Evaluating the Extent of Application of Quality Standards (JCI) in Health Facilities

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Abstracts

The current study aims to know the importance of applying the Joint Commission International (J.C.I.) quality standards in health facilities, what are the objectives of the J.C.I. standards, and what are the requirements for their application in health facilities. A questionnaire was prepared via Google and distributed to the population aged 25- 55-year-old men and women in the city of Mecca, with 600 questionnaires, which were distributed via the social networking program (WhatsApp) via mobile phone, and 590 answers were obtained via email. Quality standards in general are very important, in order to provide high-quality health service at the lowest costs and without waste. Therefore, these standards help greatly in communication and coordination between health service providers on the one hand and those who urgently need this service, and they also achieve patient safety standards to a large extent.

Keywords: evaluating, the extent, application of quality standards, (JCI), health facilities.

1. Introduction

Quality is deemed a key factor in the delivery of patient care, and initiatives to determine the quality of care delivered to patients has become the focus of attention worldwide (1).

Measurement of healthcare quality can be done in different ways including self-assessment, benchmarking against other institutions, and external assessment by an independent organisation. External assessment by an independent organisation is a widely used approach. The National Agency for Healthcare Accreditation and Evaluation defines the accreditation process as "an evaluation process carried out by independent professionals external to the health care organisation and its governing bodies, focusing on its functioning and practices as a whole. It aims to ensure that conditions regarding the safety, quality of care and treatment of patients are taken into account by the health care organisation" (2). In 2000, the World Health Organization conducted a study which revealed that no accreditation programmes were in place in the East Mediterranean (3). Since then, many countries in the region have rushed toward implementing international accreditation standards in the healthcare sector (4). Saudi Arabia is one of the countries engaging in such a programme in the region with the aim of accrediting all of its hospitals within the next few years. More than 70 healthcare facilities had been accredited when this thesis was undertaken. However, studies have failed to link any improvement in performance to the accreditation process. Furthermore, adopting such an accreditation programme is expensive, using resources that could be spent elsewhere. Quality does not have one single definition; instead, it can be defined in various ways. Although few could provide a definition of quality in the context of healthcare, people often think they know quality when they see it, which suggests that quality lies in the eye of the beholder. Pioneers and other contributors to the field of quality have offered a wide range of alternative definitions, such as: Quality means a predictable degree of uniformity and dependability at a low cost with quality suited to the market. (5) Quality means fitness for use. (6) Quality is conformance to requirements. (7) Quality is meeting customers' (agreed) requirements, formal and informal, at the lowest cost, first time and every time. (8). Garvin is one of the authorities on quality who has examined different quality definitions, classifying them into five categories (9): • Transcendental: achieving the highest standard, excellence; • Product-based: related to the attributes, fitness for use; • User-based: satisfying customer's needs and wants; • Manufacturing-based: conformance to requirements; • Value-based: excellence at an acceptable price. The literature on quality development in healthcare reveals discrepancies in terms of time spans, with historical references to the beginnings of the quality movement ranging from 30 to 3,000 years ago. According to Ellis and Whittington (10), quality initiatives in healthcare dated back to ancient Egypt, China, Assyria, Rome, and Greece. They refer to this as the "Embryonic" stage of quality assurance. However, healthcare is now much more complex, so we may have more to learn from the more recent past of quality assurance. Many would consider this began with Florence Nightingale, a social reformer and statistician, and founder of modern nursing. Ahead of her time, she tracked death rates in hospitals during the Crimean War, and attempted to link these to potential contributing factors, in the hope of improving the delivery of patient care. Nightingale's improvement strategy met with resistance from medical staff, but her efforts were supported by the government, allowing her to continue her strategy to improve sanitation and living conditions in hospitals for the soldiers. In the early 20th century, Medical Education in the United States and Canada. which suggested standards should be introduced for the training of medical students, and an evidence-based approach to the choice of services and products in hospitals, "To ensure quality patient care while adhering to fiscal responsibility". The 1960s and 1970s are considered to be the beginning of formal quality assurance in healthcare as we now know it. The 1980s and 1990s

witnessed the application of the latest quality models. These are "total quality management" (TQM) and "continuous quality improvement" (CQI). These two models differ from the previous model of quality assurance in that they require an ongoing effort from all employees of an organisation to continuously improve meeting the needs and expectations of patients. In a sense, quality assurance is about meeting predefined standards: quality improvement is about exceeding them. (11) concluded that "what constitutes quality is linked to an individual's values and expectations" (p. 21). Therefore, exploring these values from the position of involved parties such as patients, communities, and health professionals is the only way to define quality (11). Professionals with different areas of interest tend to define quality according to their own practical experience, which ultimately contradict each other (Seawright & Young, 1996). Seawright and Young also stated that most contributors to quality literature are practitioners. Their definitions of quality arise from their experience within their specific field of interest. These practitioners, however, are not demonstrating conflicting views when defining quality, but rather examining a different range of perspectives (12). This claim was supported by Reeves & Bednar who stated that it is worth examining the origins of different quality definitions, recognising their weaknesses and strengths relating to managerial. usefulness, measurement and generalizability, and conformance to specifications, and selecting one over another according to different circumstances (13). Despite these arguments stating that quality has no single accepted definition and varies according to the circumstances, there are still some common concepts of quality in the healthcare system. Campbell and colleagues proposed that there are two essential aspects when defining quality of care; these are access and effectiveness (14). They defined quality healthcare in the following terms: Whether individuals can access the health structures and processes of care that they need and whether the care received is effective. The Joint Commission is a 501(c) tax-exempt, non-profit organization based in the United States (15). The commission accredits more than 22,000 U.S. health care organizations and programs (16). The international branch of the committee accredits medical services around the world. The majority of US governments recognize Joint Commission accreditation as a condition of authorization to receive Medicaid and Medicare payments (17). The committee's headquarters is located in Oakbrook Terrace, Illinois, a suburb of Chicago (18). Joint Commission International (JCI) was founded in 1998 as a division of the Joint Commission, a non-profit organization engaged in international accreditation, consulting, publications, and educational programs. JCI also expands JCI's reach around the world by helping to improve the quality of patient care, assisting international healthcare organizations, public health agencies, ministries of health and others in assessing, improving and demonstrating the quality of patient care; And enhancing patient safety in more than 60 countries (19). International hospitals seek accreditation to demonstrate quality, and JCI accreditation can be considered a seal of approval by medical travelers from the United States (20).

