



Joint Commission International Accreditation

FINAL ACCREDITATION SURVEY FINDINGS REPORT

AZ Groeninge

Kortrijk, Belgium

International Health Care Organization (IHCO) Identification Number: 60000401

Survey Dates:	12 - 16 May 2025
Program:	Hospital
Survey Type:	Triennial
Surveyor Team:	Mahyar Sadeghi, DDS, MBA, MS, Administrator, Team Leader Lahoucine Naim, CPHQ, Physician Rasa V. Kasniunas, RN, MS, Clinician Deborah E. Lee, MBA, RN, Nurse

OUTCOME:

Based on the findings of the Triennial Hospital survey of 12 May 2025 to 16 May 2025 and the Decision Rules of Joint Commission International (JCI), AZ Groeninge has been granted the status of ACCREDITED.

Upon confirmation from the JCR Finance Department indicating that all survey related fees have been paid, you will receive the JCI Hospital certificates and, if necessary, your organization's entry on the JCI website will be updated. You also have access to The JCI Gold Seal of Approval™, the JCI Accreditation Gold Seal of Approval™ Guidelines, and the JCI Accreditation Publicity Guide under the "Resources" tab in JCI Direct Connect.

The Joint Commission International Hospital Standards are intended to promote continuous, systematic and organization-wide improvement in daily performance and in the outcomes of patient care. It is our expectation that all of the issues identified in the following survey report will have been satisfactorily resolved and full compliance with each identified standard will be demonstrated at the time of your next accreditation survey. Therefore, AZ Groeninge is encouraged to immediately place organization-wide focus on the standards with measurable elements scored as "Not Met" and to implement the actions necessary to achieve full compliance.

Between surveys, AZ Groeninge will be expected to demonstrate compliance with the most current edition of the JCI standards at the time, which includes the JCI accreditation policies and procedures published on the JCI website.

JCI will continue to monitor AZ Groeninge for compliance with all of the JCI Hospital standards on an ongoing basis throughout the three-year accreditation cycle. The compliance monitoring activities may include but not be limited to document and record reviews, the review of data monitoring reports, leadership interviews and staff interviews. The monitoring activities may take place on-site or off-site. JCI also reserves the right to conduct an unannounced, onsite evaluation of standards compliance at its discretion.

REQUIRED FOLLOW-UP:

Some of the findings identified in this report suggest that if not attended to in a timely manner can evolve into a generalized threat to patient and/or staff health and safety and may over time result in a sentinel event. These health and safety risks would be counter to the improvement efforts your organization has accomplished to date, and counter to the spirit of continual improvement in quality and continual reduction of risk that are considered part of the accreditation process. This is of concern to us and we believe should be a priority concern for your organization. For this reason, a Strategic Improvement Plan (SIP) describing the sustainable measures that will be implemented to achieve full compliance is required for the following standard(s) and measurable element(s):

- FMS.05.00, ME #5
- IPSPG.03.00, ME #2
- IPSPG.04.01, ME #1, ME #2
- MMU.04.01, ME #4

The SIP must be submitted to JCI within the next 60 days or by 20 Jul 2025 for review and acceptance. Details regarding access to the SIP system will be sent to you by way of a separate notification.

Survey Analysis for Evaluating Risk (SAFER)

Joint Commission International (JCI) has implemented the Survey Analysis for Evaluating Risk (SAFER) matrix, which is a comprehensive visual representation of survey findings. This will provide your healthcare organization with the information it needs to prioritize resources and focus strategic improvement plans in areas that are most in need of compliance activities and interventions.

SAFER will help your organization to:

- More easily identify Measurable Elements (ME) with higher risk
- Identify potential for widespread quality initiatives
- Better organize survey findings by level of potential patient, staff, and/or visitor impact

Each Measurable Element (ME) scored “Not Met” is placed on the SAFER matrix according to the likelihood the observation could harm a patient(s), staff and/or visitor(s) and the scope at which non-compliance was observed. As the risk level increases, the placement of the standard and ME moves from the bottom left corner (lowest risk level) to the upper right (highest risk level) of the matrix.

