☐ADMINISTRATE POLICY & PROCEDURE (APP)	☐ INSTITUTIONAL POLICY & PROCEDURE (IPP) ☐ INTERDEPARTMENTAL ☐ INTERNAL	
TITLE		**POLICY NUMBER/V#**
Quality improvement and Patient Safety Program		MMC – ADM – 13 (01)
INITIATED DATE	**EFFECTIVE DATE**	**REVISED DATE**
02/08/2025	**01/09/2025**	**01/08/2028**
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N/A		**14**
APPLIES TO	**RESPONSIBILITY**	
All Admin workers	**Quality and patient safety**	

1. PURPOSE

1.1 To ensure the quality of the center's services and its continuous improvement.

1.2 To provide guidelines, for establishing, implementing and monitoring mechanisms to ensure systematic, coordinated and continuous Quality/Performance Improvement that leads to engaging the center's staff in Quality, Risk Management and Patient Safety activities, reducing risk exposures and improving patient's safety and better outcomes.

1.3 To provide a structured framework for monitoring and improving performance as well as supporting innovation.

2. DEFINITION

2.1 Quality: Quality refers to the extent to which processes, products, and services are free from constraints, waste, variation and defects with stability around optimum target, on a consistent basis even under stressful condition, to achieve customer's trust and loyalty.

2.2 Quality Improvement Team: Individuals (cross-department functions/services) knowledgeable about a particular aspect of care or service and commissioned to improve a process that has been identified as requiring attention.

2.3 Quality Control: A management process in which performance is measured against expectations and corrective actions are taken.

2.4 Process Improvement: Mechanisms utilized to make improvements to a process through the use of continuous quality improvement methods.
2.5 PDCA: scientific method utilized to improve processes. Acronym components: Plan the improvement. Do the improvement. Check the results. Act to improve the process and hold gains. Also known as the Shewhart cycle or learning cycle of change.
2.6 Indicators: 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.

3. VISION

3.1 To be the leader and reference in Quality, Risk Management and Patient Safety in the region.

4. VALUES

4.1 Patient-Centered Organization: The organization's primary focus is the care of individual and their families with the goal of maintaining and promoting health, alleviating disability and preventing illness. The organization's policies and procedures and employees emphasize and continually demonstrate respect for the individual patient, their values, and their privacy. These policies and procedures reinforce the patient's right to be provided with information, in an understandable language and terms, that relate to their health care and to participate in decisions affecting their health care.

4.2 Integrity: We are honest and forthright in all our dealings with our customers, patients, vendors, suppliers, and with each other. We comply with the laws and regulations governing our business and professions because it is the right thing to do.

4.3 Accountability: As an institution and as individuals, we accept full responsibility for our performance and acknowledge our accountability for the ultimate outcome of all that we do. We strive for continuous improvement, believing that competence, reliability and rigorous adherence to process discipline are the keys to excellence.

4.4 Teamwork: We believe in teamwork and the limitless possibilities of collaborative energy. We achieve excellence by putting collective goals ahead of personal interests. We support and encourage open communication and meaningful cooperation among colleagues from varying backgrounds and disciplines. We respect individual differences and we value diversity.

4.5 Leadership: We strive to be the best at what we do both as an institution, and as individuals. We embrace the qualities of personal leadership, courage, competence, confidence and a passion for surpassing expectations.

4.6 Just Culture Environment: the QRMPS plan will adopt the Just Culture Model by creating an open, fair, and just culture, creating a learning culture, designing safe systems and managing behavioral choices, it's about reinforcing the roles of Risk, Quality and Safety

5. GOALS and OBJECTIVES

5.1 Goal – 1: Establishment of Quality Improvement culture throughout the center& promote an organization wide commitment to maintain high Quality of Patient care and services and leadership involvement in improving quality.

