Haute Autorité De Sante (France)
Ministry of Public Health (Lebanon)

The National Accreditation Procedure of Healthcare Organizations as of January 2009

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Abbreviations

Following are the abbreviations that are used in this document:

1. HCO: Healthcare Organizations
2. AE: Auto-Evaluation
3. HANC: The Hospitals Accreditation National Committee
4. HATC: The Hospitals Accreditation Technical Committee
5. EPP: Evaluation of Professional Practices- Clinical Practice Assessment
6. MOPH: Ministry of Public Health
7. AO: Audit Organization

P.S.: Auto Evaluation and Self Assessment are used interchangeably in this document and they have the same meaning.

The objective of this document is to describe the process of accreditation of Healthcare Organizations (HCO) in Lebanon starting January 1st, 2009. Starting this date, the public and private HCO would have already undergone and benefited from a first or even, in a later phase, a second accreditation process.

Many years ago, the Lebanese healthcare authorities tried to improve the performance of healthcare services without directly intervening with the medical practices. However, this intervention was clear in the fields of economy and finance. Also, attempts to improve the situation faced a lot of resistance, which lead to no improvement and organization of the work. Therefore, the professional healthcare staff enforced an idea to regulate the whole issue. As a result, the evaluation of quality of care appeared to be a good tool to provoke an awakening that will correct the current deficiencies, and optimize the cost/benefit ratio according to a professional and societal approach, aiming to increase the customer satisfaction level.

The quality improvement process depends on the development of standards and criteria and their application with evidences and measures. On this concept the Lebanese accreditation system was built. The accreditation system encourages the HCO to examine their services and functions (organizational, professional and clinical practices) and the satisfaction of their customers with respect to the services rendered for continuous improvement of their performance.

The teaching dimension of this accreditation is important as well. It consists of initiating a dynamic progress, starting with an objective evaluation of the level of conformity based on standards set by professionals.
The accreditation process helps the HCOs to develop a decisive practice more coherent with their internal and external environmental conditions. Also, the process will aid in the transition from a reactive attitude slowly to a decision taking behavior depending greatly on anticipation.

Furthermore, the accreditation is important for the integration of the different technical, scientific, social and economical dimensions of the three pillars of the organization, which are the Nursing, Medical and the Administrative bodies. The stress is usually greater on the evaluation of the medical services provided to the patients.

The new system of accreditation for the Lebanese HCO differs from the previous one by:

- The addition of two new chapters to the Accreditation Manual:

    - The Patient Safety and Risk Management
    - The Evaluation of Professional Practices
- The establishment of a Hospital Accreditation Technical Committee (HATC) auxiliary to the Minister of Public Health.
- The agreement with the audit organizations (AO) to implement the audit or accreditation visits.
- The possibility for the HCO to provide comments and observations on the content of the report or to dispute the decisions of the HANC.

I- Accreditation: Definition and Objectives:

The International Society for Quality in Healthcare (ISQua) defines accreditation as follows:

- "A process of self assessment as well as external evaluation by peers. It is used by the healthcare organizations for evaluating their performances in a proper manner against pre-established standards and for using the appropriated methods targeted towards improving the healthcare system continuously".
- "A public recognition of achievement by a healthcare organization of requirements of national healthcare standards. This is proven through the external and independent peer review based on the level of performance of the organization against the set standards".

The process is an assessment and an analysis of the quality program of an accreditation system in order to ensure its effectiveness and the proper implementation of the requirements.

The objectives of an accreditation are:

- To evaluate the quality and the safety of the medical care practices
- To evaluate the HCO ability to improve the work conditions, the care and the global management of patients.
- The establishment of comprehensive recommendations
- The external recognition of the quality of care of the HCO and the public's confidence.

The adopted approach for the accreditation of Lebanese HCO includes quality assurance, continuous improvement and risk management:

- The quality assurance helps in building confidence between the providers of care and the patients, while providing documented evidence that the organization has the means to deal with risks of failures.
- The continuous improvement of the quality relies on the analysis of the functioning of the processes in order to improve quality. This method should be multidisciplinary and includes various professional groups concerned with the studied process. This method forms a real management tool, in which there are no pre-set priorities. It is the role of the professional staff to define the improvement steps and the indicators needed for the follow up and maintenance of the quality level.
- Risk management is based on the correction, prevention and control of risks encountered, not only by the patients and their surrounding environment but also by the HCO staff.

Any HCO requesting to get engaged in the accreditation process, has to work on developing a quality system that will allow the healthcare professionals to provide the best level of services to the patients through:

- Identification and working on the key aspects related to patients' safety
- Conducting self assessment/AE and improving the key aspects of services in conformity with the accreditation standards
- Implementing corrective actions for identified gaps
- Hiring of external and independent auditors in order to evaluate the quality of services provided
- Use the results and the recommendations for continuous improvement

An accredited HCO reflects the following:

- The establishment of a process of risk management covering all sectors of activities to ensure optimal safety for the patients and users.
- The establishment of a comprehensive quality system capable to identify weak areas and correcting them.
- An optimal conformity level against the national accreditation requirements.

A hospital is accredited when its resources and activities are arranged to constitute standards and quality healthcare service.

Also, the accreditation program contributes to the establishment of contracts among the hospitals, the MOPH and the third party payers. This can have an impact on the reimbursement schemes taking into account the Accreditation level.

II- Organization concerned with the accreditation:

All HCOs, concerned with the accreditation scheme, are considered as hospitals; however named, dedicated to deliver medical services:

- whether as hospitals or private clinics
- as having private, public or related to social security funding schemes,
- as profit or non-for-profit
- regardless of their complexity level, and
- whether open to provide different types of services or limited to one discipline or specialization.

The accreditation procedure is targeted for the HCO authorized to provide acute hospital care in Lebanon.

The Accreditation process permits each HCO to apply to one of the following related categories:

- University Hospitals
- Non-University Hospitals with tertiary care
- Hospitals with intermediary care
- Secondary Hospitals

This system permits any HCO to be not penalized because of non applicable standards (absence of any activity or service). The level of the accreditation takes into account uniquely the activities authorized and provided by the HCO. Thus, any non applicable part of the accreditation manual will not be considered.

When the HCO has many sites for offering hospital services, it is up to its legal representative/management to determine whether its legal engagement in the accreditation is going to be as a whole organization or as several sites. The decision should respect the patient care process within HCO (as single process or multiple logical processes).

Therefore, to be eligible to participate in the accreditation process, an organization shall:

- be an acute care hospital
- be functional for at least 12 months before the accreditation visit
- ensure the availability of necessary services in order to fulfill the mission of the organization. These services can be provided directly by the organization or can be outsourced.

In case the HCO has already been accredited or certified by an international body, this initiative will be taken into consideration but it will not exempt the HCO from undergoing the Lebanese National Accreditation process.

