity sectors. It is therefore the responsibility of the organization to widely communicate the issue beforehand with all professionals in order to involve everyone through the representativeness of the different groups.

9. 2. Preparatory Stages of the Visit

9. 2. 1. Planning of the visit

No later than two months before the visit and according to the expected schedule with the Ministry of Public Health, the organization shall develop, in consultation with the approved body, a proposed program of the visit taking into account its organizational constraints, the duration of the visit, and the expected number of auditors for the visit. This planning takes

into account such factors as varied as the number and the duration of thematic processes, the optimal duration of each meeting or interview, the time needed to review the material, the moments of synthesis or the logistics of the auditors, etc.

The approved body may appoint a project manager responsible for monitoring the visit progression and must appoint the coordinator auditor of the visit one month before the visit.

The coordinator contributes to the adjustment of the scheduling and logistics of the visit.

The visit durations vary between one and five days, depending on the size and activity of the organization. The number of auditors ranges from 2 to 6.

9. 2. 2. Preparation of documentation

Alongside this period of self-assessment, the organization collects and classifies documents to make them available to the auditors on the site, and index them by chapter or by reference. Beside the predefined grid, the self-assessment "elements of proof" complement the observations made during the processes and meetings.

Documentation should be easy to navigate and must be on paper. It is desirable that the person who would have handled the material remains available for the duration of the visit in order to help auditors at their request to easily find a document.

In some cases the documentation can be accessed by computer.

If an organization has already implemented a relevant document management, it is not necessary to revisit this classification; however it is essential to provide a clear indexing according to references and criteria.

9. 3. The Visit Process

The main steps of the visit are:

- Initial meeting;
- Meeting with the steering committee;
- General inspection of the site;
- Analysis of documents on site,
- Patient pathways;
- Transversal processes;
- Meetings with self-assessment groups;
- Organizational meetings (meetings or individual interviews);
- Night visit;
- Daily record with the organization;
- Synthesis time between auditors;
- Preparation of the debriefing session and development of the auditors' report;
- Debriefing session.

9. 3. 1. Initial meeting

The initial meeting allows the organization's managers (management team, medical director) and members of the audit team to meet and introduce:

- The organization;
- The missions of the organization, its context;
- The quality policy...;
- The objectives of the visit.

Furthermore, the initial meeting helps identify the individuals involved in the daily record and confirms the schedule of the visit.

9. 3. 2. Meeting with the steering committee's members

The meeting with the members of the steering committee aims to:

- Introduce the members of the steering committee;
- Present the history of the quality process and the link between the accreditation visits (findings of previous accreditation report, analysis of the situation in light of these findings, planned areas of improvement, initiated or completed actions, evaluation of tracking procedures...).

In small size organizations, the initial meeting may be jointed to the meeting with the steering committee.

9. 3. 3. Site visit

The site visit allows the auditors to understand the following:

- The circuit of the reception and care of patients;
- The medical-technological circuit;
- The logistical circuit;
- The technical circuit.

9. 3. 4. Analysis of documents on site

On the basis of the self-assessment process, the analysis of the documents on site allows the auditors to:

- Obtain information on additional data labelled under "documents of proof" consultation;
- Search for objective evidence in support of information available in the self-assessment report.

9. 3. 5. Patient track visits

The monitoring of patient pathways following the different areas of specialty (medicine, surgery, paediatrics ...) allows auditors to:

- Meet professionals working there;
- Have individual interviews (to consider as needed);
- Meet patients and/or members of their entourage;
- Review patient records.

The encounter with the patients and/or members of their entourage aims to assess the consistency with the answers provided by the professionals at the organization.

9. 3. 6. Transversal processes (drug circuit, logistical, technical and hotel functions, human resources, information system…)

This step allows the auditors to:

- Understand the organization of work;
- Meet professionals in their workplace;
- Evaluate the coordination, the interfaces and the organization of the care supporting processes.

9. 3. 7. Meetings with self-assessment groups

These meetings provide an opportunity to:

- Assess the multi-professional trait of self-assessment and the professionals' commitment to the process;
- Validate the observations made during the processes and clarify any discrepancies between the self-assessment and the findings during the processes;
- Highlight the ongoing improvement actions and evaluate the quality dynamics of the relevant theme.

