

# An Overview of Hospital Accreditation: What can Lebanon learn from other countries?

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Hospital accreditation has been defined as "A self-assessment and external peer assessment process used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve". Reduction of medical error, improvement of healthcare services, and maintenance of patient safety are key roles of the accreditation process. Accreditation is opposed to licensing or regulation of healthcare facilities, which is usually mandatory and state-imposed. Central to accreditation are two features: the principle of external review and the use of standards.

Hospitals are vital components of any advanced, well-organized and humane society, they need to be safe, not only for patients but for the staff and general public. Many governing bodies are concerned with hospital safety and quality of health care services such as governments, NGO's providing healthcare services, and professional organizations like the order of physicians and syndicate of hospital. However, ideally, the functioning and finance of hospital accreditation schemes should be independent of government control as it has been shown in different countries.

This paper will present selected hospital accreditation schemes that are available worldwide showing their differences and similarities and introducing some of the lessons that Lebanon can take from other countries in order to improve its accreditation system.

There are two main types of hospital accreditation:

- 1) Hospital accreditation that takes place within national borders
- 2) International healthcare accreditation

## ***National hospital accreditation schemes***

There are different national accreditation schemes with varying quality, size, intent and marketing skills. They also vary considerably in terms of the cost incurred by hospitals and healthcare institution and have varying degrees of commitment to assessing medical ethical and clinical standards. Some of the well-known providers of national healthcare accreditation services are listed below:

- Australian Council for Healthcare Standards International, or ACHSI - based

in Australia

- Canadian Council on Health Services Accreditation, or CCHSA - based in Canada
- Malaysian Society for Quality in Health, or MSQH - based in Malaysia
- Trent Accreditation Scheme, TRENT - based in UK-Europe and Hong Kong
- The Netherlands Institute for the Accreditation of Hospitals, NIAZ - based in the Netherlands
- Joint Commission (JC) - based in the USA
- Community Health Accreditation Program (CHAP) - based in the USA
- Accreditation Commission for Health Care Inc. (ACHC) - based in the USA
- The Compliance Team: "Exemplary Provider Programs" - based in the USA
- Healthcare Quality Association on Accreditation (HQAA) - based in the USA
- TUV Healthcare Specialists - based in the USA

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## **International healthcare accreditation**

Some national accreditation schemes providers also undertake international healthcare accreditation work. The Trent Scheme was the first to accredit a hospital in Hong Kong in 2000. Since then others such as Joint Commission International (JCI) have entered the market. The USA has a large number of accreditation schemes, with the Joint Commission, or JCI, being the best known. The cost of becoming JCI accredited may be considerable. The Canadian Council on Health Services Accreditation is another provider of international hospital accreditation with several Middle Eastern countries as customers.

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## **Hospital Accreditation in selected countries**

### **UNITED STATES**

The first initiative towards accreditation was taken in the United States of America around 1917, following the initiative of E A Codman, when surgeons decided that they would not operate in hospitals that did not provide them with a minimum standard of quality in their working conditions. Over a period of time after several experiments and developments, the Joint Commission on Accreditation of Healthcare Organization (JCAHO), a national accreditation program, established itself as an esteemed accreditation body by 1987 and by 1993, almost 80% of American hospitals were covered by JCAHO. JCAHO has high standards of quality assurance and rigorous process of evaluation, which makes it a much-esteemed agency for accreditation. Health services certified by JCAHO are given 'deemed status'. Subsequently, models building on the American approach have been developed in Canada and Australia.

JCAHO is by far the largest accrediting agency. The corporate members of the 'Joint Commission' include the American Medical Association, the American Hospital Association, the American College of Physicians, the American Society of Internal Medicine, the American College of Surgeons, and the American Dental Association. Operations are directed by 28 members of the Board of Commissioners for JCAHO. Commissioners consists of seven members from the American Hospital Association, one nurse, one dentist, six members from the public, and the rest are appointed by the American Medical Association, American College of Physicians, or American College of Surgeons. JCAHO has been given a lot of weight during the past years. Hospitals need to pay on average 23,000 USD to participate in JCAHO surveys. In addition, institutions need to be JCAHO accredited in order to be able to participate in Graduate medical education programs and insurance companies often use JCAHO as a verification of payment eligibility. For a JCAHO inspection, a team (a medical doctor, a registered nurse, and a hospital administrator) conducts a "Full Survey" of each participating medical facility every three years.