Objectives:

- Conducting regular quality awareness lectures about the basic concepts of quality for all staff.
- Conducting a quality rounds to all departments in which the quality personnel try to disseminate the culture of quality.
- Communicating all quality activities to the leaders for revision and approval during the Quality Committee and approving all cross functional teams and committee's term of reference from the leadership.

5.2 Goal – 2: Ensures continuous monitoring and improvement of clinical and non-clinical services, by increasing the probability of desired patient outcomes, including patient and staff satisfaction.

Objectives:

- Establish and prioritize performance indicators in collaboration with all clinical, managerial, and support areas.
- Involving all departments in the performance improvement projects.
- Ensure the coordination and integration of all performance improvement activities.

5.3 Goal – 3: Meeting the International Patient Safety goals.

Objectives:

- Improving the accuracy of patient identification
- Improving the effectiveness of communication among care givers
- Improving safety in using medication
- Eliminating wrong-site, wrong-patient, wrong procedure surgery
- Reducing the risk of health care-associated infections
- Reducing the risk of patient's harm resulting from falls

6. SCOPE

The leaders of the center develop the Quality, Patient Safety and Risk Management program collaboratively.

6.1 Quality Improvement:

The Quality Improvement program covers processes of care involving high risk, high volume, Problem-prone, high cost, and impact on patient satisfaction, patient safety, staff satisfaction and accreditation status.

6.1.1 Performance Improvement:

6.1.1.2 The program utilizes key performance indicators, and patient and staff surveys to measure performance and improve clinical and managerial areas.

6.1.1.3 The Quality Improvement program is monitoring the performance through regular data collection (KPI) and analysis.

6.1.1.4 The performance monitoring is based on valid data that reflect the actual performance.

6.1.1.5 The clinic leaders define and implement a set of performance indicators that focus on important managerial and clinical areas.

6.1.1.6 For each indicator, there is a clear definition, sample size, data collection method, frequency, analysis, numerator and denominator.

6.1.1.7 Indicators represent key care and service structures, processes and outcomes based on the Mission and scope of services.

6.1.1.8 Data are collected and aggregated on a quarterly basis from qualitative and quantitative sources.

6.1.1.9 Data analysis with areas of improvement is communicated to the departmental directors to have the corrective actions.

6.1.1.10 The information generated is readily accessible on a timely basis to those responsible for and/or involved in the delivery of the services, and is utilized for making improvements and supporting the leaders' decision making.

6.1.1.11 Quality improvement projects are developed at least once per year and when needed.

6.1.1.12 Data are coordinated with other performance monitoring activities such as patient safety and risk management.

6.1.2. Policies and Procedures:

6.1.2.1 Policy and procedure tracking sheet that serves as a Database for development and monitoring of the center Policies and Procedures.

6.1.2.2 All policies are developed and processed as per Control policy. the Document

6.1.3 Accreditation coordination and monitoring.

6.1.3.1 All the center's staff work collaboratively to get accredited or to maintain the accreditation as per the center's strategic plan.

6.1.3.2 Development of an integrated database containing the standards of the accreditations bodies.

6.1.3.3 Working with accreditation team to achieve the requirements.

6.1.3.4 The executive committee is overviewing and monitoring the implementation and compliance of standards.

6.1.4 Quality of care reviews (Best practices and Medical Record Review).

6.1.4.1 Clinical Practice Guidelines:

6.1.4.1.1 To identify the top CPGs in the center.

6.1.4.1.2 To develop a clinical Protocol/Pathways to be integrated in HIS

6.1.4.1.3 To conduct several education sessions to the concerned staff.

6.1.4.1.4 To develop a mechanism of monitoring the selected Clinical guidelines and to ensure compliance.

6.1.4.2 Medical Record Review:

6.1.4.2.1 The hospital has a medical committee, with members representing the medical staff, the nursing staff and other professionals privileged to write on the medical records.

6.1.4.2.2 The committee oversees and monitors the documentation in medical record for quality, completeness, and timeliness.