As for the long term care HCOs, they are not concerned with the current accreditation scheme.

III- The Accreditation Bodies:

3.1 The Hospital Accreditation National Committee (HANC):

A decree law # 9862 issued on 22 June 1962, and modified by another legislative decree issued on September 16 1983 and later by the law # 546 issued on October 20, 2003, specifies in the Article #7 that "it is established within the Ministry of Public Health an evaluation committee for the classification and accreditation of hospitals". As a result, the HANC was established. Several evidentiary documents are present particularly the internal regulations, allowing the institutionalization of the new accreditation procedure and structure.

The mandate of this committee will be to support, within the public and private hospitals, the development of healthcare evaluation processes as well as to implement the accreditation process.

The members of this committee are assigned based on the recommendations of the Minister of Public Health.

For each member of the committee, a substitute is appointed as per the same conditions. The substitute member does not participate in the committee meetings unless the original member is absent or unable to attend.

The HANC is chaired by the General Director of the MOPH, and the members of the HANC are:

- 2 representatives from the Syndicate of Private Hospitals
- 2 representatives from the Order of Physicians
- One representative from the Army Medical Services
- One representative from the National Social Security Fund
- One representative form each faculty of medicine in Lebanon
- A qualified person in health care management field
- A healthcare director in the MOPH
- A head of the hospitals section in MOPH (reporter)

The HANC is responsible for:

- Defining the strategic orientations of the hospitals accreditation scheme.
- Ensuring the coordination of the necessary actions done for the hospitals accreditation scheme
- Correcting all the failures and gaps of the accreditation visits
- Validating the hospitals accreditation procedure
- Validating and distributing the hospitals accreditation standards. The distribution is done through a ministerial decree via the Government Journal (الجريدة الرسمية).
- Approving the AOs based on the opinion of the HATC.
- Approving the audit reports established by the AO and verified by the technical committee
- Defining the accreditation levels of HCOs
- Studying the appeal requests
- Proposing financial incentives related to the results of the accreditation

The HANC has the prerogatives to request the assistance of a third party to support its mission, and to keep abreast of the latest standards.

The HANC meets at least 4 times per year based on the request of its chairperson.

The HANC adopts all the necessary organizations and functions that allow it to satisfy its assigned responsibilities in the best way possible.

3.2 The Hospital Accreditation Technical Committee (HATC):

The HATC is an impartial entity that has the competence and the reliability needed to ensure the proper functioning of AOs, which are approved for the Accreditation of HCO. It makes the necessary arrangements of the needed structure and resources, including human resources, to ensure the proper control and the surveillance of the related steps and actions. Also, it ensures the continuity and consistency of the accreditation program.

The committee is formed of 5 qualified foreigners proposed by the HAS and nominated for 3 years by a decision from the Minister of Public Health.

The committee is supported by the external audits conducted by the approved AOs as mentioned in the document "Terms of Approval and Functioning of the Auditing Organizations for the Lebanese Healthcare Accreditation", and by all the available arrangements and resources of the National Accreditation program. It functions with perfect coordination with the HANC.

The committee meets upon the request of its chairperson. He/she can arrange for urgent meetings if deemed necessary. The committee prepares an annual report regarding its services, which should be approved by its steering committee based on the "memorandum document" between the MOPH and the HAS.

The committee is in charge of the following:

- Analysis of the application forms of the AOs
- Selection of the AOs
- Analysis of the audit reports done by the AOs
- Proposing the accreditation reports to the MOPH
- Controlling the approved AO and providing a report to the Minster of Public Health.

IV- The Accreditation Duration:

With the exception of any serious problem observed or encountered by the auditors regarding the safety of the HCO personnel and processes, and in accordance with the legislative decree #136 issued on September 16, 1983, the duration of the accreditation is for 2 years.

All organizations that undergo the accreditation process according to the rules established in the present document benefit from an accreditation of 2 years regardless of the accreditation level (cf X). Also, all HCOs have a supplementary delay of one year to implement all the needed corrective actions and finalize the quality improvement program.
It is up to the HCO to re-launch the accreditation process during this additional year. This way, the delay between two accreditation processes is maximum 3 years.

V- Engagement in the procedure:

Starting January 1, 2009, the planning of the procedure is initiated directly by the Minister of Public Health based on the request of the HCO.

The terms and modes of planning are related to the results of the previous accreditation survey. Therefore, an HCO which is accredited for a period of 18 months should engage in the accreditation procedure mentioned in this document before May 2009 (for a survey visit before May 2010).
The rest of the HCOs should engage in the procedure before the end of 2010 (for a visit before the end of 2011), but they can, if they wish, to undergo the process before.
The legal representative/management of the HCO sends to the HANC at the soonest possible and 1 year ahead of time of the survey visit, the engagement file including the following information:

- The AO chosen to perform the survey visit of the accreditation.
- The time period chosen to undergo the visit survey.

The HATC then plans the process of the accreditation with the HANC and specifies the expected schedule and the timelines of the committee decision.
The accreditation scheme is proposed and based on a continuous cycle of maximum of 3 years. The planning and organization of the procedure are implemented in a manner whereby any delay should be respected.

5.1. Preparation of the organization:

To engage in the process of the accreditation, the management of the HCO, and after consulting with the governing board, sends to the MOPH a file consisting of the following: :

- The identification and planning of the audit form;
- The strategic planning of the HCO;

- The changes that have been done since the last accreditation relative to the legal aspect or management of patient care.
- Description of the Quality Improvement Plan;
- The follow up of the recommendations provided by the last audit;
- The AO chosen by the hospital for the audit visit (the Terms of Approval and Functioning of the Audit Organizations for Lebanese Healthcare Accreditation);
- The expected schedule to end the auto evaluation and to undergo the audit.

Upon the reception of the file, the MOPH shall proceed to the registration and analysis of this application.

5.2 The accreditation contract:

Based on the information collected from the identification and planning of audit form, the MOPH shall prepare the accreditation contract. This contract, when finalized, is sent to the concerned HCO for signature around 6 months before the audit visit.

This contract specifies the commitments of the HANC, the HATC, the concerned HCO and the chosen AO to have a sound and smooth accreditation process.

