KINGDOM OF SAUDI ARABIA

Ministry Of Health

General directorate of Health Affairs AL-Baha

Mayyara General Medical Complex

المملكة العربية السعودية
وزارة الصحة
المديرية العامة للشئون الصحية بمنطقة الباحة
مجمع ميارا الطبي العام

☐ADMINISTRATE POLICY & PROCEDURE (APP)	☐ INSTITUTIONAL POLICY & PROCEDURE (IPP) ☐ INTERDEPARTMENTAL ☐ INTERNAL

TITLE		POLICY NUMBER/V#
Performance Indicator		MMC – ADM – 06 (01)
INITIATED DATE	**EFFECTIVE DATE**	**REVISED DATE**
02/08/2025	01/09/2025	01/08/2028
REPLACES NUMBER		**NO. OF PAGES**
N/A		04

APPLIES TO	RESPONSIBILITY
All Admin workers	Quality and patient safety

1. PURPOSE:

1.1 To provide the center's staff with guidelines on Performance Improvement Indicators' selection, development, implementation and monitoring.

2. DEFINITION:

2.1 Indicator: An observation expected to measure a certain aspect of performance. It is a quantitative measure that can be used to assess and improve the performance of important administration, clinical and supportive functions that affect patient outcomes.

2.2 Performance Indicator: A measurement tool used as a guide to monitor, evaluate, and improve the quality of patient care and service.

2.3 KPI: Measures of performance that are central to success.

2.4 Indicator Types: Structure, Process and Outcome.

2.5 Structure indicators may include, but not be limited to the following: availability of essential supplies and equipment, availability of medical records, availability of emergency medications, surgical volume, and staff ratios.

2.6 Process indicators may include, but not be limited to the following: waiting time, documentation in medical records, site marking, and time out processes.

2.7 Outcome indicators may include, but not be limited to the following: Patient and staff satisfaction, patient's complaints, health-care-associated infections, medication errors, sentinel events and various adverse events.

2.8 Target / Threshold: the minimum acceptable value which is necessary to satisfy the needs according to international standards.

2.9 Center leaders: Clinic Director, Clinic manager, Chief Medical Officer, Nurse manager.

2.10 The center Prioritization Criteria:

2.10.1 High risk
2.10.2 High volume.
2.10.3 Problem prone.
2.10.4 Impact on patient satisfaction
2.10.5 Cost reduction
2.10.6 Impact on accreditation status
2.10.7 Impact on patient safety
2.10.8 Impact on staff satisfaction

3. POLICY:

3.1 The center leaders prioritize and select a set of indicators that focus on the structure, process, and outcome of the services provided within the center.

3.2 Key performance indicators shall be utilized to measure the performance of the services provided.

3.3 All concerned staff shall be notified of the performance findings, and the information provided is utilized to further improve the clinical and managerial areas (structure, process, and outcome).

3.4 A quarterly report shall be presented to the governance with improvement action plans if required.

4. PROCEDURE:

4.1 Requester identifies the need for a Performance Improvement Indicator (PII).

4.2 The selection process is based on the center's important processes and priorities.

4.3 Requester will fill the Performance Indicator Development Template and submit it to the clinic manager.

4.4 The clinic manager will receive and review the submitted Performance Indicator Development Template against set criteria for completion:

4.4.1 The requested indicator meets strategic planning requirements, departmental scope of service, accreditation standards.

4.4.2 The requested indicator meets the center prioritization criteria.
4.4.3 A similar PI does not already exist.
4.4.4 The PI Development Form is filled completely and correctly.

4.5 If the above set criteria are not met, the clinic manager will communicate this to the requestor with reasons of rejection and will provide the requester with a training session on the proper way of PIID form completion.

4.6 Each indicator has an operational definition, data collection method, frequency for collection, analysis by the clinic manager, mathematical expression such as a ratio, with a defined numerator and denominator or a percentage and a desirable target.

4.6.1 If the above set criteria are met, the clinic manager will submit the PIID Form to the executive Committee for review and approval.

4.6.2 In case the request is rejected, the QIPS Data Analyst will return the form back to the requester, with the reasons for rejection.

4.7 The clinic manager will then inform the requester and send him/her a copy of the approved form.

4.8 The data will be collected by the identified entity, as per the related PIID Form.

4.9 If applicable (a new indicator, sudden change in the performance,…), the clinic manager will identify the needs for data validation (recollection of data), the data will be validated by a second entity not involved by the original data collection.

4.10 The indicators are compared internally by historical trends and externally by benchmarking to other similar centers when available.

4.11 A summary report, based on data analysis, is discussed by the identified entity with the related teams to make an Action plan with recommendations.

4.12 The identified entity will forward a status report, along with the recommendations and action plans, to the clinic manager.

4.13 The performance monitoring results are discussed with staff, utilized in their evaluation, and reported quarterly to the governance together with action plans taken for improvement.

5. RESOURCES:

5.1 N/A

6. CROSS REFERENCE:

6.1 N/A

7. REFERENCES:

7.1 CBAHI National Standards for Ambulatory Care Centers, Effective Jan,2020.
7.2 The Joint Commission International (JCI), 7th Edition, Effective Jan 2021.

8. FORMS & ATTACHMENT:

8.1 Performance Indicator development form.

9. Approved

APPROVALS & REVIEWS::			
Prepared By	**Title**	**Date**	**Signature**
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