6.1.4.2.3 The committee regularly reviews a sample of 5% on a quarterly basis of the medical records of open and closed files based on specific criteria.

6.1.5 **Committees Management:**

6.1.5.1 Overseeing the center committees and monitoring the functions of the committees against their terms of references by having a quarterly report about the committee performance.

6.2 <u>Patient Safety:</u>

6.2.1 Patient safety program is an integrated part of the quality and the risk management plan which is oversighted by the QRMPS committee.

6.2.2 The aim of the patient safety program is to promote a "Just culture" and encourage reporting of adverse events and near misses.

6.2.3 The patient safety program is committed to comply with the International Patient safety Goals and other accrediting bodies.

6.2.4 The center leaders support the patient safety activities by providing the resources needed and assigning an annual budget for these activities.

6.2.5 Patient safety culture assessment is done annually and the data is analyzed and action plans are put in place accordingly.

6.2.6 The center leaders conduct regular leadership patient safety rounds in patient care services to encourage reporting of incidents/near misses and to identify potential risks and hazards.

6.2.7 Other activities are related to educating, training of staff on different patient safety aspects clinic wide and departmental level.

6.2.8 Initiation of performance improvement projects when needed.

6.2.9 Initiation of a patient safety dashboard that include the list of indicators affecting patient safety.

6.3 Risk Management:

6.3.1 The fundamental components of the risk management plan are the risk register and the risk domains in addition to educating the staff on their roles and responsibilities related to the activities of the risk management program.

6.3.2 The risk register refers to a dynamic living document which records details of all the risks identified for an organization, their grading in terms of probability of occurrence and their severity on the organization. The risk register shall be updated annually /as needed with the concerned entities.

6.3.3 The risk domains: every risk shall be categorized under the one of the following domains: Strategic/reputational, financial, operational/clinical, human, technological, legal/compliance.

6.3.4 The scope of the risk management program covers both clinical, managerial and financial risks and includes but not limited to the following activities:

6.3.4.1 Patient care-related risks: including Confidentiality and appropriate release of patient medical information, Protection of patients from abuse and neglect and from assault by other patients, visitors, or staff, securing appropriate informed patient consent to medical treatment, nondiscriminatory treatment of patients, regardless of race, religion, nationality, or payment status, protection of patient valuables from loss or damage, access to care concerns.

6.3.4.2 Medical staff-related: Medical staff activities that are crucial for the risk management function include medical staff credentialing, appointment, and privileging processes.

6.3.4.3 Employee-related: A main concern of the risk management program is maintaining a safe work environment for employees, reducing the risk of occupational illness and injury, and providing for the treatment and compensation of workers who suffer on-the job injuries and work-related illnesses, also protection of staff from abuse of patients and/or other senior staff.

6.3.4.4 Property-related: protection of the organization's assets from risk of loss due to malfunctioning by users or due to fires that might damage or destroy such property.

6.3.4.5 Visitors-related: Visitor's safety and wellbeing is of great importance to the center, that's why we ensure having an optimized environmental of care to serve this purpose.

6.3.4.6 The Risk Management Program is an integrated comprehensive dynamic program designed to oversee all aspects of risk.

6.3.4.7 The risk management cycle starts by:

6.3.4.7.1 Risk Identification: is the process whereby the risk management professional becomes aware of risks in the health care Environment; many information sources to identify potential risks:

6.3.4.7.2 Reactive Risk identification: through the reporting of incidents and variances, patients' morbidities, and clinical and financial claims constitute the program's essential reactive arm in addition to clinical review process, Patient complaints and satisfaction survey results, Environmental and tracer rounds, Survey results by external entities, Internal audit plan and reports.

6.3.4.7.3 Proactive Risk Identification: through development and implementation of at least one proactive risk management approach per year. The proactive approach should target improving practices that are high risk, problem prone, or high volume, that have a substantial financial impact, such as insurance rejections or that can markedly improve patients or staff satisfaction.