The definitions for the likelihood to harm a patient/staff/visitor and scope are as follows:

Likelihood to harm a patient/staff/visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

SAFER Matrix Placement	Strategic Improvement Plan (SIP) Required
High/Limited High/Pattern High/Widespread	• Not Met MEs will require a SIP
Moderate/Pattern Moderate/Widespread	• Not Met MEs will require a SIP
Moderate/Limited Low/Pattern Low/Widespread	• Not Met MEs will not require a SIP
Low/Limited	

SAFER Matrix

Program Name: Hospital

Likelihood to harm a patient/visitor/staff	ITL			
	High	IPSG.04.01 ME 1		
	Moderate	AOP.05.02 ME 5 FMS.05.00 ME 2 PCC.01.04 ME 3	FMS.05.00 ME 5 IPSG.03.00 ME 2 IPSG.04.01 ME 2 MMU.04.01 ME 4	
	Low		FMS.06.01 ME 4	ASC.04.02 ME 1 FMS.05.00 ME 3
		Limited	Pattern Scope	Widespread

REPORT OF SURVEY FINDINGS:

Note: The Accreditation Committee may request follow-up for any or all of the standards after the accreditation decision.

Assessment of Patients

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

Measurable Element #5

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

Not Met

Likelihood to Harm: Moderate

Scope: Limited

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

Anesthesia and Surgical Care

ASC.04.02 Information about the surgical procedure is documented in the patient's medical record to facilitate continuing care.

Measurable Element #1

Surgical reports, templates, or operative progress notes include at least the following elements:

- Preoperative diagnosis and planned procedure
- Postoperative diagnosis
- Name of operative surgeon and assistants
- Procedures performed and description of each procedure findings
- Perioperative complications
- Tubes and/or drains placed intraoperatively
- Surgical specimens sent for examination
- Amount of blood loss and amount of transfused blood
- Date, time, and signature of responsible physician

Not Met

Likelihood to Harm: Low

Scope: Widespread

It was observed that one of seven (15% compliance) surgical reports included a postoperative diagnosis and any mention of perioperative complications.

Facility Management and Safety

FMS.05.00 The hospital implements a program for the management of hazardous materials and waste.

Measurable Element #2

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

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The following were observed:

1. The hospital's comprehensive inventory of hazardous materials identified quantities and locations; however, it did not address the hazard type.
2. The comprehensive inventory of the hazardous material did not include radioactive materials, cytotoxic medications, and pressurized medical gases.

Measurable Element #3

The hazardous materials and waste program establishes and implements procedures for clear labeling, safe handling, storage, and use of hazardous materials that is consistent with safety data sheets.

Not Met

Likelihood to Harm: Low

Scope: Widespread

The following were observed:

1. Open containers and bottles of hazardous products without an expiration date were observed in the following areas: Central Sterile Supplies Department, Medical Unit, and the Geriatric Unit.
2. Suma Cal and Clinell did not have the same pictograms as presented in the safety data sheets observed on the Medical Unit.

Measurable Element #5

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

Not Met

Likelihood to Harm: Moderate

Scope: Pattern

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

1. The housekeeping staff used disinfectant and cleaning solutions on the patient care units; however, no eyewash mechanism was available to flush the eyes in case of exposure to chemicals, as required by the safety data sheet (SDS).
2. In the waste collection area, where a considerable amount of chemical wastes were stored, there was no eyewash mechanism to flush the eyes in case of exposure to chemicals.
3. In the Nuclear Medicine Department, where staff could accidentally be exposed to radioactive material, there was no eyewash mechanism to flush the eyes in case of exposure.
4. Across the oncology services, normal surgical gloves were used when administering chemotherapy through a closed system, and no other forms of personal protective equipment were made available, nor had the manufacturer's guidance been investigated.
5. Formaldehyde was stored in the Operating Room area for surgical specimen preservation; however, no emergency eyewash mechanism was available nearby in case of exposure to the

eyes. The nearest eyewash mechanism was located one floor below in the Central Sterilization Department.

6. The hospital implemented a process for hazardous medications and addressed the crushing of non-cytotoxic hazardous medications; however, the process did not include other manipulations of non-cytotoxic hazardous medications (such as risk of splashing) and, therefore, broader occupational exposure risks were not addressed.

FMS.06.01 The hospital maintains fire safety equipment and fire safety building features.