2. Material and Methods:

The study started in (the holy city of Mecca in Saudi Arabia), began writing the research and then recording the questionnaire in January 2024, and the study ended with data collection writing and end the study in June 2024. The researcher used the descriptive analytical approach

that uses a quantitative or qualitative description of the social phenomenon (evaluating the extent of application of quality standards (JCI)in health facilities) The independent variable (application of JCI quality standards globally) and the dependent variable (application of JCI quality standards in Mecca), This kind of study is characterized by analysis, reason, objectivity, and reality, as it is concerned with individuals and societies, as it studies the variables and their effects on the health of the individual, society, and consumer, the spread of diseases and their relationship to demographic variables such as age, gender, nationality, and marital status. Status, occupation (21), And use the Excel 2010 Office suite pie chart to arrange the results (22). A questionnaire is a remarkable and helpful tool for collecting a huge amount of data, however, researchers were not able to personally interview participants on the online survey, only answered the questionnaire electronically, it consisted of ten questions, all of which were closed.

3. Results and discussion:

The percentage of approval to participate in responding to the questionnaire (evaluating the extent of application of the Joint International Commission quality standards in health facilities) was 100%, and the age of the participants was as follows: from 25-34 years old 41.7%, and from 35-44 years old 50%' and from Age 45-55 years: 8.3%. Their gender is as follows: the percentage of males is 25%, the percentage of females is 75%. Their nationalities are as follows: Saudis 75%, non-Saudis 25%. As for marital status: married 66.7%, single 33.3%, divorced 0%, widower 0%. As for educational status, it was as follows: not working (cause) and student 8.3% (same percentage), government employee 83.3%, retired 0%, self-employed 0%. As for moving on to answer the questionnaire the results were as follows: Do you know the quality standards (Joint Commission International) (JCI)? Yes, 85.3% and No, 41.7%. The second question: Do you know what types of JCI standards are? Yes, 54.5% and No, 45.5%. The third question: Do you know what the patient safety goals are according to the Joint Commission standards? Yes 83.3% and no 16.7%. Question Four: Are the Joint Commission International quality standards applied in health centers and hospitals? Yes 90.9% and no 9.1%. The fifth question: Have health centers recently obtained international quality standards? Yes, 90.9% and No, 9.1%. The sixth question: Have the hospitals obtained the Joint Commission International standards? Yes 91.7% and no 8.3%. Question Seven: Is there a difference between health facilities that applied International Commission standards and those that did not apply quality standards (Joint Commission International)? Yes 91.7% and no 8.3%.

From the participants' responses, the following result became clear: They are fully aware of the Joint Commission International standards, that there are health facilities (health centers and hospitals) that apply these standards, and the application of the standards has led to a reflection of the health service provided to the patients.(Table.no.1)(figure No.1).

Table.no.1: percentage of males and females

males	females
25%	75%

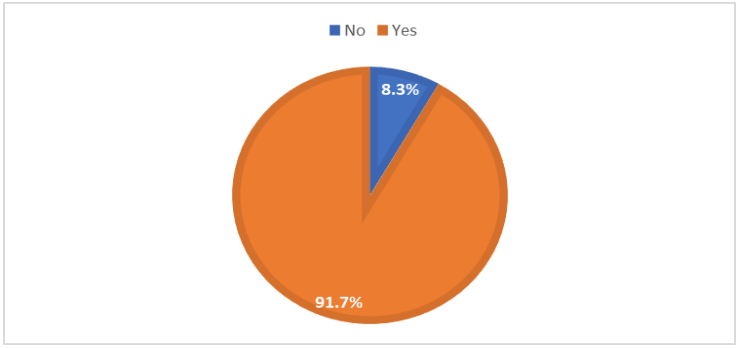

Figure No,1: Responses of participants in the questionnaire on the application of quality standards (JCI) from health facilities

4. Conclusion:

These standards help a lot in communication and coordination between health service providers on the one hand and those who urgently need this service, as they achieve patient safety standards to a great extent. The results of the study made it clear through the participants that the standards of quality, diversity, and competition in obtaining them, whether (CBAHI, Joint Commission International, etc.), are important in providing excellent health service at the lowest costs to the community, and my study is completely different from the result of the study of Ali Al Mansour (23) which says that It does not allow for definitive versions but at least there is no evidence of its existence purpose of Accreditation This belief is completely incorrect.

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