These commitments are:

- The scope of the process: the/those legal organizations and entities involved in this process
- The decided visit period, (month and year)
- The signed contract between the HCO and the chosen AOs
- The requirements to generate the necessary documents including the auto evaluation matrixes. The requirements include the respect of the deadlines, the quality of information provided, and the transparency of relation with the AOs. The exact dates of the visit should be known and approved by both the AO and HCO at least 2 months in advance before the visit. Also, the number of days and the auditors assigned for each step in the visit should be specified and approved by the HCO and AO at least 2 months in advance. In case of any change, the HCO and its AO should mention and explain the reasons for these modifications or delays of the visit. In case of failure or non compliance of the process methodology by the HCO, the HATC can decide that there is a non compliance in the procedure
- The responsibility of the AO to report, at the time of the accreditation visit, all the situations threatening the quality of the procedure and/or the safety of the patients or personnel

- The mutual commitment to good and professional conduct regarding issues of confidentiality, transparency and the respect of deadlines.
- Acceptance of financial contributions

The accreditation process includes 4 key components:

- Preparation and implementation of the self assessment by the HCO
- Audit by an approved AO to certify and approve the self assessment results
- Presentation of the audit results and the definition of the accreditation level
- The continuous quality improvement

VI- The Selection of the Audit Organization (AO):

Following the selection of an AO, the HCO signs a contract according to the rules and regulations present in the Annex VIII of the document "the Terms of Agreement and Functioning of the AOs for the Lebanese Healthcare Accreditation".

The AO are selected and approved based on the terms and conditions stated in the "the terms of agreement and functioning of the AOs for the Lebanese healthcare accreditation". This document specifies the rules of the audit procedure and the control of the AO for a period of 3 years, as well as the rules and regulations of selection, intervention and evaluation of the surveyors.

VII- Accreditation and the quality process:

One of the objectives of the accreditation is to recognize the efficiency and the continuity of the quality improvement process in the HCO. It is; therefore, necessary that the responsible individuals initiate and support a genuine process of quality improvement based on the accreditation manual.

7.1 Leadership and coordination:

The process of the accreditation constitutes a major engagement for a HCO. In order to ensure the success and the continuous improvement of quality and safety, it is necessary to have the proper structure, key components and the adequate supports.

Even if each organization has its own strategy, some important aspects have to be established to ensure appropriate leadership, management and coordination of the accreditation process. These include:

- Management Commitment
- Establishing a steering committee for the accreditation
- Appointing an accreditation coordinator

7.1.1. Management Commitment

It is important that the top management encourages the activities related to the accreditation and to be actively involved during the process.
It should communicate the key reasons for engaging in the accreditation process and the advantages that the organization is looking for to obtain from this process.
All of this is done to create the proper and adequate conditions for all the personnel who are participating in this process.

7.1.2. Steering Committee for the Accreditation Process:

In order to ensure the continuity of the accreditation process it is necessary to form a committee to steer the accreditation process, in case there is no quality committee already existing. This committee should be inter-hierarchal and multi disciplinary. Also, it can be established only for this purpose or it could be part from other existing committees like administrative committee, quality management committee etc… The responsibilities of this committee are to:

- Establish the objectives of the accreditation
- Define the general plan for implementing the procedure
- Ensure the appropriate training/education and other necessary support for the organization
- Promote the accreditation process in the HCO
- Determine the composition of the teams that would perform the self assessment
- Ensure proper coordination among all levels of management
- Monitor the continuity of the activities of the accreditation coordinator
- Ensure the follow up on the recommendations provided after the accreditation visit

7.1.3. The Accreditation Coordinator

The accreditation process requires that the HCO assigns a person as an “accreditation coordinator” to manage the accreditation activities and establish the links between the HCO and the AO.

His/her duties are to:

- Establish an action plan for the accreditation process
- Contribute to the defining of the accreditation objectives
- Evaluate the needs for the training of the teams and coordinate the training program
- Direct the teams during the self assessment phase
- Provide all the necessary resources and tools to the assigned teams, for example the accreditation manual and guides to perform the self assessment
- Ensure an effective communication and collaboration through out the accreditation process;
- Ensure that the checklists for the self assessment are completed and submitted on time;
- Organize and allocate all the necessary logistical support during the accreditation visit;
- Compile, file and index all the available documents in the HCO;
- Prepare the self assessment teams to meet with the auditors during their visit;
- Communicate with the chosen AO.

This role is naturally for the Quality Coordinator if this role already exists in the organization. If not, a member of the HCO personnel can be chosen uniquely to assume this role. An accreditation coordinator should be competent in the domains of quality management, project management, management of documents and have a good knowledge of the accreditation process. He/she can rely on an organization logistics and supports suited for the purpose.

7.2 The project calendar and timelines:

The proposed accreditation system is based on a continuous cycle of 3-years. The HCOs should incorporate in the 3-year-cycle, as part of their continuous quality improvement planning, all the steps of the accreditation process:

- The preparation
- The self assessment
- The visit/audit
- The continuous evaluation

In order to ensure proper management of the accreditation process, a "road map" should be established to indicate all the activities and major steps of the process that should be completed within a specific timeframe. A general timelines can be established according to the following table:

Months	Action
-12	Registration in the accreditation process Training of the self assessment teams
From -12 till -6	Choosing the Audit Organization (AO)
From -9 till -3 (according to the size of the organization)	Conducting the self assessment
-6	Signing the contract between the HCO and the HATC
-3	Sending the results of the self assessment to the AO
-2	Developing the schedule of the visit by the AO
-2	Appointment of the audit team by the AO
0	**Undergoing the Accreditation visit**
+1	Sending the results of the audit to the HATC and the HCO
+2	Formulating the potential observations or disputes by the HCO
+5	Sending the accreditation report to the HCO and publishing it on the internet
+12 to + 24*	Registration in the follow up procedure of the accreditation process
+18 to + 36*	New accreditation visit

It is up to the HCO to take the initiative to be engaged, after the approval of the MOPH, in a new procedure.

VIII- Self Assessment (Auto-Evaluation):

The self assessment is an innovation in the accreditation process, as a pre-assessment phase and an essential method for a good progress of the accreditation.

The self assessment helps the HCOs examine their daily activities and to evaluate them according to the accreditation requirements. It is about putting the organization under the scope of the accreditation program and enabling it to assess the progress of the situation.

Also, it helps not in only detecting the compliances, but also the opportunities for improvement.

8.1 The self assessment teams:

In order to conduct the auto evaluation, teams of self assessment should be created. The composition of these teams has to reflect a multidisciplinary approach of the healthcare services.

The composition of the teams has to be based on the competency level of the members rather than on their job positions.

The self assessment teams have to, as per their composition, reflect the services offered by the HCO as well as the structure of the accreditation manual. It is important that the self assessment teams should reflect the standards required and not a service or department. For example, the self assessment team of the Human Resource (HR) department has to reflect the requirements of the Human Resources chapter throughout the organization and not only the department of HR. Also, a self assessment team for patient care has to take into consideration the patient care process during his/her care throughout the HCO and not only in a given service or department.

Every team can include an average of 6 to 10 members. The number of the teams depends on the number of services provided by the establishment.
In small HCOs, a single multidisciplinary self assessment team can be created for the whole institution.
Concerning the Evaluations of the Professional Practices (EPP), a self assessment group is established for every evaluation activity. (Reference EPP).

In most of the cases, these actions concern several professional categories. Thus, it is beneficial to involve all the related parties and individuals concerned with the same subject.