9. 3. 8. Organizational meetings

These encounters, conducted in the context of meetings or in individual interviews, allow the auditors to evaluate:

- The involvement and coordination of policy makers in developing and monitoring policies of the hospital including assessment and continuous improvement of quality;
- The social climate of the health organization;
- The position assigned to users within the structure.

9. 3. 9. Night visit

This step helps:

- Assess the continuity and coordination of the patient care for associating the night staff to the process;
- Assess the involvement of the night staff in the operation of the organization and the continuous improvement of quality. The time of transmissions must be included in the night visit.

9. 3. 10. Daily record with the heads of the organization

This step is an opportunity for the auditors to:

- Inform the management and those responsible for the process progression during the day before (it is understood that if, during the visit, the auditors identify a serious and/or noteworthy event, they shall not wait to include it in this record but must inform immediately the heads of the organization);
- Validate certain information and obtain additional information;
- Review the timetable of the next day (timing schedule, request of additional meetings, etc.);
- Have a feedback from the heads of the organization about the progression of the ongoing visit.

9. 3. 11. Time for synthesis between auditors

The program must include daily times for synthesis between the auditors to enable them to:

- Ensure information consistency and exchange to facilitate subsequent meetings and visits and prepare the report and the debriefing session;
- Consult the documentation before the visits and meetings with the synthesis groups;
- Add any additional courses to the program.

9. 3. 12. Preparation of the debriefing

A time of consultation is essential to auditors to:
- Prepare the debriefing meeting;
- Consensually develop proposals of decisions;
- Prepare, wherever possible, a media presentation of the visit's findings (slideshow).

9. 3. 13. Debriefing meeting

The meeting, to which the staff is invited, aims to:
- Present the main findings of the auditors on the entire manual as well as the identified major areas for improvement;
- Explain the context of the visit along the process, and particularly specify the timing of subsequent stages until reaching the final decisions.

X. THE AUDIT REPORT

Following the audit conducted on site, the auditing team writes an audit report based on data contained in the self-assessment report prepared by the organization and the data collected during the visit, and intended to the organization and the Technical Committee of Hospital Accreditation.

10. 1. Structure of the Audit Report

The audit report reflects the level of quality achieved and the dynamics of quality initiated by the organization under the chapters and references of the Accreditation Manual.

It contains the following parts:
- Short presentation of the organization
- Part 1: Quality process and self-assessment
  - History and organization of the quality process
  - Tracking of the recommendations of the previous procedure
  - Methods of achieving self-assessment
- Part 2: Findings by chapter
- Part 3: Outstanding actions
- Part 4: Proposals of decisions

The audit report does not suggest a level of accreditation. This will be determined by the Technical Committee of Hospital Accreditation and validated by the National Committee of Hospital Accreditation based on the recommendations, but also on any comments and / or claims submitted by the organization (see 8.3).