6.3.4.7.4 Risk Prioritization: The risk is prioritized, from one hand, according to the score resulting from the calculation of the probability and severity/harm of occurrence and from another hand based on the extreme severity (see attached risk matrix).

6.3.4.7.5 Risk Evaluation/Analysis: is the process of determining the potential severity of the loss associated with an identified risk and the probability that such a loss will occur. Together, those factors establish the seriousness of a risk and the selection of an appropriate risk treatment strategy.

6.3.4.7.6 Risk Control: with 2 main components risk prevention and risk reduction.

6.3.4.7.7 Risk prevention efforts are proactive ones which include staff education and policy and procedure review, implementation of effective control measures and conducting a FMEA for any expansion or renovation of specific area.

6.3.4.7.8 The risk reduction strategies aim mainly at limiting the potential consequences of a given risk thus focusing on reducing the severity of losses. These strategies include prompt incident investigation, written plans to support emergency management, conducting drills for the different codes.

6.3.4.7.9 Risk Monitoring: It's the final step in the risk management process; the purpose it to evaluate and monitor the effectiveness of the risk management program. This evaluation should be done biannually/ as needed through the following indicators: Number of open tasks out of total number of recommended actions. Number of performance improvement projects arisen from the risk management program Number of mitigated High risks out of total identified high risks.

6.3.4.7.10 The risk management program addresses patient safety issues and makes use of the information developed from investigation of the following:

a. All litigations involving the hospital and its staff.
b. Adverse incidents including near misses and sentinel events.
c. Patient complaints.
d. Data and reports related to patient safety issues.

e. Mortality and significant morbidity cases.

6.3.4.7.11 Information from the risk management program, including incidents, analysis, and improvement projects, is communicated to staff and the governing body at least quarterly.

6.3.4.7.12 The risk management activities are integrated and coordinated with the quality improvement and patient safety activities.

7. ORGANIZATION/AUTHORITY AND RESPONSIBILITY

All the center staff will participate in executing this plan starting from:

7.1 The Board of Director (BOD) who delegates to the CEO the authority and the accountability for the organizational support and maintenance of the QRMPS Plan. The Board of Directors:

7.1.1 Approve the QRMPS plan.

7.1.2 Provide the necessary support and resources including the budget to implement this plan.

7.1.3 Review and approve the annual report of achievements reported by the QRMPS Committee.

7.2 Executive Committee & Chief Executive Officer (CEO)/Clinic Director is responsible to:

7.2.1 Provide support for the proper functioning of the quality and risk management activities and safety efforts.

7.2.2 Designate and/or chair the Executive Committee to perform oversight of the program.

7.2.3 Charge the Executive Committee with ensuring that the relevant Quality, patient safety and risk management policies and procedures are implemented.

7.2.4 Allocate the proper budget and the necessary resources for QRMPS activities.

7.2.5 Approve the clinic wide policies and procedures.

7.2.6 Disseminate patient-related risk management information to the appropriate chairpersons of clinical departments and heads of departments and sections.

7.2.7 Ensure compliance with the applicable accreditation standards.

7.2.8 Provide feedback on trending and benchmarking analysis.

7.3 Medical Executive Committee & Chief Medical Officer (CMO) is responsible for:

7.3.1 Supervising all clinical activities of the medical staff, including determination of qualifications, recruitment, and assessment of the competence of performance at his discretion, may exercise this supervision by delegation to medical staff department directors and overseeing the continuous improvement of the Medical Department.

7.3.2 Required credentialing and privileging of the medical staff to ensure licensing and competency for patient safety.

7.3.3 Coordinating continuous reviews of patients' medical records with deficiencies being reported to appropriate staff for corrective action as appropriate.