The working teams define the methods, identify the sample size, collect the data, analyze and communicate the results. Also, they propose and follow up on the improvement actions.

8.2 The implementation of the self assessment

The self assessment is implemented by the assigned teams over a period of 6 months, depending on the size and functions of the HCO. During this period, the self assessment teams shall meet regularly. A track of these meetings is kept (ex: attendance sheet).

Experience has shown that meetings can be held once a week for one or two hours or once per month for a half a day. Whatever is the process, it is necessary to respect the key stages during the self assessment. They include:

- Training;
- Discussion;
- Agreement on the system conformities and the opportunities for improvement;
- Compilation of the evidences of conformities;
- Identification of the available support documents;
- Quotation/rating according to the evaluation scale

8.2.1 Training

Before starting the self assessment, the members should know:

- The objectives and the process of the accreditation
- The objectives of the self assessment
- Their duties within the context of the self assessment
- The structure and the general contents of the accreditation manual and not only the part related only to the scope of their team. This allows having a good understanding of the requirements of the various sectors of the HCO.

8.2.2. Discussion

The discussions and the debates within the self-assessment teams are an added value to the global accreditation process. Through the encouragement of open discussions, the teams have to answer some key questions such as:

- What activities do we perform with respect to every standard?
- What are we doing correctly?
- Where could we improve?
- Are we doing anything regarding this matter?
- What evidences we have to secure to validate what we are doing?
- From whom can we request to obtain a clearer idea on our performance? Staff? Partners? Customers?

For every reference, the standards present specific elements to define which types of proof and evidences are necessary to verify the compliance. These criteria, as well as the examples and the illustrations presented in the guidelines associated with the references, establish a starting point for the teams during their discussions.

8.2.3 Agreement on the principles of conformities and opportunities of improvement

During the discussions, the team has to try to identify what the measures are to evaluate the activities of the HCO against the set standards. In case the activities are not conformant to the requirements, the team has to identify the actions to be done in order to be compliant. It is necessary that every team agrees on these points and that all the reached conclusions are properly documented.

8.2.4 Compilation of the Evidences

Following the evaluations of the teams of the conformance levels against the set requirements, it is necessary to identify which proofs and evidences can be presented to justify these observations. These proofs and evidences will be examined during the visit of accreditation to allow the auditors to validate the self-assessment reports. By identifying the evidences, the self-assessment team has to examine the links among the structures, the processes and the results. In case of an opportunity for improvement, a quality improvement plan should be established as an evidence of improvement.

8.2.5 Self Assessment and Evaluation of Professional Practices (EPP)

In the new version of the accreditation, several criteria present in certain references are related to the evaluation of professional practices. This can be present and shown in the organization policy, in the environment of care, in the medical care, and in the field of patient safety.

To ensure a sufficient degree of commitment in the process of the EPP, a minimum number of projects are required. This number varies according to the size of the HCO and the number of services, according to the following table:

<table>
<tr><th></th><th>From 1 to 50 beds Complete and day</th><th>From 51 to 150 beds Complete and day</th><th>More than 150 beds Complete and day</th></tr>
<tr><td>EP 4</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>EP5</td><td rowspan="2">1 (You have a choice)</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>

For specialized HCO, the EPP often focuses on the clinical specialty of the HCO.

8.3 The Self-Assessment Report

The Accreditation manual includes chapters of references/standards. These references/standards are detailed into criteria. So the chapter of " Anesthetics AN " includes 13 references/standards. The references/standards establish the basis of the self assessment process.

8.3.1. Self Assessment Matrices

The self assessment matrices are available on the Internet site of the MOPH to allow the professionals of the HCO to complete the auto evaluation reports (the appendix II presents the auto evaluation matrix of the Quality System Chapter).

The auto-evaluation matrix suggests listing the "evidences" which will allow the HCO to provide the factual proofs necessary for the objectivity of the results.

For the EPP, the number of projects done for auto evaluation is limited based on the required projects.

The objectivity and the credibility of the results constitute important criteria for the proper implementation of the self assessment. This implies that the answers and the possible comments are based on validated facts.

8.3.2. Quotation of the references (except EPP)

All the references are subject to have a quotation by the self assessment teams.
All the criteria shall be evaluated according to their degree of implementation based on three possible answers:

- Yes, totally
- Not, in no way
- Partially.

In case the HCO is not concerned by certain criteria, then it should identify them as "not applicable" in the auto evaluation matrix.
The healthcare professionals have to comment objectively on every criterion to allow the auditors to understand the exact situation against the standards.
The quotation depends on the answers of every criterion and is based on the following scale:

- A: the HCO answers fully and continuously meet all the criteria of the reference
- B: the HCO generally or most of the time answers and meets the criteria of the reference
- C: the HCO answers only partially or rarely to the criteria of the reference
- D: the HCO does not answer at all to the criteria of the references
- NA: not applicable reference

This quotation allows:

- The teams to measure the attained quality level;
- The auditors to prepare their visit plan;
- The exchange of information between the professionals of the HCO and the auditors during the visit.

8.3.3. Quotation of the EPP reference

For the references concerning the EPP, the quotation is not based on evaluation of criteria but on projects or actions presented according to the following rules:

Quotation A: EPP action achieved in the establishment or application of an improvement plan action
Quotation B: EPP action achieved at a less advanced stage (analysis of the process is in progress)
Quotation C: EPP action identified but not started
Quotation D: EPP action not identified

8.3.4. Analysis of the reference

The analysis allows to highlight the positive points relative to the reference and to identify improvement actions.

This analysis should not exceed five lines

- The positive points: points particularly well implemented by the HCO
- The improvement actions: the malfunctions, the failures, the nonconformities and the problems, these should not be considered to have punitive measures but rather opportunities for improvement that should be highlighted.

The objective of the evaluation is to identify the tracks of improvement, to establish priorities and the necessary timelines for implementation.

8.3.5. Validation of self assessment report:

At the end of the process of the self assessment, the HCO provide the chosen AO the auto-evaluation reports after being validated by the Director of the HCO.

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

- Composition of the auto-evaluation teams;
- Analysis of the auto-evaluation, with:
  - The strengths points
  - The opportunities for improvement
  - The priorities for improvements identified in a quality improvement plan
  - The findings of the auto-evaluation and the rates of every criterion
  - The signature of the chief of the auto-evaluation or accreditation coordinator

IX. The Accreditation Visit

9.1 The Objectives of the visit

The visit aims at assisting and enforcing the effective implementation of continuous quality improvement system. It does not constitute in any way an external control.

The visit, which one of its objective is to validate the auto-evaluation, focuses on all the HCO activities under the accreditation scope.

It is based on a series of steps allowing the auditors to measure the quality level achieved in all areas influenced by the accreditation procedure and to assess the developed quality dynamics. It is based on the results of the auto-evaluation done by the HCO.