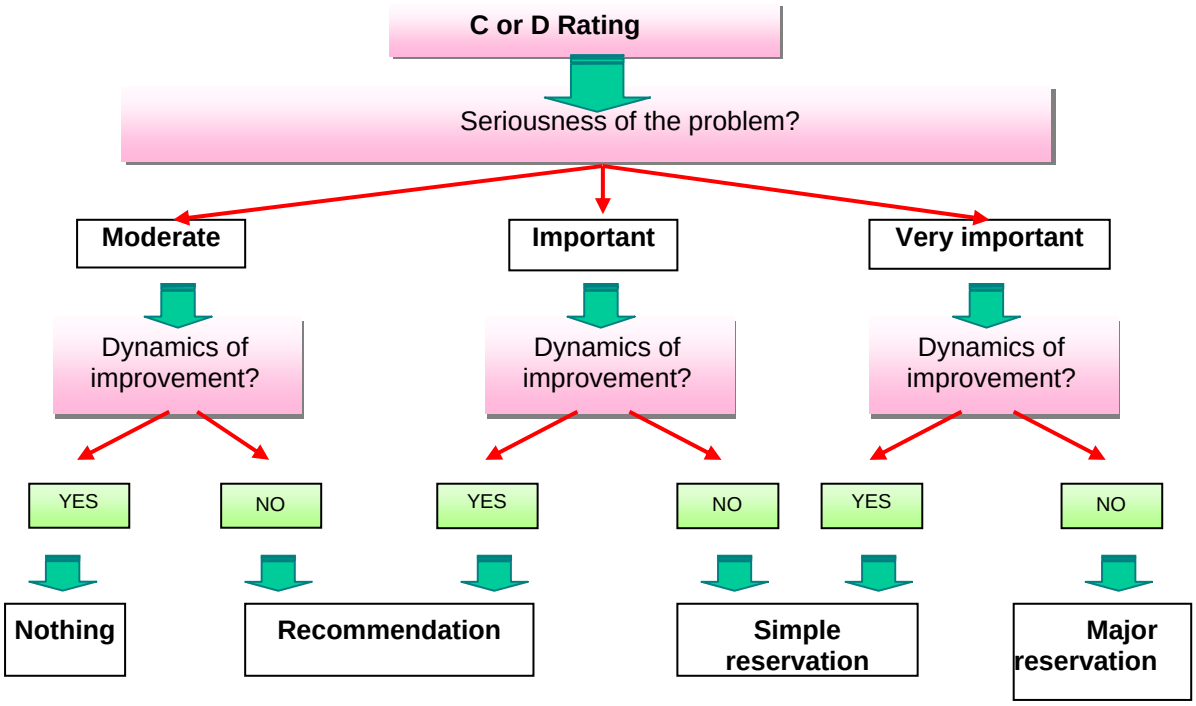
10. 2. Proposed Decisions

In the audit report, three types of decision can be proposed:
- **Recommendation**
- **Reservation**
- **Major reservation**

These proposals are made according to:

- References rating
- Recurrence of the problem since the previous procedures
- Frequency and severity of the problem
- Level of control shown by the organization
- Existence of an improvement dynamics against the identified problem

Only references rated C or D can lead to the establishment of a decision according to the following decision tree based on the auditors' assessment of the seriousness of the problem and the identification of a possible dynamics of improvement:



The type of decisions determines the final level of accreditation defined by the National Committee of Hospital Accreditation, after the approval of the Technical Committee of Hospital Accreditation (cf. 11. 3.).

10. 3. Circuit of the Audit Report

The approved body shall simultaneously transmit the audit report to:

- The Technical Committee of Hospital Accreditation by mail with acknowledgment of receipt;
- The organization by mail with acknowledgment of receipt.

The health care organization has one month from the date of receipt of the report to submit any comments or objections.

All comments shall be simple comments or any corrections to inaccuracies in the findings and proposals of the auditors. Thus, the organization shall not state the corrective actions put in place following the auditors' visit.

The objections are related to the decisions recommended by the auditors.

10. 3. 1. In the absence of comments or objections

If the health care organization accepts the report of the approved body, it sends a registered letter with acknowledgment to the Technical Committee of Hospital Accreditation informing it of its decision of not commenting.

10. 3. 2. In the presence of comments and objections

If, otherwise, the health care organization wishes to express its views on the contents of the report or challenge the proposed decisions, it has a period of one month after receiving the report to submit its opinion to the Technical Committee of Hospital Accreditation, using the form shown in Appendices III and IV.

The health care organization includes in the development of comments all names involved in the issue according to the manner it deems appropriate.

The document can contain comments on:

- The presentation of quality approach and the methodological assessment;
- The auditors' findings as regards the criteria of each chapter;
- The synthetic comments on the quality dynamics.

These comments should not be subject to a submission of an action plan in response to the auditors' suggestions.

These comments should not be accompanied by the production of attachments.

The organization must not amend under any circumstances the original drafting of the report of the approved body.

XI. THE ACCREDITATION REPORT

The accreditation report is the final step of the accreditation process. Its objectives are as follows:

- Provide health care organizations with a measure of their level of quality and safety and an assessment of the dynamics developed;
- Provide independent information on the quality and safety of care to insurers, third party payers and guardianship of the health care organizations;
- Inform the public about the state of quality and safety in health care organizations.