JCAHO examines the hospital, the prescribed procedures on the units, evaluates records, interviews staff and patients, and observes the actual practice of hospital employees. The hospital receives scores in 45 performance areas based on compliance with approximately 500 standards. The compliance with a standard depends on the state of nature in which the hospital is performing. In other words, it attempts to determine whether the medical facility is giving appropriate care

under its circumstances. The effect of this arrangement should be that the JCAHO survey score is functionally a normalized score; that is, each score measures how well the hospital performed relative to patient needs. Significant non-compliance with specific performance standards results in a follow-up survey to re-inspect those standards. The re-inspection is the only incremental penalty. Severe non-compliance with standards can result in the loss of accreditation after a lengthy appeals process. A series of studies have shown that JCAHO accredited hospitals outperformed those who are not and have lower patient mortality and better quality of care. In order to receive Medicare funds, hospitals in the US need to be either state accredited or accredited by a national accreditation scheme. In addition, JCAHO results are available to the public which is an indirect incentive for hospitals to provide good medical services.

On the other hand, JCAHO's accreditation process was criticized for being too "collegial" with hospitals, for using a survey process that was unlikely to identify poor patterns of care, and for generating survey results that do not distinguish high and low quality hospitals. A report in 2004 by the Government Accountability Office (GAO) found that JCAHO failed to detect significant hospital safety and performance problems. As a response to the report, JCAHO increased regulatory activity and began unannounced re-inspections of hospitals that had substandard areas in the Full Survey. JCAHO has announced that they will move to an unannounced triennial survey strategy by 2006. By specifying a period of time between inspections and a set of standards that must be inspected, it limited the concern of the conflict of interest between JCAHO and the hospitals. JCAHO does have the discretion to make the standards stricter and the duration shorter. With an unannounced strategy, hospitals will roughly know when JCAHO is due to arrive, but not the date. Therefore, hospitals will have the ongoing incentive to maintain survey readiness.

### **CANADA**

In Canada, the move towards accreditation started in 1952 with the initiative from the medical profession similar to the United States. Presently, the Canadian Commission

on Hospital Accreditation is the sole agency to accredit hospitals and enjoys complete monopoly. The Canadian Council on Health Services Accreditation (CCHSA) is a not-for-profit organization independent of government that sets standards for, evaluates and accredits healthcare organizations in Canada and several other countries including Saudi Arabia, Abu Dhabi, Bahrain, UAE, and Bermuda. The CCHSA has also provided mentoring for a number of nations as they developed their own accreditation systems, including France, Italy and Ireland.

The Canadian Accreditation scheme is an inspirational process based on achievable standards, voluntary participation, arms-length from government and peer review. This is in contradistinction to compulsory minimum standard models that are the hallmark of government operated accreditation in some countries including Belgium, France and Scotland. The focus of accreditation is to help organizations understand what they are doing well and what opportunities are available for improvement. In compulsory government accreditation programs, the focus is on what organizations do that is hazardous or harmful.

In 2001, the CCHSA introduced the Achieving Improved Measurement (AIM) Accreditation Program. The Canadian approach to accreditation is a rigorous peer review process comprised of a self-assessment against a set of standards, an on-site survey and follow-up action on recommendations that arise from the survey. In Canada, the process occurs over a three-year cycle. The standards are national in scope and allow for both standardization and benchmarking against similar organizations throughout Canada. The standards were developed and are updated using a broadly based consultation process with input from healthcare professionals across Canada. The standards address patient care issues within a quality framework that defines the program. The quality framework is applicable to the organization as a whole and is based on four quality dimensions: Responsiveness, System Competency, Client/Community Focus and Work-life. The quality dimensions represent a balanced scorecard relevant to healthcare organizations within which organizations may structure their quality improvement

initiatives. Surgery and all other care teams function within this framework. While the quality framework underpins the accreditation program, it also forms a basis for delivery of acute care services such as surgery.

In the self-assessment process, accreditation teams assess their relative strengths and identify opportunities for improvement. During the on-site survey, the self-assessment is validated by peer surveyors. The surveyors also identify exceptional practices that are publicized by the CCHSA in order that all Canadian healthcare organizations may benefit from the knowledge. The accreditation survey consists of four standards sections common to all organizations. These are Leadership and Partnership, Human Resources, Environment and Information Management. In addition, there are 15 client services standards.