Through the participation of all the sectors and the categories of hospital professionals, the self-assessment allows to analyze in a detailed and global way the activity of the HCO. The primary role of the auditors is to assess the self-assessment and the used methodology.

- Was it related with all the sectors?
- Did it really involve all the concerned stakeholders?
- Was it implemented in a multidisciplinary way?
- Did the various professional categories participate?
- Were the answers enough, complete, objective, and documented?

It is the HCO task, as per the results of the auto-evaluation, to demonstrate the satisfaction of a chapter or given criteria. The auditors team tries to cross information to validate the detailed assessment collected during the auto evaluation.

The results of the auto-evaluation give the auditors an overview of the activities of the HCO. The quality of the visit depends essentially on the modes of implementation and the objective content of the self assessment.

In other terms, the visit allows the auditors to assess:

- The HCO policy and management commitment;
- The impact of the internal organization on the quality;
- The analysis of the implemented tools and practices for quality and safety;
- The evaluation of the results and the obtained improvements.

The visit consists of the following steps:

- The preparation with the chosen AO;
- The sending of the auto-evaluation reports to the auditors before the visit;
- A meeting at the beginning of the visit to review the follow-up of the conclusions of the previous accreditation process with the steering committee;
- Visit to various HCO departments related to the patient route or to a selected thematic flow to assess the satisfaction of the set criteria and the quality level. The auditors shall meet with the groups of self-assessment for a second time, these meetings allow to discuss differences between the results of the self-assessment and the finding noted during the observation process;

- Assessment of the clinical services rendered to the patient in the context of the EPP and the patient safety. This will lead the auditors to understand and monitor patient flow by types of services. During these surveys, the auditors observe the work organization and the interfaces between the clinical departments and the other supporting departments;
- Visit of the medico-technical, logistic and support settings that may be managed by external organizations to understand the reality of the interfaces between these organizations and the same HCO department.

It is worth mentioning that the auditors neither meet with all the HCO professionals nor visit all the sectors of various activities. Therefore, it is up to the HCO to communicate widely to all responsible professionals to involve everyone in the audit process through the proper representation of the groups.

9.2 The Preparation Steps

9.2.1 Planning of the visit

At least two months before the visit and according to the schedule planned with the MOPH, the HCO shall develop, in consultation with the approved AO, a proposed visit program, taking into account its organizational constraints, the duration of the visit and the number of the auditors planned for the visit. This planning takes into consideration various factors such as the number and the duration of the thematic routes, the optimal duration of each meeting or interview, the necessary time to review the documentations, the time spent on the analysis and the logistic preparation of the auditors.

The approved AO can appoint a project manager responsible for monitoring the visit... Also, the audit coordinator should be appointed one month before the visit.

The coordinator appointment allows adjusting the schedule and logistics of the visit when needed.

The durations of the visit vary between one and five days, depending on the size and the activities of the HCO. The number of auditors varies between 2 to 6.

9.2.2 Preparation of the documentation

During the self assessment period, the HCO should start collecting and classifying the necessary documents and data needed to be provided to the auditors on site. These documents should

be filed by chapter and even by reference. On the side of the matrixes, evidences should be present on the auto-evaluation of the findings observed during the survey and the meetings conducted.
The documentation should be easy to read and have to be on paper. It is preferable that the person managing the documentation is available during the visit in order to help eventually, upon their demand, the auditors to retrieve documents easily.

In some case, some documents can be presented electronically.
If an HCO has already established a pertinent documentation management system, it is not necessary to review this classification; on the contrary it is essential to provide the related indexes of these documents as per the references and the criteria for modification.

9.3 The visit process

The principle steps of the visit are:

- Initial meeting;
- Meeting with the steering committee;
- General visit of the site;
- Analysis of the documents on site;
- Patients flow;
- Cross path;
- Meeting with the auto-evaluation teams;
- Meetings in the HCO (meetings or individual interviews);
- Night visit;
- Daily review ;
- Auditors sort summary
- The preparation of the summary session and writing of the audit report
- Restitution session;

9.3.1 Initial Meeting

This initial meeting allows the HCO responsible staff (management team, medical director) and the members of the audit team to get to know each other and to present:

- The HCO,

- The missions of the HCO, its context,
- The quality policy
- The objectives of the visit

It allows also to present precisely the persons participating in the visit and to confirm the visit timelines.

9.3.2 Meeting with the steering committee

This meeting has the following objectives:

- Present the members of the steering committee
- Present the history of the quality process and the links between the accreditation visits (conclusions of the previous accreditation report, the analysis of the situation in relation to these conclusions, the foreseen areas of improvement, the actions committed to or implemented, evaluation and follow up processes…).

In small organizations the initial meeting can be the same as the meeting with the steering committee.

9.3.3 Site visit

This step allows the auditors to comprehend the course of the:

- reception and patients flow
- medico-technical processes
- logistic areas
- technical areas

9.3.4 Analysis of documents on site

Based on the auto-evaluation report, this step allows auditors to:

- Get acquainted with additional information and obtain the evidences.
- Look for objective supporting elements of the auto-evaluation report.

9.3.5 The patients route/flow

The follow-up of the patient flow through out the various fields (medicine, surgery, pediatrics) allows the auditors to:

- Meet with the professionals working in the HCO;
- Have individual interviews (to be considered according to the needs);
- Meet the patients and\or their relatives;
- Examine the patients' medical records.

The meeting with the patients and\or their relatives shows the coherence between the answers provided by the patients and the professionals.

9.3.6 Transversal processes (medication route, hotelier services, logistics and techniques, human resources, information system,)

This step allows the auditors to:

- Understand the work organization
- Meet with the professionals at the HCO
- Assess the coordination, the interfaces and the organization of the care process.

9.3.7 Meetings with the auto-evaluation teams

This step allows the auditors to:

- Assess the multi-disciplinary characteristic of the auto-evaluation and the professionals' involvement.
- Validate the observations during audit round and to clarify the possible differences between the auto-evaluation and the round results.
- Highlight the improvement actions in progress and the quality dynamics of certain topics.

9.3.8 The meetings in the HCO

These meetings, done in meetings or individual interviews, allow the auditors to observe and assess:

- The commitment and the coordination of policy makers in the developing and monitoring of HCO policies specifically the quality assessment and continuous improvement
- The social environment
- The roles assigned to the users within the organization.

9.3.9 The night visit

This step allows:

- To evaluate the continuity and the coordination of patient care during night shifts
- To highlight the involvement of the night personnel in the organization and the continuous quality improvement process. The time of changing shifts should be included in the night visit.

9.3.10 The daily outcome and report with the management of the HCO:

This step is the time where the auditors:

- Inform the management about the previous day (it should be noted that, during the visit, if the auditors notice a serious event and/or an issue susceptible to alert, they do not wait for the daily summary meeting to notify the management)
- Validate certain information and obtain additional information
- Confirm the schedule of the next day (setting timetable, ask for additional meetings,
- To have an opinion from the management the HCO on the progress of the current visit.