11. 1. Circuit of the Accreditation Report

Upon receipt of an acknowledgment of receipt of the report from the healthcare organization, the Technical Committee of Hospital Accreditation analyzes the various documents:

- Audit report
- Comments if any
- Objections if any

Based on these factors, the TCHA develops an accreditation report proposal, which it transmits to the National Committee of Hospital Accreditation for validation.

Upon agreement of the members of the NCHA, the Ministry of Public Health in Lebanon sends the accreditation report to the organization and puts it online for publication on its website.

11. 2. Contents of the Accreditation Report

The accreditation report includes the following parts:

- Short presentation of the organization
- Part 1: Quality process and self-assessment
  - History and organization of the quality process
  - Tracking of the recommendations of the previous procedure
  - Methods of achieving self-assessment
- Part 2: Findings by chapter
- Part 3: Outstanding actions
- Part 4: NCHA's decisions with follow up arrangements

11. 3. Levels of Accreditation

The NCHA's decision defines the level of accreditation based on the recommendations proposed by the TCHA according to the following table:

Type of decision	Level of accreditation
No decision	Level 1
At least one recommendation	Level 2
At least one reservation	Level 3
At least one major reservation	Level 4

According to what is provided in § IV. of this document, the term of accreditation is three years, starting from the date the organization follows the procedure and that no problems in terms of safety of goods and people has been highlighted during the accreditation visit by the approved body.

11. 4. Objections

In the presence of any objections regarding the accreditation report, the healthcare organization may call for a second deliberation from the NCHA within one month of receipt of the accreditation report and on the basis of a thesis which elements must be current at the date of the initial visit.

The initial decision may be maintained or modified based on the data provided by the organization.

XII. FOLLOW UP DECISIONS

The following table shows the different follow up methods used by a health care organization according to the accreditation level:

Initial level of accreditation	Follow up methods*
Level 1	None
Level 2	
Level 3	Report
Level 4	Audit

*The deadlines of the monitoring methods are defined by TCHA depending on the situation

According to the used method, the health care organization should:

- Send a monitoring report to the TCHA before the deadline defined in the report;
- Organize a follow-up audit with the same approved body and under the same terms as those set for the accreditation audit,

According to the data provided in the follow up report or the follow-up audit report, the TCHA determines whether the reservations have been lifted or not.

In accordance with § 11.3. and in case the health care organization has not implemented adequate corrective actions to lift the major reservation(s), a non-accreditation may be imposed thereby calling the health care organization to reinstate the accreditation process .

XIII. THE FINANCING OF THE PROCESS

Appendix IX of the document "Terms of approval and operation of the audit bodies for the accreditation of health organizations in Lebanon" specifies the means of financing the process to ensure efficiency and sustainability, as regards approved bodies as well as accreditation authorities.

Two financial flows are well planned:

- From the health organization to the approved body chosen for the accreditation visit
- From the approved body to the Ministry of Health to finance the Technical Committee of Hospital Accreditation.

This document was produced in January 2010.

I.S.B.N.

APPENDIX I

IDENTIFICATION AND PLANNING FORM

THE NATIONAL PROCEDURE FOR HOSPITAL ACCREDITATION
IDENTIFICATION AND PLANNING FORM

Topic 1: Identification of the process scope

Identification of the healthcare organization		Address of the healthcare organization	
Type of the organization	University Hospital Type U ☐ Tertiary Hospital Type T ☐	General Hospital Type G ☐ Intermediary Hospital Type I ☐	Private ☐ Public ☐

Name and surname of the legal representative :		Direct line:		E-mail:	
Name and surname of the director:		Direct line:		E-mail:	
Name, surname and title of the person in charge of the follow-up of the certification:		Direct line:		E-mail:	
Mailing address for sending the procedure documents:					
Telephone number (switchboard):		Fax number for sending the procedure documents:			
For private facilities, specify, if applicable, the business name of the group which the legal entity belongs to:					
Name of the main organization where the auditors will be received:					

ACTIVITES of the organization	Medicine	Surgery	Paediatrics	Gynaecology/ Obstetrics	Psychiatry	Dialysis	Blood Bank	Cardiac Catheterization
	☐	☐	☐	☐	☐	☐	☐	☐

