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CRITICAL ANALYSIS OF PATIENT AND FAMILY EDUCATION STANDARDS IN JCI ACCREDITATION AND CBAHI FOR HOSPITALS

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ABSTRACT

Patient and Family Education (PFE) is a common chapter available in the Joint Commission International (JCI) Accreditation[1] (fifth edition) and Central Board for Accreditation of Healthcare Institutions (CBAHI) Standards for hospitals (second edition)[2]. JCI Accreditation is a USA based international healthcare accrediting organization, whereas CBAHI is the Kingdom of Saudi Arabia based national accrediting organization. However, both these standards are accredited by Ireland based International Society for Quality in Health Care (ISQua), which is the only accrediting organization who "accredit the accreditors' in the world. In Patient and Family Education chapter of JCI Accreditation for hospitals, there are five (5) standards and seventeen (17) measurable elements (ME) whereas in CBAHI Accreditation there are twelve (12) standards, forty six (46) sub-standards and eighteen (18) evidence(s) of compliance (EC). The scoring mechanism is totally different in both these accrediting organizations. The researcher has identified thirty two (32) common parameters from JCI Accreditation and CBAHI standards, intent statement, measurable elements, sub-standard and evidence of compliance. On the basis of these identified common parameters, the researcher has compared the Patient and Family Education chapter in JCI Accreditation and CBAHI Standards.

Methods

This is a comparison study (normative comparison) in which the researcher has critically analyzed and compared the Patient and Family Education (PFE) chapter of JCI (Joint Commission International) Accreditation of USA (United States of America) and CBAHI (Central Board for Accreditation of Healthcare Institutions) of the Kingdom of Saudi Arabia.

Data Collection

Primary data are collected from the JCI Accreditation Standards for hospitals, fifth edition, 2013 and CBAHI Standards for hospitals of Kingdom of Saudi Arabia, second edition, 2011. Secondary data are collected from relevant published journals, articles, research papers, academic literature and web portals.

Objectives of the Study

The aim of this study is to analyze critically Patient and Family Education Standards in JCI Accreditation and

CBAHI Standards to point out the best in among both these standards.

Conclusion

This critical analysis of patient and family education standards in JCI Accreditation and CBAHI Standards for hospitals clearly shows that the Patient and Family Education Standards in CBAHI Standards are very comprehensive, to the point and are much better than the JCI Accreditation.

KEYWORDS: PFE (Patient and Family Education), Joint Commission International (JCI) Accreditation, USA (United States of America), CBAHI (Central Board for Accreditation of Healthcare Institutions), KSA (Kingdom of Saudi Arabia), Isqua (International Society for Quality in Healthcare)

INTRODUCTION

According to the World Health Organization (WHO), Accreditation can be the single most important approach for improving the quality of health care structures. Accreditation is not an end in itself, but rather a means to improve quality.

Each patient and family visiting to any healthcare organization is unique with their own medical, physical, psychosocial, discharge needs and spiritual/cultural values & beliefs. A good healthcare organization always works to establish faith and open communication with their patients/ families and to understand and protect each patient's/family's cultural, psychosocial, and spiritual values. Patients and families have a right to receive appropriate education, so they can utilize their knowledge to participate in their care process and make informed care decisions.

The patient and family education process includes identifying patient/family educational needs, developing individualized education plans, providing education accordingly, evaluating the effectiveness of the educational process and maintain patient rights. To ensure appropriate patient and family education, the organization must have adequate resources, including but not limited to staff, space and educational materials etc.

As the growth of health care continues to outpace inflation in many countries around the world, health policy makers have increasingly focused their attention on cost containment. Cost containment studies show that educating patients results in significant savings. Educated patients maintain better health and have fewer complications; as a result, they require fewer hospitalizations, emergency department visits, and clinic and physician visits.

REVIEW OF LITERATURE

Studies by managed care organizations have consistently shown patient teaching to be cost-effective. Following is a summary of studies that show the cost-effectiveness of specific patient teaching programs.

- Asthma group education-reduced emergency room admissions and hospitalizations. Cost per patient was $37. Savings were $217 per patient, resulting in a cost benefit ratio of 1:5.8. (Cost-benefit ratio = cost of education per patient divided by total savings per patient.)
- Asthma pediatric education-reduced annual emergency room visits from 7.4 to 1.9 per child. Cost per patient was $180. Savings were $687, resulting in a cost benefit ratio of 1:3.8
- Prenatal care/nutrition counseling and smoking cessation-reduced pre-term births from 6.9 percent to 1.7 percent. Cost per patient was $93. Savings were $183, resulting in a cost benefit ratio of 1:2

- Diabetes education in a public health department-reduced hospitalization by 44 percent. Cost per patient was $150. Savings were $442 per patient, resulting in a cost benefit ratio of 1.29
- Chronic pain counseling in an outpatient clinic-reduced clinic visits by 36 percent. The cost was $101 per patient. Savings were $312 per patient, resulting in a cost benefit ratio of 1:3.1
- In none of the studies, did costs exceed savings. On the average, for every dollar invested in these and similar programs, between $3-4 were saved.