### **LATIN AMERICA AND CARIBBEAN COUNTRIES**

Accreditation in Latin American and the Caribbean countries have begun in the early nineties with the release of a set of hospital standards by the Pan American Health Organization (PAHO) and the Latin American Federation of Hospitals. The ministry of health of Argentina and the Argentina Society of Medical Auditing prepared the original draft of the PAHO manual with inputs from other experts. The standards have two dimensions: compulsory minimum standards and the non-compulsory standards. Compulsory minimum standards have five areas of evaluation namely the organization of medical care, technical and support areas, building documentation, functional physical structure and installations.

After several sub-regional meetings, different countries chose accreditation schemes that fit their needs. Some countries such as Bolivia, Peru, Cuba, Guatemala and the Dominican Republic adopted a modified version of the PAHO manual. Venezuela and Trinidad and Tobacco adopted the JCAHO manual. Brazil also adopted a modified version of the PAHO manual in some of its states while Rio de Janeiro signed a contract with JCAHO. Mexico is a pioneer in Latin American countries in encouraging the quality of care movement and in developing accreditation standards through the National Institute of Public Health and its collaboration with CCHSA. Finally, Argentina, given its leading role in the development of the PAHO manual, strictly follows this manual making adjustments and updating it accordingly.

### **AUSTRALIA**

In Australia, accreditation was introduced in 1926, with the state initiative but it was only in the early seventies that the Australian Council on Hospital Standards was set up. Though the accreditation program has not received a very extensive coverage, it assures interested groups that health professionals consider it a responsibility to monitor their standards of performance. It has with other medical colleges, developed a set of clinical outcome indicators for accreditation.

### **UNITED KINGDOM**

In the United Kingdom, there have been multiple attempts to devise and measure standards. As a result, there are many accreditation systems like the King's Fund Organizational Audit, the Hospital Accreditation Program, Trent Community Hospital, and the South

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Western Health Records. The regional health authorities have supported some of them. Among them, The King's Fund Organizational Audit Program and the Hospital Accreditation Program are significant.

## FRANCE

Accreditation was first performed in France in 1996 by a government decision that was taken without consulting of parliament as a result of high healthcare costs. Unlike the United States and Canada whereby the accreditation was introduced by the medical professions, accreditation in France was introduced by the government against the opposition of the medical profession.

The accreditation body in France consists of an agency, a manual and surveyors. The agency is the Agence Nationale pour l'Accréditation et l'Evaluation en Santé (ANAES). Its members are appointed by the Minister of Health and it is financed one third by the Department of Health, one third by the National Health Insurance fund, and the remainder by the survey fees of the hospitals. A notable feature of ANAES is the importance of professional representation: the health professions comprise at least three quarters of the board and more than half are medical doctors. The accreditation manual is compiled by the ANAES with the help of several healthcare professionals including physicians. The manual contains information on patients and patient care, management and organization, and quality and prevention. The surveyors are well-trained health professionals.

Accreditation moved from being voluntary to compulsory and the procedure consists of self-assessment followed by the survey visit and a report, the purpose of which is to assess the compliance of the hospital with the standards defined in the accreditation manual. Results of the accreditation are made available to the public and surveys are repeated at least every 5 years to insure continuity of quality improvement. The patient is at the center of the accreditation process in France.

## NETHERLANDS

The Netherlands Institute for Accreditation of Hospitals (NIAZ) was established in 1998 by the Netherlands hospital association, the Netherlands association of university hospitals and the Netherlands organization of medical specialists. NIAZ is independent from the government and was established as a result of increase in healthcare costs and following a need to maintain quality of care. The Canadian model of accreditation was mainly followed to establish the NIAZ standards which were validated in the Dutch environment. Accreditation is a voluntary peer-review process and is performed once requested by the hospital management. It has no financial incentives. The accreditation process consists of two phases: in the first phase, the hospital writes a self-evaluation report explaining how and whether the requirements in the standard quality system are met. Based on this report, surveyors decide whether the hospital is expected to qualify for an accreditation certificate and select which departments they need to inspect further to evaluate the quality system in practice. In the second phase, the selected departments are expected to undergo a self-evaluation by means of the department-specific accreditation

guides. Moreover, the departments submit their quality documents to the surveyors for review. After analysis of these documents, the surveyors visit the selected departments, interview the persons they have selected and inspect the effectiveness of the quality system in daily practice. In addition, surveyors may also check on departments that have not prepared themselves. The surveyors then prepare a report including strong areas and areas that need improvement and advise NIAZ whether to grant accreditation. The hospital is then required to write an action plan. Following these steps, accreditation is granted normally for four years with continuous monitoring if the hospital meets the following requirements:

- Demonstration of a culture for improvement
- Being in the 'to do' phase of the PDCA cycle in each part of the 'quality system'
- The safety of the employees, patients and environment is assured.