9.3.11 Auditors assessment time

The program has to allocate adequate times for the auditors to allow them:

- To ensure the coherence and the sharing of information in order to facilitate the meetings and the upcoming visits and prepare the report and the restitution session
- To check the documentations before the visits and the meetings with the assessment groups
- To identify any additional course or routes for inspection

9.3.12 The preparation of the restitution meeting:

A time of dialogue is essential for the auditors in order to:

- Prepare the restitution meeting
- Generate in a consensual matter the decisions proposals
- Prepare, as possible, a presentation of the conclusions of the visit (slideshow)

9.3.13 The restitution meeting

This meeting, to which the staff is invited, aims at:

- Presenting the main findings of the auditors regarding the accreditation manual as well as identifying the major areas of improvement.
- Explaining the context of the visit through out the process, and particularly clarifying the timings of the subsequent stages to reaching the final decisions.

X. The Audit Report

At the end of the audit, the audit team writes, from the data obtained from the auto-evaluation reports and during the visits, an audit report for the HCO and the HATC.

10.1 The Structure of the Audit Report

The audit report reflects the quality level achieved and the quality dynamic commitment by the HCO in terms of the chapters and references of the accreditation manual.
It contains the following parts:

- Summary presentation of the HCO.
- Part 1: Quality and accreditation process
  - History and organization of the quality process
  - Follow up of the previous audit procedure recommendations
- Part 2: Findings by chapter
- Part 3: Suggestions and recommendations

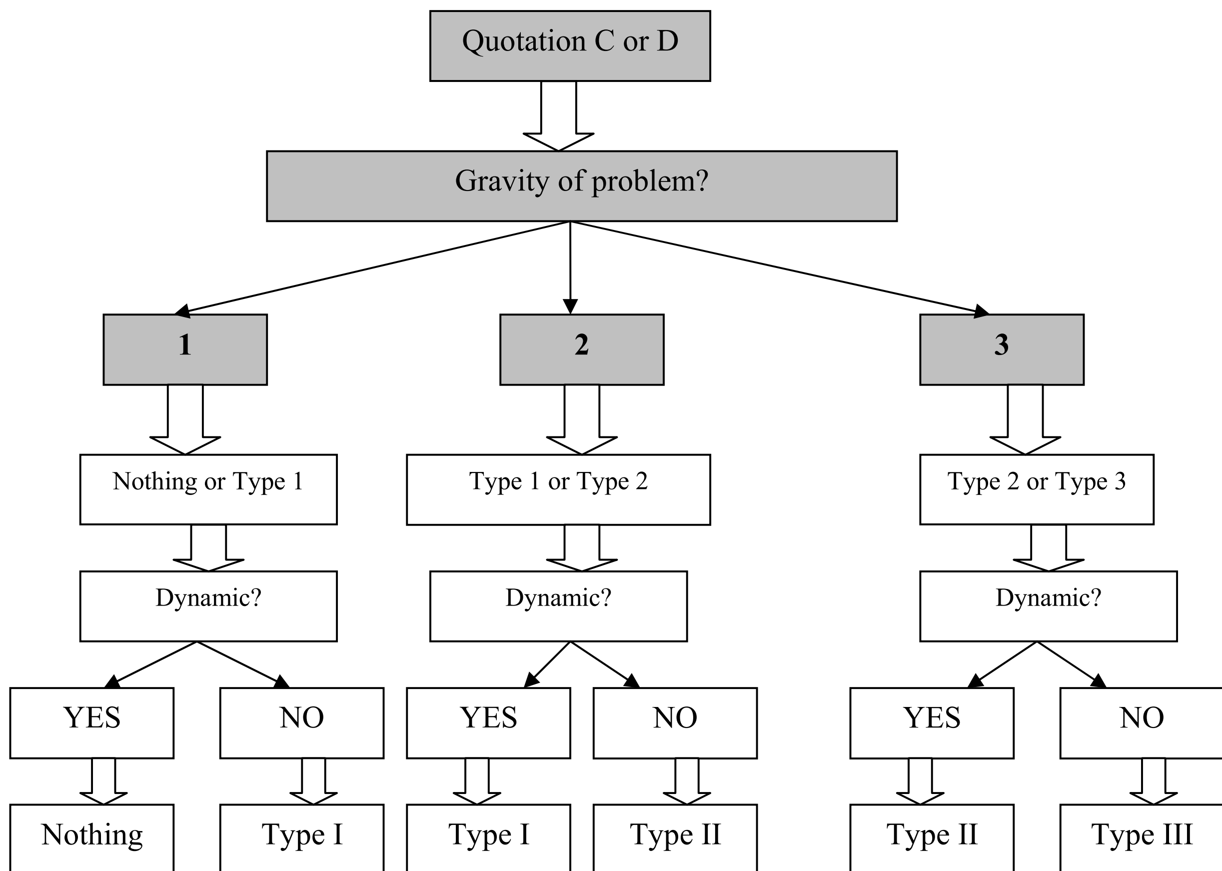
The audit report does not suggest the accreditation level. This is determined by the HATC and validated by the HANC based not only on the recommendations but also on any comment or objection raised by the HCO (cf. 8.3).

10.2 The Decisions

In the audit report, the recommendations are established and weighted according to “type I”, “type II”, or “type III” in terms of:

- The quotation/rate of the references
- The recurrence of the problems since the previous procedures
- The frequency and severity of the problem
- The level of control displayed by the HCO
- The existence of an improvement processes for the problems found

Only the references rated C or D may give the HCO a recommendation according to the following decision tree and based on the assessment by the auditors of the seriousness of the problem and if there is a dynamic process for improvement:



The decision types will determine, after the validation by the HATC, the final accreditation level based on the decision taken by the HANC (cf. 10.2).

10.3 The Audit Report Flow

The approved AO simultaneously sends the audit report to:

- The HATC
- The HCO

The HCO has a one month period after receiving the report to formulate the observations and disputes/objections.

The observations are simple comments or possible corrections of inaccuracies of the results and suggestions of the auditors. It is not about initiating corrective actions following the visit.
The comments shall be related to the decisions recommended by the auditors.

10.3.1 In case of no observations or comments

If the HCO accepts the report of the AO, it sends a letter, with acknowledgment of receipt, addressed to the HATC informing it about the decision of not having any observations or comments.

10.3.2 In case of observations or comments

If the HCO wishes to express observations and comments on the content of the report or dispute the proposed decisions, it has a period of one month as from the date of reception of the report to establish and compile the observations to the HATC by using the form presented in appendices III and IV.