At least 20 percent of all patients who are admitted to a U.S. hospital make a repeat visit within 30 days of discharge, according to Medicare and others who've studied the pervasive problem of hospital readmissions.[3]

Studies show that incorporating the concepts of cultural competence and patient- and family-centeredness into the care process can increase patient satisfaction and adherence with treatment.[4]

No longer considered to be simply a patient's right, effective communication is now accepted as an essential component of quality care and patient safety.[5]

Agency for Healthcare Research and Quality (AHRQ) estimates that one in five patients have a complication or an adverse event, such as a drug interaction, after being discharged from the hospital, drastically increasing their odds of a costly Emergency Department visit or readmission.[6]

In particular, patients who have a clear understanding of their after-hospital care instructions, including how to take their medicines and when to make follow-up appointments, are 30 percent less likely to be readmitted or visit the emergency department than patients who lack this information.[7]

At Del Sol Medical Center, El Paso, Texas, the adoption of a patient education software system that allows staff to print out patient information about heart failure and heart attacks in multiple languages, including Spanish, contributed to a drastically reduced heart failure readmission rate during the study period— from 16 percent to 7 percent.[8]

A year-long study of 109 heart failure patients at Columbia San Jose Medical Center in 1998 found that patients who participated in a low-cost educational program in increasing self-care and medication compliance were nearly half as likely as nonparticipants to be readmitted to the hospital.[9]

A growing body of research documents that a variety of patient populations experience decreased patient safety, poorer health outcomes, and lower quality care based on race, ethnicity, language, disability, and sexual orientation.[10]

DATA ANALYSIS

The author has analyzed PFE Chapter standards in JCI Accreditation and CBAHI Standards by thirty two (32) critical comparison parameters after studying these standards. These thirty two (32) critical comparison parameters are divided into four categories for statistical purpose to measure the standards, intents, measurable elements, sub-standards and evidence of compliance as follows:

- **Common Standards**

These standards (standards, intents, measurable elements, sub-standards and evidence of compliance) are common

in both accreditations, i.e. JCI Accreditation and CBAHI Standards.

- **Clearly Mentioned**

These standards (standards, intents, measurable elements, sub-standards and evidence of compliance) are clearly mentioned (to the point) in JCI Accreditation and CBAHI Standards.

- **Clearly Not-Mentioned**

These standards (standards, intents, measurable elements, sub-standards and evidence of compliance) are not-clearly mentioned (to the point) in JCI Accreditation and CBAHI Standards.

- **Not-Mentioned**

These standards (standards, intents, measurable elements, sub-standards and evidence of compliance) are not mentioned (to the point) in JCI Accreditation and CBAHI Standards.

Table 1: PFE Chapter Standards Critical Analysis in JCI Accreditation and CBAHI Standards Based on Critical Comparison Parameters

Sl. No.	Critical Comparison Parameters (PFE)	JCI Accreditation Standards, Intent Statement, Measurable Elements (ME) of PFE	CBAHI Standards, Sub-Standards, and Evidence of Compliance of PFE
1	**Leadership supports**	(Intent Statement PFE-1, Standard PFE-1, ME-1, 2 and 3)	(PFE-1; EC-1, 2, and 3)
2	**Appropriate structure or mechanism**	(Intent Statement PFE-1, Standard PFE-1, ME-1, 2 and 3)	(PFE-2; EC-1, 2, and 3)
3	**Role of Medical and Nursing staff**	(Intent Statement PFE-1, Standard PFE-1, ME-1, 2 and 3)	(PFE-3; EC-1 and 2)
4	**Appointment of professional staff to help educate patients**	(Intent Statement PFE-1, Standard PFE-1, ME- 3)	(PFE-4; EC-1)
5	**Educational needs assessment and documentation**	(Intent Statement PFE-2, Standard PFE-2, ME-1, 2, and 3) (Intent Statement PFE-2.1, Standard PFE-2, ME-1, 2,3 and 4)	(PFE-7; PFE-7.1, PFE-7.2, PFE-7.3, PFE-7.4, PFE-7.5, PFE-7.6, PFE-7, EC-1)
6	**Patient and Family Education Methods and Documentation in Medical Records**	(Intent Statement PFE-3, Standard PFE-3, ME-1, 2, and 3)	(PFE-8; PFE-8.1, PFE-8, EC-1)
7	**Collaborative Effort**	(Intent Statement PFE-4, Standard PFE-4, ME-1, 2,3 and 4)	(PFE-10, PFE-10.1, PFE-10.2, PFE-10.3, PFE-10.4, PFE-10.5 and EC-1)
8	**Necessary education and information by healthcare professionals to all patients**	---	(PFE-5, PFE-5.1, PFE-5.2, PFE-5.3, and PFE-5.4, PFE.6-EC.1)
9	**Surgical Patient**	---	(PFE-5.5, PFE-5.6, PFE-5.7, and PFE-5.8)
10	**Radiology**	(PFE-2, Intent Statement)	(PFE-5.10)
11	**Dietician**	---	(PFE-5.11, DT-7.1, DT-7.2)
12	**Emergency Department**	(MOI-10.1.1, ME-4)	(PFE-5.12)
13	**Follow-up clinic appointment**	--	(PFE-5.13)
14	**The patient is unable to comprehend the instructions**	--	(PFE-9, PFE-9.1, PFE-9.2, PFE-9.3, PFE-9, EC-1)
15	**Guidelines for health educators (nurses, physicians, dietitians, etc.) on how to teach the patient/family**	--	(PFE-10, PFE-10.1, PFE-10.2, PFE-10.3, PFE-10.4, PFE-10.5, EC-1)
16	**Patient and Family's Involvement**	(PFE-2, Intent Statement)	(PFE-11, PFE-11.1, PFE-

