



# CPHQ for Business

## 1. Credentials & Jobs | 3 Golden Rules

Ahmed Yahia, MD, MPH, CPHQ

[www.success-experts.net](http://www.success-experts.net)

# PART I



# Quality Credentials



TOGETHER WE DEFINE EXCELLENCE  
IN HEALTHCARE QUALITY



MY ACCOUNT

LOGIN 

[ABOUT NAHQ](#)

[CPHQ CERTIFICATION](#)

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## Commit to Quality. Commit to the CPHQ.

### Why earn the CPHQ?

As healthcare continues to evolve, more and more staff in healthcare organizations will be involved in quality. That's why it is more important than ever before to differentiate yourself as a healthcare quality professional with the Certified Professional in Healthcare Quality (CPHQ) certification.

As a healthcare quality professional, you bring together data analytics, performance improvement, risk management, patient safety and much more, helping others see the bigger picture.

Prove that commitment by earning your CPHQ credential.

### What is the CPHQ?



▶ [CPHQ Exam](#)

[CPHQ Recertification](#)

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## Certification Board for Professionals in Patient Safety

Enter search criteria...



More in this Section... ▼

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### About Certification

The Certification Board for Professionals in Patient Safety (CBPPS) was formed to oversee a rigorous and comprehensive credentialing process that attests to patient safety competencies and expertise. The board's chief responsibility is the development and administration of an evidence-based examination that provides candidates with a process by which they can demonstrate their competency in patient safety science and application.

This professional certification program

- Establishes core standards for the field of patient safety, benchmarks requirements necessary for health care professionals, and sets an expected proficiency level.

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Management

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AUC Web » Business » Management Center » Institute of Quality Management » Post Graduate Diploma In TQM For Healthcare Reform

## Post Graduate Diploma In TQM For Healthcare Reform

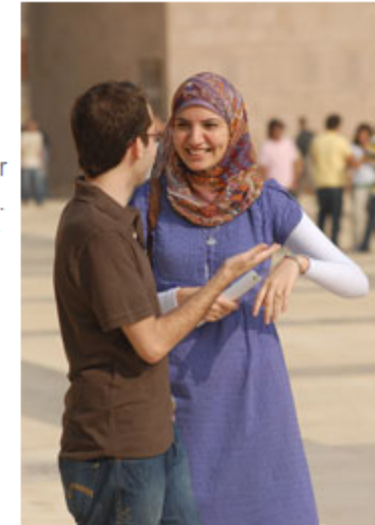
This is a three-semester diploma that is approved by the Egyptian Supreme Council of Universities. Each semester is twelve weeks long and covers two courses. Classes meet once a week, to allow participants to tend to their jobs. The six courses of the diploma were designed to provide the participants with the necessary background, together with hands-on-experience to implement what is learned in real practice context.

Objectives:

- To prepare participants to lead the quality activities of healthcare reform in their organizations.
- To provide participants with the skills necessary to assure quality in healthcare services.
- To quality participants to train their service providers on quality skills.
- To provide participants with about 70% of the body of knowledge required for the exam of the Healthcare Quality Certification Board (HQCB)B, in the U.S.A, and become a Certified Professional for Healthcare Quality (CPHQ).

Contents:

- Management Information in Healthcare.
- People Management.
- Planning for Top Quality in Healthcare Services.
- Quality / Environment System Standards in Healthcare.



# المعهد العربي للمهنية الإدارية (معتمد) اتحاد الأطباء العرب



الرئيسية | البرامج التدريبية | مكتبة الصور | قالوا عن المعهد | أحياء معتمد | أنشطة | إستطلاع الرأي

اتحاد | حفل تخرج الدفعة الخامسة - دبلوم التغذية الإكلينيكية

جديد الأخبار

الرئيسية « الدبلومات المهنية الإدارية » جودة الخدمات الصحية

## مقال إسبوعي

 4

### فوائد الزبادي الصحية

بقلم : معتمد  
15/06/2015 12:00:00 ص



يعتبر الزبادي وجبة غذائية متكاملة لها العديد من الفوائد الصحية للإنسان بشكل عام ومنها :