7.4 Clinical and Non-Clinical Departments' Directors are responsible to:

7.4.1 Implement and support the QRMPS Plan in their departments.

7.4.2 Monitor the department's activities through quality indicators established in their department.

7.4.3 Design and monitor improvements that are either the result of cross-functional team decisions or of intra-departmental initiatives to improve performance.
7.4.4 Approve operational and process-oriented policies and procedures.
7.4.5 Coordinate and integrate services with other departments and services.
7.4.6 Provide orientation and training for all staff of the department or service appropriate to their responsibilities.
7.4.7 Disseminate relevant information to sections and units.
7.4.8 Identify educational needs regarding Quality and risk management and communicate those needs to the Executive Committee.
7.4.9 Participate in taskforce groups and sentinel event teams when requested.
7.4.10 Communicate projects to the QI Designees.

7.5 Clinic Manager/Supervisor:

7.5.1 Prepare and implement the QRMPS Plan.
7.5.2 Receives quality indicators reports and raw data to be analyzed on a monthly basis.
7.5.3 Implement a sequence of data analysis, trending, intervention, evaluation, corrective action, and prepare periodic (monthly, quarterly, and annually) aggregate analysis reports for improvement sustainability.
7.5.4 Maintain a proactive risk management program (Departmental/Unit Risk Registers) in compliance with the provisions of local rules and regulations.
7.5.5 Review, investigate, track and trend all serious adverse events.
7.5.6 Initiate root cause analysis process, whenever applicable
7.5.7 Initiate Failure Mode and Effect Analysis (FMEA), whenever applicable.
7.5.8 Coordinate the management of sentinel events and follow-up the implementation of the action plans.
7.5.9 Investigate near-miss occurrences and propose action plans for prevention of similar occurrences.
7.5.10 Ensure the safekeeping of records and associated documents related to risk management in a secure manner.
7.5.11 Review and update all the center rules and regulations regarding patient safety practices and ensure their implementation.
7.5.12 Ensure full and continuous compliance with the applicable accreditation standards.
7.5.13 Conduct staff education activities as part of the orientation program of new staff and to selected target groups as indicated by the findings.
7.5.14 Communicate with departments to address areas of improvements.

7.6 All Staff are responsible to:

7.6.1 Report unusual and /or undesirable patient, staff and environment related occurrences.
7.6.2 Provide professional insight to the quality taskforces when requested.

7.6.3 Implement/ comply with the recommended modifications in policies, procedures and practices.

7.6.4 Observe the relevant patient safety standards and goals.

8. TRAINING and EDUCATION PLAN

8.1 Training will be provided in various methodologies and to the different levels of the organization. Acquiring this knowledge will increase management's and staff's awareness of the center leadership's commitment to introduce a culture of quality and safety, and their understanding of quality improvement and patient safety. The training will also enable staff members to participate in quality improvement activities.

8.2 Board members/Clinic Director/CEO/CMO will be familiarized with the fundamental concepts of QI, Risk Management, Patient Safety and the accreditation process so they can exert knowledgeable oversight and support of the entire process.

8.3 During Employee orientation and on ongoing basis: Staff will receive education and training during their initial orientation process and on ongoing basis on quality concepts, Accreditation Process, and PI and methodologies including the need and method to report medical/healthcare errors.

8.4 Conferences and Workshops: Can be provided internally or externally (sponsoring staff)

8.5 Just in Time Training: Employees will be trained to participate in teams, when they are selected to be team members of a performance improvement project for example or any other activity.

8.6 Education of the medical staff and of nursing and other clinical and non-clinical managers will be extensive, including the basic concepts of quality improvement, statistical tools, and team dynamics, so they can act as leaders of quality improvement teams, whenever requested.

8.7 The clinic manager will organize education for all staff members so they are aware of reporting mechanisms about OVR or sentinel event and the awareness of the just culture.

8.8 Staff training and education activities are developed in collaboration in coordination with the Human Capital Department.