Sl. No.	Critical Comparison Parameters (PFE)	JCI Accreditation Standards, Intent Statement, Measurable Elements (ME) of PFE	CBAHI Standards, Sub-Standards, and Evidence of Compliance of PFE
	in the care provided		11.2, PFE-11.3, PFE-11.4, PFE-11.5, EC-1)
17	**Nurses Role in Patient and Family Education**	--	(PFE-12, PFE-12.1, PFE-12.2, PFE-12.3, PFE-12.4, PFE-12.5, PFE-12.6, EC-1)
18	**Pain Management**	--	(PFR-23.7, PFR-23, EC-2)
19	**Anesthesiology**	(PFE-2, Intent Statement)	(AN-36.2, AM-10-EC-1)
20	**Social Worker**	--	(SC-6, EC-1, SC-12.3)
21	**Physiotherapy**	--	(RH-13, EC-1)
22	**Outpatient Department and Clinics**	--	(AM-7, AM-7.1, AM-7.2, AM-7.3, AM-7.4, EC-1)
23	**If an Outpatient procedure is planned to be done**	(PFE-2, Intent Statement)	(AM-9, EC-1, EC-2, EC-2, EC-4)
24	**If admission is needed, the patient should be informed**	--	(AM-8, EC-1)
25	**Dental**	--	(DN-7, EC-1)
26	**Medical Records**	--	(MR-12.8, EC-1)
27	**Pharmacy**	--	(PH-30, EC-1, EC-2)
28	**Medical Staff and Provision of Care**	(PFE-2, Intent Statement)	(MS-37.8, MS-79, EC-3)
29	**Nursing**	--	(NR-56, EC-1, NR-58, EC-1)
30	**On External Transfer of Patient's**	--	(MS-98.6, EC-1, NR-58.1)
31	**Organ Donation**	(PFR-6, ME-1, 2, 3 and PFR-6.1, ME-2)	(PFR-27, EC-1, EC-2)
32	**Infection Control**	PCI 11, ME-2	--

The Table No.1 depicts that:

Common Standards (In JCI Accreditation and CBAHI Standards)

- Leadership supports
- Appropriate structure or mechanism
- Collaborative Effort
- Emergency Department
- Organ Donation

Clearly Mentioned in JCI Accreditation

- Educational needs assessment and documentation
- Patient and Family Education Methods and Documentation in Medical Records
- Infection Control

Clearly Mentioned in CBAHI Standards

- Role of Medical and Nursing staff

- Appointment of professional staff to help educate patients
- Necessary education and information by healthcare professionals to all patients
- Surgical Patient
- Radiology
- Dietician
- Follow-up clinic appointment
- The patient is unable to comprehend the instructions
- Guidelines for health educators (nurses, physicians, dietitians, etc.) on how to teach the patient/family
- Patient and Family's Involvement in the care provided
- Nurses Role in Patient and Family Education
- Pain Management
- Anesthesiology
- Social Worker
- Physiotherapy
- Outpatient Department and Clinics
- If an Outpatient procedure is planned to be done
- If admission is needed, the patient should be informed
- Dental
- Medical Records
- Pharmacy
- Medical Staff and Provision of Care
- Nursing
- On External Transfer of Patient's