Topic 2: Hospital activity and capacity of the organization involved in the process

DATE : / /	Full Hospitalization		Partial Hospitalization (day, night)		Outpatient treatment and care		
	Number of installed beds	Number of days	Number of places	Number of arrivals	Total number of sessions	Dialyses sessions	Number of dialyses stations (*)
Medicine							
Surgery							
Intensive Care Unit (ICU)							
Surgical ICU							
Gynaecology/obstetrics, neonatology and neonatal ICU							
SUB-TOTAL OF SHORT-TERM CARE							
General psychiatry							
Infant-juvenile psychiatry							
SUB-TOTAL OF PSYCHIATRY							
TOTAL							

(*) For the dialyses, kindly specify the number of dialysis stations and not the number of patients.

Topic 3: Quality process

Date of the last accreditation visit:

Summary description of the quality organization as established in the organization (involved persons, bodies, actions…):

APPENDIX II

SAMPLE OF SELF-ASSESSMENT GRID (QS CHAPTER)

Hospital:

SELF-ASSESSMENT GRID
QUALITY SYSTEM

Name and surname of the self-assessment team leader:

Names and surnames of the staff members who participated in the self-assessment process:

Reference 1			
Criteria	**Answers** *(YES, PARTLY, NO)*	**Comments** *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	**Reference rating**
1. 1. A current organisational chart of the staffing structure of the hospital exists			
1. 2. A current organisational chart of the Committee's structure exists			

Proposed actions for improvement	**REFERENCE SUMMARY**

Documents of proof:

Reference 2: Annual quality improvement including sections

Criteria	Answers *(YES, PARTLY, NO)*	Comments *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	Reference rating
2. 1. Management			
2. 2. Finance			
2. 3. Medical services			
2. 4. Nursing services			
2. 5. General services			
2. 6. Key performance/indicators that are specific, measurable, achievable, realistic and have timelines are a must			
2. 7. Evidence of continual monitoring of the plan is available			

Proposed actions for improvement	REFERENCE SUMMARY

Documents of proof:

Reference 3 : Multi-disciplinary quality improvement committee			
Criteria	**Answers** *(YES, PARTLY, NO)*	**Comments** *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	**Reference rating**
3. 1. Terms of reference			
3. 2. List of members			
3. 3. Minutes of all meetings			
3. 4. The documented monitoring of the quality improvement plan is conducted at least quarterly			

	REFERENCE SUMMARY
Proposed actions for improvement	

Documents of proof:

Reference 4			
Criteria	**Answers** *(YES, PARTLY, NO)*	**Comments** *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	**Reference rating**
4. 1. An annual report is presented to the Management of the hospital regarding the quality improvement plan			

Proposed actions for improvement	**REFERENCE SUMMARY**

Documents of proof:

Reference 5			
Criteria	**Answers** *(YES, PARTLY, NO)*	**Comments** *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	**Reference rating**
5. 1. A staff member is designated as the quality improvement coordinator (however named) with specific time allocated to the role as reflected in the relative job description			

	REFERENCE SUMMARY
Proposed actions for improvement	

Documents of proof:

Reference 6

Criteria	Answers *(YES, PARTLY, NO)*	Comments *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	Reference rating
6. 1. Each department conducts an annual assessment of the continuing staff education requirements and forwards the report to either the education department (if applicable) or to the quality coordinator			
6. 2. Copies of each department's education program are held by the quality improvement committee			

	REFERENCE SUMMARY
Proposed actions for improvement	

Documents of proof:

Reference 7: Documented policy and procedure for complaints

Criteria	Answers *(YES, PARTLY, NO)*	Comments *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	Reference rating
7. 1. Patients			
7. 2. Staff			
7. 3. Visitors / Others			
7. 4. Investigation and resulting actions from complaints are documented			

	REFERENCE SUMMARY
Proposed actions for improvement	

Documents of proof:

Reference 8

Criteria	Answers *(YES, PARTLY, NO)*	Comments *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	Reference rating
8. 1. A system exists for determining patient and staff satisfaction			
8. 2. Analysis is conducted regarding patient and staff satisfaction			
8. 3. Documented planned intervention to address any deficits identified			
8. 4. Documented evidence is required to demonstrate that the actions have taken place and results have been re-audited			