The HCO cooperates, when writing the observations, with all the necessary the stakeholders and parties concerned where appropriate.
The document can include:

- The presentation of the quality process and the assessment methodology;
- The auditors' findings against the criteria of each chapter;
- The comments on the analysis of the quality system process

These comments should not be about a plan of corrective action in response to suggestions from the auditors.

These comments should not be accompanied by evidentiary documents.

The HCO must not modify the original text of the report established by the AO

XI. The Accreditation Report

The accreditation report is the final stage of the accreditation process, its objectives are to:

- Provide the HCO a measure of the quality and safety levels, and assessment of the developed quality systems;
- Provide independent information on the quality and safety of healthcare to the insurers, third party payers and other guarantors
- Inform the public about the status of quality and safety in various HCOs

11.1 The itinerary of accreditation report

Upon the receiving of the acknowledgment of receipt of the report from the HCO, the HATC analyses the different documents:

- Audit report
- Audit observations
- Audit comments and objections

On the basis of these elements, the HATC establishes a proposition of an accreditation report which will be send to the HANC for approval.

Upon the approval of the HANC, the Lebanese MOPH sends the accreditation report to the HCO and puts it on the internet site of the MOPH.

11.2 Content of the audit report

The report contains the following parts:

- Summary presentation of the HCO
- Part 1: quality and accreditation process

- History and organization of the quality process
- Follow up on the previous procedure recommendations
  - Part 2: Findings by chapter
  - Part 3: Suggestions and recommendations

The decision taken by the HANC defines the level of accreditation based on the recommendations proposed by the HATC, according to the following table:

Recommendations	Level of accreditation
No recommendations or recommendations of type I	1
At least one recommendation of type II	2
At least one recommendation of type III	3
No accreditation	4

Based on the previous part of section "V" of the present document, the accreditation duration is 3 years, from the time when the HCO has started the procedure and in case during the accreditation visits there was no serious problem in terms of safety.

11.3 The Comments

In case of disputes and comments regarding the accreditation report, the HCO can request within one month of the reception date of the accreditation report and on the basis of information collected from the initial visit, a second consideration of the HANC.
The initial decision could be maintained or modified based on the information and data provided by the HCO

XII. Financing the system

The annex IX of the document "Terms of Approval and Functioning of the Audit Organizations for the Lebanese Healthcare Organizations Accreditation" specifies the financing terms of the system, in order to ensure the efficiency and the sustainability of the process by the AO and the accreditation bodies.
Two financial streams are provided:

- From the HCO to the approved AO chosen for the audit visit.
- From the approved AO to the MOPH in order to ensure the funding of the HATC.

ANNEX I

IDENTIFICATION AND PLANNING FORM

COMPONENTS OF IDENTIFICATION AND PLANNING

<u>Heading I:</u> Identification of the Process Scope

Identification of the Healthcare Organization (HCO)		Address of the HCO						
Type	CHRU/CHU ☐	Private ☐			Public ☐			
Name and surname of the legal representative/			Direct line:		E-mail:			
Name and surname of the General Director:			Direct line:		E-mail:			
Name, surname and function of the person in charge to monitor the Accreditation:			Direct line:		E-mail:			
Mailing address for sending the procedure documents:								
Telephone Number:			Fax number for sending the procedure documents:					
For private HCO state, if applicable, the business name of the group to which the legal entity belongs to:								
Name of the main organization where the auditors will be received:								
ACTIVITIES of the HCO	Medicine	Surgery	Pediatrics	Gynecology/ Obstetrics	Psychiatry	Dialysis	Blood Bank	Cardiac Cath
HCO Name 1 (main):	☐	☐	☐	☐	☐	☐	☐	☐
HCO Name 2:	☐	☐	☐	☐	☐	☐	☐	☐
HCO Name 3:	☐	☐	☐	☐	☐	☐	☐	☐

Heading 2: Hospital activity and capacity of all HCO involved in the process

DATE: / /	**Complete Hospitalization**		**Partial Hospitalization (day, night)**		**Ambulatory care and treatment**		
	Beds present	Number of days	Number of places	Number of units	Total number of sessions	Dialysis Sessions	Number of dialysis units*
Medicine							
Surgery							
Medical Reanimation							
Surgical Reanimation							
Gynecology/obstetrics, neonatology and neonatal reanimation							
SUB-TOTAL of Short term care							
General psychiatry							
Infant-Juvenile psychiatry							
PSYCHIATRY SUB-TOTAL							
TOTAL							

(*) For the dialysis, thank you for mentioning the number of dialysis units and the number of patients

Heading 3: Quality Process

Date of the last accreditation visit:

Summarized Description of the organization quality set up in the Organization (responsible staff, concerned parties, bodies, actions…):

Annex II

Auto-Evaluation Matrix

Name of the Hospital:

AUTO-EVALUATION MATRIX

QUALITY SYSTEMS

Name of the Auto-Evaluation Team Leader:

Name of the Staff that Participated in the Auto-Evaluation:

Auto-Evaluation Matrix

<table>
<tr><td colspan="4">Standard 1</td></tr>
<tr><td>Criteria (Sub Clauses of the Standard)</td><td>Response
(Yes, Partially, No)</td><td>Comments
(Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).</td><td>Quotation of the Standard</td></tr>
<tr><td>1.1. A current organizational chart of the staffing structure of the hospital exists</td><td></td><td></td><td></td></tr>
<tr><td>1.2. A current organizational chart of the committee structure exists</td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Proposed Action for Improvement</td><td colspan="3">Analysis of the Standard</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Documents of Proof:

Auto-Evaluation Matrix

Standard 2: An annual wide quality improvement exists which includes sections for			
Criteria (Sub Clauses of the Standard)	**Response** (Yes, Partially, No)	**Comments** (Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).	**Quotation of the Standard**
2.1. Management			
2.2. Finance			
2.3. Medical Services			
2.4. Nursing Services			
2.5. General Services			
2.6. It must key performance / indicators that are specific, measurable, achievable, realistic and have timelines			
2.7. Evidence of continual monitoring of this plan must be available			
Proposed Action for Improvement	**Analysis of the Standard**		

Documents of Proof:

Auto-Evaluation Matrix

Standard 3: A multi-disciplinary quality improvement committee exists with			
Criteria (Sub Clauses of the Standard)	**Response** (Yes, Partially, No)	**Comments** (Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).	**Quotation of the Standard**
3.1. Terms of reference			
3.2. List of members			
3.3. Minutes of all meetings			
3.4. Documented monitoring of the quality improvement plan is conducted at least quarterly			
Proposed Action for Improvement	**Analysis of the Standard**		

Documents of Proof:

Auto-Evaluation Matrix

Standard 4			
Criteria (Sub Clauses of the Standard)	**Response** (Yes, Partially, No)	**Comments** (Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).	**Quotation of the Standard**
4.1. An annual report is presented to the management of the hospital in relation to the quality improvement plan			
Proposed Action for Improvement	**Analysis of the Standard**		

Documents of Proof:

Auto-Evaluation Matrix

<table>
<tr><td colspan="4">Standard 5</td></tr>
<tr><th>Criteria (Sub Clauses of the Standard)</th><th>Response
(Yes, Partially, No)</th><th>Comments
(Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).</th><th>Quotation of the Standard</th></tr>
<tr><td>5.1. A staff member is designated as the quality improvement coordinator (however named) with specific time allocated to the role as reflected in their job description</td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Proposed Action for Improvement</td><td colspan="3">Analysis of the Standard</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Documents of Proof:

Auto-Evaluation Matrix

Standard 6			
Criteria (Sub Clauses of the Standard)	**Response** (Yes, Partially, No)	**Comments** (Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).	**Quotation of the Standard**
6.1. Each department conducts an annual assessment of the continuing education requirements of staff and forwards the report to either the education department (if applicable) or to the quality coordinator			
6.2. Copies of each department education program are held by the quality improvement committee			
Proposed Action for Improvement	**Analysis of the Standard**		

Documents of Proof:

Auto-Evaluation Matrix

<table>
<tr><td colspan="4">Standard 7: A documented policy and procedure for complaints exists for</td></tr>
<tr><td>Criteria (Sub Clauses of the Standard)</td><td>Response
(Yes, Partially, No)</td><td>Comments
(Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).</td><td>Quotation of the Standard</td></tr>
<tr><td>7.1. Patients</td><td></td><td></td><td></td></tr>
<tr><td>7.2. Staff</td><td></td><td></td><td></td></tr>
<tr><td>7.3. Visitors/Others</td><td></td><td></td><td></td></tr>
<tr><td>7.4. Investigation and resulting actions from complaints are documented</td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Proposed Action for Improvement</td><td colspan="3">Analysis of the Standard</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Documents of Proof:

Auto-Evaluation Matrix

<table>
<tr><td colspan="4">Standard 8</td></tr>
<tr><td>Criteria (Sub Clauses of the Standard)</td><td>Response
(Yes, Partially, No)</td><td>Comments
(Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).</td><td>Quotation of the Standard</td></tr>
<tr><td>8.1. A system exists for determining patient and staff satisfaction</td><td></td><td></td><td></td></tr>
<tr><td>8.2. Analysis is conducted regarding patient and staff satisfaction</td><td></td><td></td><td></td></tr>
<tr><td>8.3. Documented planned intervention to address any deficits identified</td><td></td><td></td><td></td></tr>
<tr><td>8.4. Documented evidence is required to demonstrate that the actions have taken place and results have been re-audited</td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Proposed Action for Improvement</td><td colspan="3">Analysis of the Standard</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Documents of Proof:

Auto-Evaluation Matrix

Standard 9			
Criteria (Sub Clauses of the Standard)	**Response** (Yes, Partially, No)	**Comments** (Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).	**Quotation of the Standard**
9.1. An improvement log process is operational			
9.2. The improvement log(s) show evidence of the quality feedback loop			
Proposed Action for Improvement	**Analysis of the Standard**		

Documents of Proof:

Auto-Evaluation Matrix

Standard 10			
Criteria (Sub Clauses of the Standard)	**Response** (Yes, Partially, No)	**Comments** (Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).	**Quotation of the Standard**
10.1. There is a suggestion box for staff and patients			
Proposed Action for Improvement	**Analysis of the Standard**		

Documents of Proof:

Auto-Evaluation Matrix

Standard 11			
Criteria (Sub Clauses of the Standard)	**Response** (Yes, Partially, No)	**Comments** (Write the important information relative to the standard, while specifying the actions done, in progress or scheduled and the potential differences between activities).	**Quotation of the Standard**
11.1. Documented patients rights and responsibilities are available to all patients and relatives			
Proposed Action for Improvement	**Analysis of the Standard**		

Documents of Proof:

Auto-Evaluation Matrix

ANALYSIS OF THE AUTO-EVALUATION OF THE "QUALITY SYSTEMS"

Strengths:

Proposed actions:

Actions to be implemented by the establishment		
The responsible of the action	**Objective**	**Results**

ANNEX III

THE AUDIT REPORT COMMENTS DOCUMENT

Healthcare Organizations are: **Date of dispatch:**

COMMENTS ON THE AUDITORS REPORT

The comments include summary presentation of the HCO, "part 1" Quality and accreditation process and "part 2"comments by chapter".

Concerned **Elements** (Col.1)	**Nature of the HCO observations** (motivation of the change requested and expected changes on the elements of the report) (Col.2)	**Analysis of the comments by the audit responsible** (Col.3)	**Potential Comments** of the HAS (Col.4)
PRESENTATION OF THE HCO			
PART 1: QUALITY AND ACCREDITATION PROCESS			
		Accept ☐ or refuse ☐ If refused, comments:	
		Accept ☐ or refuse ☐ If refused, comments:	
		Accept ☐ or refuse ☐ If refused, comments:	

HCO NAME: **Date of dispatch:**

Concerned **References** (Col.1)	**Nature of the HCO observations** (motivation of the change requested and expected changes on the quotations of the report) (Col.2)	**Analysis of the comments by the audit responsible** (Col.3)	**Potential Comments** of the HAS (Col.4)
PART 2 - COMMENTS BY CHAPTER			
		Accept ☐ or refuse ☐ If refused, comments:	
		Accept ☐ or refuse ☐ If refused, comments:	

ANNEX IV

THE AUDIT REPORT DISAGREEMENT DOCUMENT

The HCO can consult with the HATC of any disagreement to the audit report.

The HCO can dispute:

- The decision,
- The criteria affected by the decision,
- The process affected by the decision
- The actions of EPP affected by the decision.

Therefore, the HCO should fill the following table, in the assigned part stating:

- The name and the file number
- The concerned decision by clarifying its wording and the annexed references
- The arguments in support of the disagreement

<u>This table will be duplicated as many times as needed as long as there are decisions to disagree with.</u>

This document, once filled, should be communicated to the HATC for analysis.

TABLE FOR THE DISAGREEMENTS OF THE AUDIT REPORT DECISIONS

Name of the Healthcare Organization (HCO): **File number:**

<table>
<tr><td>Decision:
Criteria concerned and wording of references:</td><td>Filling part by the HCO</td></tr>
<tr><td colspan="2">Argument of the HCO</td></tr>
<tr><td>Reference Number</td><td>Arguments supporting the disagreement</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">Request of the HCO for the decision:</td></tr>
<tr><td colspan="2">Analysis of the Hospital Accreditation Technical Committee (this part is reserved for the HATC)</td></tr>
<tr><td colspan="2">Admissibility **: yes ☐ no ☐
**Tick the corresponding box</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Proposal for decision after the disagreement by the HCO</td><td>Reserved section for the HATC</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Each decision should have a table: this table should be duplicated as many times as there are decisions to comment on by the HCO.