8.9 The staff education plan is monitored and evaluated periodically and necessary modifications are introduced as a result of QI/PI evaluation.

9. PERFORMANCE IMPROVEMENT

There are various data sources that reflect organizational performance. Based on these sources, Improvement Projects are initiated and monitored. These are:

9.1 Internal Data Sources:

9.1.1 Occurrence Variance Reports (OVR).

9.1.2 Sentinel Event Review; Root Cause Analysis (RCA).

9.1.3 Malpractice Cases.

9.1.4 Medical Records Review.

9.1.5 Departmental QI/PI Indicators.

9.1.6 Patient Complaints; Survey And /Or Interviews.
9.1.7 Staff Satisfaction Survey And /Or Interviews
9.1.8 Infection Control Surveillance.
9.1.9 Morbidity – Mortality Review.
9.1.10 Pharmacy and Therapeutics Committee Findings / Medication Utilization.
9.1.11 Internal and Audits/Surveys.
9.1.12 Hospital Committee Activities Reports.
9.1.13 Tracer / environmental and patient safety rounds.

9.2. External Data Sources:

9.2.1 Patient satisfaction and complaints surveys and/or interviews.
9.2.2 Benchmarking against external data sources.
9.2.3 External audits/surveys such as Ministry of Health (MOH).
9.2.4 Accreditation reports from external bodies such as CBAHI National Accreditation Program & JCI International Accreditation Program.

9.3 Prioritization Criteria:

9.3.1 The executive Committee will select, prioritize, and monitor a set of clinic-wide and department specific indicators. Organizational QI/PI priorities are assessed on a yearly basis.
9.3.2 Structuring of the QI/PI Task Force and establishing priorities for the organization QI/PI efforts as a whole are set by the Executive Committee based on the following factors:
9.3.2.1 Patient Safety.
9.3.2.2 High risk to patients.
9.3.2.3 High volume (e.g. the number of patients involved).
9.3.2.4 Problem-prone in the provision of care.
9.3.2.5 Cost effectiveness.
9.3.2.6 Newness of the service.
9.3.2.7 Results from the performance improvement process.
9.3.2.8 Effects on patient and family satisfaction.
9.3.2.9 Effects on staff satisfaction.
9.3.2.10 Patients and family rights.
9.3.2.11 Requirements of government law and regulation.
9.3.2.12 International Standards Requirements.

9.4 Performance Improvement Methodology:

Quality Improvement Tools:

The center selected FOCUS – PDCA and DMAIC methodology to be used in all its process improvement activities or /and when monitoring detects that a process may need a redesign, or when new processes are designed, such as the provision of new patient services.

9.4.1 FOCUS – PDCA:

The center implements at least one improvement project per year. Education and training, including a refresher in-service training in this method will be conducted.

FOCUS:

- F - Find an Opportunity for Improvement.
- O- Organize a Team.
- C - Clarify the Current Process.
- U - Understand the Problems/Variations in the Process.
- S - Select the Desired Outcome(s)

PDCA:

- P - Plan the Project, Assign Tasks.
- D - Do the Work That's Needed.
- C - Check the Results and Measure Changes.
- A - Act to Maintain the Changes.