Clearly Not Mentioned in JCI Accreditation

- Role of Medical and Nursing staff
- Appointment of professional staff to help educate patients
- Radiology
- Patient and Family's Involvement in the care provided

- Anesthesiology
- If an Outpatient procedure is planned to be done
- Medical Staff and Provision of Care

Clearly Not Mentioned in CBAHI Standards

- Educational needs assessment and documentation
- Patient and Family Education Methods and Documentation in Medical Records

Not Mentioned in JCI Accreditation

- Necessary education and information by healthcare professionals to all patients
- Surgical Patient
- Dietician
- Follow-up clinic appointment
- The patient is unable to comprehend the instructions
- Guidelines for health educators (nurses, physicians, dietitians, etc.) on how to teach the patient/family
- Nurses Role in Patient and Family Education
- Pain Management
- Social Worker
- Physiotherapy
- Outpatient Department and Clinics
- If admission is needed, the patient should be informed
- Dental
- Medical Records
- Pharmacy
- Nursing
- On External Transfer of Patient's

Not Mentioned In CBAHI Standards

- Infection Control

Table 2: Critical Analysis of PFE Standards in JCI Accreditation and CBAHI Standards

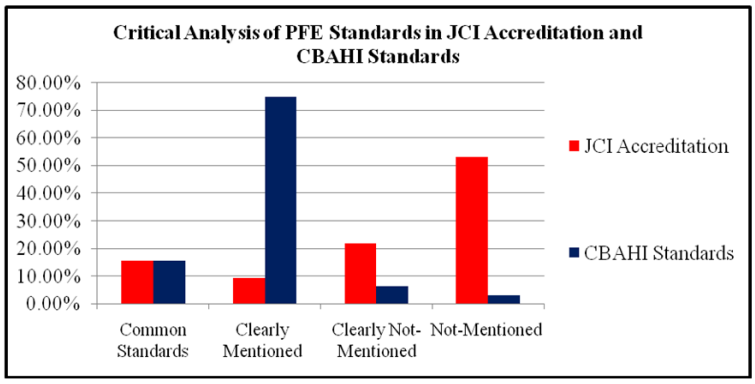
Sl. No.	PFE Standards	Common Standards	Clearly Mentioned	Clearly Not Mentioned	Not Mentioned	Total Parameters of Comparison
1	**JCI Accreditation**	5(15.62%)	3(9.37%)	7(21.87%)	17(53.13%)	32(100%)
2	**CBAHI Standards**	5(15.62%)	24(75%)	2(6.25%)	1(3.13%)	32(100%)

The Table Number-2 depicts that PFE Chapter in JCI Accreditation and CBAHI Standards has 5 (15.62%) common standards (standards, intents, measurable elements, sub-standards and evidence of compliance). In JCI Accreditation, only 3 (9.37%) of the standards are clearly mentioned as compared to 24 (75%) in CBAHI Standards. In CBAHI Standards only 2 (6.25%) of the standards are not clearly mentioned as compared to the 7 (21.87%) in JCI Accreditation. In CBAHI Standards, only 1 (3.13%) of the standards are not mentioned as compared to the 17 (53.13%) in JCI Accreditation.

Table 3: Critical Analysis of PFE Standards in JCI Accreditation and CBAHI Standards in Percentage

Sl. No.	Comparison Parameters	JCI Accreditation	CBAHI Standards
1	Common Standards	15.62%	15.62%
2	Clearly Mentioned	9.37%	75%
3	Clearly Not-Mentioned	21.87%	6.25%
4	Not-Mentioned	53.12%	3.12%

The Table Number-3 depicts that the PFE Chapter in JCI Accreditation and CBAHI Standards has 15.62% common standard (standards, intents, measurable elements, sub-standards and evidence of compliance). In JCI Accreditation, only 9.37% of the standards are clearly mentioned as compared to 75% in CBAHI Standards. In CBAHI Standards only 6.25% of the standards are not clearly mentioned as compared to the 21.87% in JCI Accreditation. In CBAHI Standards, only 3.13% of the standards are not mentioned as compared to the 53.13% in JCI Accreditation.



Graph Number 1: Critical Analysis of PFE Standards in JCI Accreditation and CBAHI Standards

The Graph Number-1 clearly shows that in PFE Chapter of JCI Accreditation the numbers of clearly mentioned standards are very minimal and not mentioned standards are very high. Whereas in PFE Chapter of CBAHI Standards, the numbers of clearly mentioned standards are very high and not mentioned standards are very low.

CONCLUSIONS

This critical analysis of patient and family education standards in JCI Accreditation and CBAHI Standards for hospitals clearly shows that the Patient and Family Education Standards in CBAHI Standards are very comprehensive, to the point and are much better than the JCI Accreditation.

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