## What can Lebanon learn from other countries experiences?

In Lebanon, hospital accreditation is supervised by the ministry of health (MOH) and was introduced as a tool to decrease health care costs and improve quality of care. Given that half of the population is covered by the MOH in Lebanon, accreditation was also used as an incentive since the MOH will only contract with those hospitals that are accredited (which still needs to be enforced). Using this incentive has been shown to be favorable in the United States whereby Medicare is only provided in JCAHO accredited hospitals. A new incentive that could be introduced in Lebanon, based on the US experience, is financial coverage by insurance companies, national social security funds and other third party payers only in those hospitals that follow accreditation standards. In addition, accreditation results could also be used to govern acceptability of hospitals in graduate medical education program. Moreover, disclosure of accreditation results to the public is expected to drive hospitals to maintain appropriate quality in healthcare. The media plays a major role in Lebanon and this could be used to communicate results of the accreditation process to the public and educate future patients on their rights for an

excellent quality of care and safety.

Although in the majority of countries, accreditation is an independent body separate from the government, experience from different countries including the US has shown that a supervisory agent is needed on the accreditation agency. Therefore, while accreditation should move to become independent from the MOH in Lebanon, the ministry of health needs to continue to act as a supervisor of the accreditation process. Having different sources of financing the accreditation process like in the US, Canada, and the Netherlands would insure independence of the organization and less outside interference. The culture of quality of care and continuous improvement needs to be progressively introduced into the hospital culture in order to insure continuous application of quality services. In fact, accreditation in several countries has been a one time process every few years and evidence has shown that hospitals work hard to apply accreditation standards just before the accreditation team comes to visit. Hence, educating hospital staff and management about the benefits of continuous quality improvement on their own organization is needed.

A study by Jardali and colleagues assessing the improvement of quality of care after implementation of accreditation among Lebanese nurses showed that accreditation improved quality of care especially in small and medium sized hospitals which supports the need to maintain accreditation and enhance its indicators to fit patient safety. There is a need to assess accreditation in Lebanon based on patient outcomes. In addition, patients' opinion about the accreditation process and whether improvements in services and outcomes have occurred as result of accreditation need to be further investigated. The accreditation system in Lebanon could be also improved by adding more indicators that are outcome-oriented and client-centered following the Canadian model.

## Aging-related memory loss: what's normal, what's not

Data are stored in different parts of the brain and categorized under long-term, short-term and recent memory. Childhood memories are stored in the remote memory compartment. After the age of 20 years, brain cells start to die and the body starts producing less of the chemicals that turn neurons on. Aging thus makes it harder to recall stored information, and defects in the recent memory are normal. However, some memory problems are not part of normal aging:

- Forgetting how to do things one has done many times before.
- Trouble learning new things.
- Repeating phrases or stories in the same conversation.
- Trouble making choices or dealing with money.
- Not being able to keep track of what happens every day.

Any of these problems urges medical attention.

## Heart Disease in Women

There are an increasing number of women dying from heart disease, because they often ignore the symptoms, mistaking the pain for what they describe as achy, tight or heavy feeling. The signs of heart disease in women are different from those in men and they include:

- Trouble breathing and/or sleeping.
- New or worse aches in the chest and head.
- Pain above the belly button, in the back between the shoulders in the chest, spreading to the jaw, neck, ear or inside of the arms.
- Feeling sick to the stomach.
- Feeling scared or nervous.

## Alcohol drinking and youth

It is possible to drink alcohol safely and legally when above 21 years of age. Alcoholism is a rough word to handle, yet nobody is too young or too old to get hit by alcoholism which is an illness. Although it is sometimes embarrassing to ask for help, especially for young alcohol abusers, there are some points that urge attention. Therefore, if you or your friends are experiencing any of the following, ask for help:

- You drink because you have problems or to relax.
- Your performance at school or work is deteriorating.
- You gulp your drinks.
- You get into trouble when drinking, even if you try avoiding it.
- You drink when you get mad at others, friends or parents.
- You ever tried to stop drinking and failed.
- You experience memory loss or concentration problems because of your drinking.
- You started drinking in the morning or out of occasions.
- You lie about your drinking.

There is no shame in asking for help, because alcoholism and other addictions are curable diseases if dealt with appropriately.