9.4.2. Six Sigma: (DMAIC)

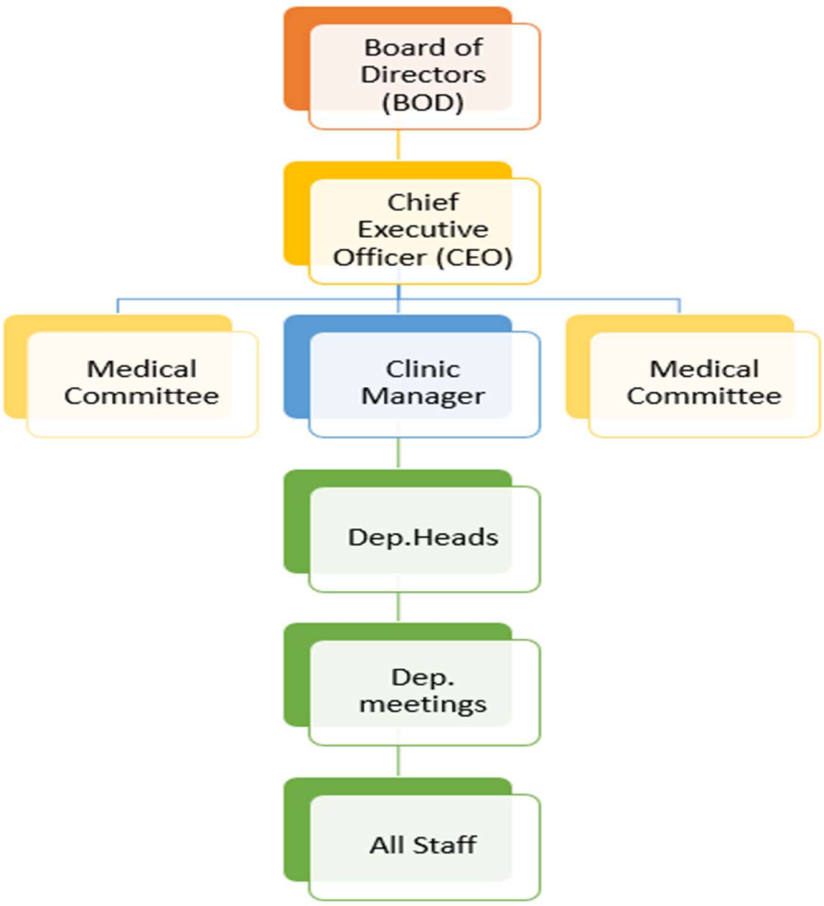
- D - Define goals of a process; define customers, their needs and expectations
- M - Measure significant data; measure performance of a process
- A - Analyze data and define cause of errors
- I - Improve the process by removing defects
- C - Control process; preventing form making errors.

9.4.3. Risk Management Tools:

- FMEA: Failure mode and effects analysis (FMEA) is a systematic approach used to examining a design prospectively for possible ways failure may occur. The ways failure may occur are then prioritized to create design improvements that will have the most benefit.
- HVA: Hazard vulnerability analysis (HVA) which is used for the identification of potential emergencies and the direct and indirect effects those emergencies may impact the center operations and demand for its services.

10. COMMUNICATION AND FLOW OF INFORMATION.

10.1 Flow of Information:



10.2 Communication Tools:

10.2.1 Face to Face Communication:

- 10.2.1.1 Building quality Teams Taskforce.
- 10.2.1.2 Establishment of clinical and non-clinical committees.
- 10.2.1.3 Quality/Environmental/Leadership Rounds
- 10.2.1.4 Initiation of Monthly Grand Rounds
- 10.2.1.5 Conferences/Workshops.

10.2.2 Emails and Reminders:

- 10.2.2.1 Communicating through intranet.

10.2.2.2 Creating the quality communication folder that contains all policies and procedures, programs and plans, KPI results, Improvement projects, OVR reports,

10.2.2.3 Sending Regular Quality Tips.

11. EVALUATION

11.1 The effectiveness of the QRMPS plan will be evaluated on an annual basis by the executive Committee and could be revised when necessary.

11.2 The QRMPS Plan will be approved by the Clinic Executive Committee every three (3) years.

11.3 A summary of activities and improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this plan will be compiled by the clinic manager and forwarded to the Executive committee for review and action.

11.4 This evaluation is shared with the board of Directors for their recommendations.

12. REFERENCES

11.1 CBAHI National Standards for Ambulatory Care Centers, Effective Jan,2020.

11.2 The Joint Commission International (JCI), 7th Edition, Effective Jan 2021.

13. Approved:

APPROVALS & REVIEWS::			
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