Measurable Element #4

The fire safety program includes clearly visible exit signage that is understandable to the hospital's occupants.

Not Met

Likelihood to Harm: Low

Scope: Pattern

The following were observed:

1. On the roof of block A of the hospital, where the chiller systems were located, there were no directional signs toward the emergency exit when the exit was not clearly visible.
2. In the diesel generator room and the medical air compressor area no exit signage was affixed to indicate the designated emergency exit.
3. In the hospital's kitchen, doors from one room would open into other rooms. There were no emergency exit sign(s) available on the doors that could provide a clear exit direction toward a final emergency exit.

International Patient Safety Goals

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

Measurable Element #2

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

Not Met

Likelihood to Harm: Moderate

Scope: Pattern

The hospital implemented a process for managing high-alert medications, which included applying a high-risk label; however, the following were observed:

1. Narcotic medications, although identified by the hospital as high-alert medications, were not labeled with a high-risk warning label.
2. Tailored risk-reduction strategies, such as specific warnings for neuromuscular blockers and concentrated electrolytes, were not consistently implemented.

IPSG.04.01 The hospital implements a process for the time-out that is performed immediately prior to the start of the surgical/invasive procedure and the sign-out that is conducted after the procedure.

Measurable Element #2

Before the patient leaves the area in which the surgical/invasive procedure was performed, a sign-out process is conducted, which includes at least the following:

- Name of the surgical/invasive procedure that was recorded/written
- Completion of instrument, sponge, and needle counts, as applicable
- Labeling of specimens
- Any equipment problems to be addressed, as applicable

Not Met

Likelihood to Harm: Moderate

Scope: Pattern

Before the patient left the area in which invasive procedures without sedation were performed, a sign-out process was conducted using a pop-up template in the electronic medical record. The template included two of four elements (50% compliance) required in the intent. The following two elements were not included:

1. Completion of instrument, sponge, and needle counts, as applicable
2. Any equipment problems to be addressed, as applicable

Measurable Element #1

The full team actively participates in a time-out process, which includes the following elements in the area in which the surgical/invasive procedure will be performed, immediately before starting the procedure, and this is documented:

- Correct patient identity
- Correct procedure to be done
- Correct surgical/invasive procedure site

Not Met

Likelihood to Harm: High

Scope: Limited

In the Intensive Care Unit (ICU) time-out procedures were not conducted when invasive procedures were performed. It was also observed that the documentation system did not provide a functionality to document time-outs. The issue was only for the invasive procedures in the ICU. The ICU had their own documentation system that was different from the rest of the hospital.

Medication Management and Use

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

Measurable Element #4

Additional elements of complete medication orders or prescriptions include, at minimum, the following as appropriate to the order:

- Data necessary to accurately identify the patient
- When generic or brand names are acceptable or required
- Specific guidelines for the use of PRN orders
- Weight-based orders
- Rates of administration for intravenous infusions
- Special orders such as titrating, tapering, or range orders
- Titration orders include the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes.

Not Met

Likelihood to Harm: Moderate

Scope: Pattern

The hospital had a policy on "single-dose medications," which stated that PRN analgesia could be given to patients with a pain score of 4 or more. There was no guidance on how to decide when multiple analgesics or other medications were prescribed as PRN. For example:

1. Throughout the hospital, multiple types of PRN written on one prescription chart without guidance on how the nurses choose which analgesia should be given.
2. On the Inpatient Chemotherapy Unit, different types of anti-emetics were prescribed on the same form as PRN, with no guidance or assessment scales available for patients.

Patient-Centered Care

PCC.01.04 The hospital identifies its vulnerable populations and the risks to those populations.

Measurable Element #3

The hospital performs a vulnerable population risk assessment, annually, at minimum, to identify the following:

- Vulnerable populations the hospital serves
- Risks associated with each vulnerable population
- Specific resources needed to support the care, treatment, and services of these vulnerable populations, including community resources for continuity of care postdischarge
- Staff education for select vulnerable populations, as determined by the hospital

Not Met

Likelihood to Harm: Moderate

Scope: Limited

The pediatric inpatient and day hospital allowed entrance and exit to all at two entrances, posing a risk of child abduction.