Proposed actions for improvement	**REFERENCE SUMMARY**

Documents of proof:

Reference 9			
Criteria	**Answers** *(YES, PARTLY, NO)*	**Comments** *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	**Reference rating**
9. 1. An improvement log process is operational			
9. 2. The improvement log(s) show evidence of the quality feedback loop			

Proposed actions for improvement	**REFERENCE SUMMARY**

Documents of proof:

Reference 10			
Criteria	**Answers** *(YES, PARTLY, NO)*	**Comments** *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	**Reference rating**
10. 1. There is a suggestion box for staff and patients			

Proposed actions for improvement	**REFERENCE SUMMARY**

Documents of proof:

Reference 11			
Criteria	**Answers** *(YES, PARTLY, NO)*	**Comments** *(Note the relevant information related to the reference criteria, stating the actions undertaken or underway or planned and any differences between the activity sectors)*	**Reference rating**
11. 1. Documented rights and responsibilities of the patients are available to all patients and relatives			
Proposed actions for improvement	**REFERENCE SUMMARY**		

Documents of proof:

SUMMARY OF SELF-ASSESSMENT - « QUALITY SYSTEM » CHAPTER

Strengths:

Proposed actions:

Actions highlighted by the organization		
Title of the action	**Objective**	**Results**

APPENDIX III

SUPPORTS FOR THE FORMULATION OF COMMENTS ON THE AUDIT REPORT

NAME OF THE ORGANIZATION: Date of dispatch:

COMMENTS ON THE AUDITORS' REPORT

Comments can be about the presentation of the organization, Part 1 "Quality Process and Accreditation" and Part 2 "Comments by Chapter".

Related **Elements (col.1)**	**Nature of the organization's comments** (motivation behind the requested change and expected amendments on the report's elements) (Col. 2)	**Analysis of the comments by the audit officer** (Col. 3)	**Comments of the High Authority of Health (HAS), if any** (Col.4)
PRESENTATION OF THE ORGANIZATION			
PART 1: Quality Process and Accreditation			
		Accept ❑ or refuse ❑ If refused, argument:	
		Accept ❑ or refuse ❑ If refused, argument:	
		Accept ❑ or refuse ❑ If refused, argument:	

NAME OF THE ORGANIZATION: Date of dispatch:

Related **References (col.1)**	**Nature of the organization's comments** (motivation behind the requested change and expected amendments on the report's elements) (Col. 2)	**Analysis of the comments by the audit officer** (Col. 3)	**Comments of the High Authority of Health (HAS), if any** (Col.4)
PART 2 – Comments by Chapter			
		Accept ❑ or refuse ❑ If refused, argument:	
		Accept ❑ or refuse ❑ If refused, argument:	

APPENDIX IV

SUPPORTS FOR THE FORMULATION OF OBJECTIONS TO THE AUDIT REPORT

The healthcare organization can provide the Technical Committee of Hospital Accreditation with any objections to the audit report.

The organization can challenge:

- The decision
- The criteria related to the decision
- The care related to the decision
- The EPP actions related to the decision.

Accordingly, the organization should complete the following table, the assigned part in particular, mentioning:

- The name and the file number of the organization
- The relevant decision by clarifying its wording and the attached references
- The arguments in support of the objection.

<u>This table should be duplicated as many times as there are decisions.</u>

This document, once completed, should be forwarded to the Technical Committee of Hospital Accreditation for analysis.

TABLE FOR THE OBJECTIONS TO THE AUDIT REPORT DECISIONS

Name of the organization: **File n°**:

Part to be filled by the organization

Decision :
Criterion(a) involved and wording of references:

Arguments of the organization

Reference Number	Arguments supporting the objections

Aspiration of the organization regarding the decision:

Analysis of the Technical Committee of Hospital Accreditation

Part to be filled by the Technical Committee of Hospital Accreditation

Admissibility** : Yes ☐ No ☐

***Check the appropriate box*

①	②

Proposal of decision after objection *Part to be filled by the Technical Committee of Hospital Accreditation*

One table per decision: This table should be duplicated as many times as there are decisions to be challenged.