المزيد

أشترك في قائمتنا البريدية

اشترك

## جودة الخدمات الصحية

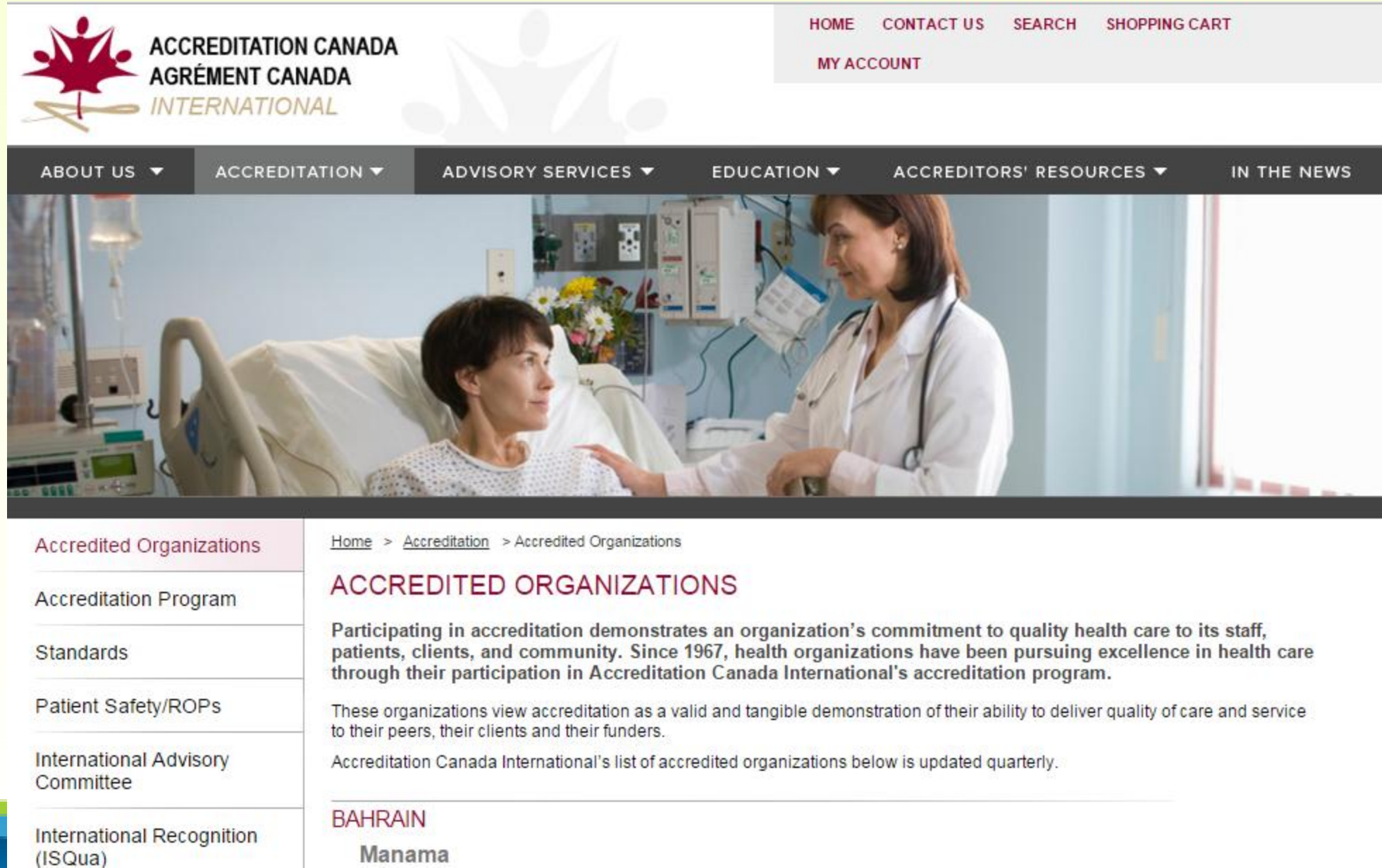


الدبلوم المهني في جودة الرعاية الصحية  
Professional Diploma in Healthcare Quality Management

# Academic Degrees: Diploma, Master, PhD

- Healthcare Quality and Patient Safety
- MPH
- Health Administration

# JOBS



The screenshot shows the Accreditation Canada International website. The header includes the logo and navigation links: HOME, CONTACT US, SEARCH, SHOPPING CART, and MY ACCOUNT. A secondary navigation bar contains: ABOUT US, ACCREDITATION, ADVISORY SERVICES, EDUCATION, ACCREDITORS' RESOURCES, and IN THE NEWS. A large banner image depicts a doctor in a white coat talking to a patient in a hospital bed. The main content area is titled 'ACCREDITED ORGANIZATIONS' and includes a breadcrumb trail: Home > Accreditation > Accredited Organizations. The text explains that accreditation demonstrates an organization's commitment to quality health care and lists the following categories: Accredited Organizations, Accreditation Program, Standards, Patient Safety/ROPs, International Advisory Committee, and International Recognition (ISQua). The first category, 'BAHRAIN', is expanded to show 'Manama'.

**ACCREDITATION CANADA**  
**AGRÉMENT CANADA**  
*INTERNATIONAL*

HOME CONTACT US SEARCH SHOPPING CART  
MY ACCOUNT

ABOUT US ACCREDITATION ADVISORY SERVICES EDUCATION ACCREDITORS' RESOURCES IN THE NEWS

Accredited Organizations

Accreditation Program

Standards

Patient Safety/ROPs

International Advisory Committee

International Recognition (ISQua)

Home > Accreditation > Accredited Organizations

## ACCREDITED ORGANIZATIONS

Participating in accreditation demonstrates an organization's commitment to quality health care to its staff, patients, clients, and community. Since 1967, health organizations have been pursuing excellence in health care through their participation in Accreditation Canada International's accreditation program.

These organizations view accreditation as a valid and tangible demonstration of their ability to deliver quality of care and service to their peers, their clients and their funders.

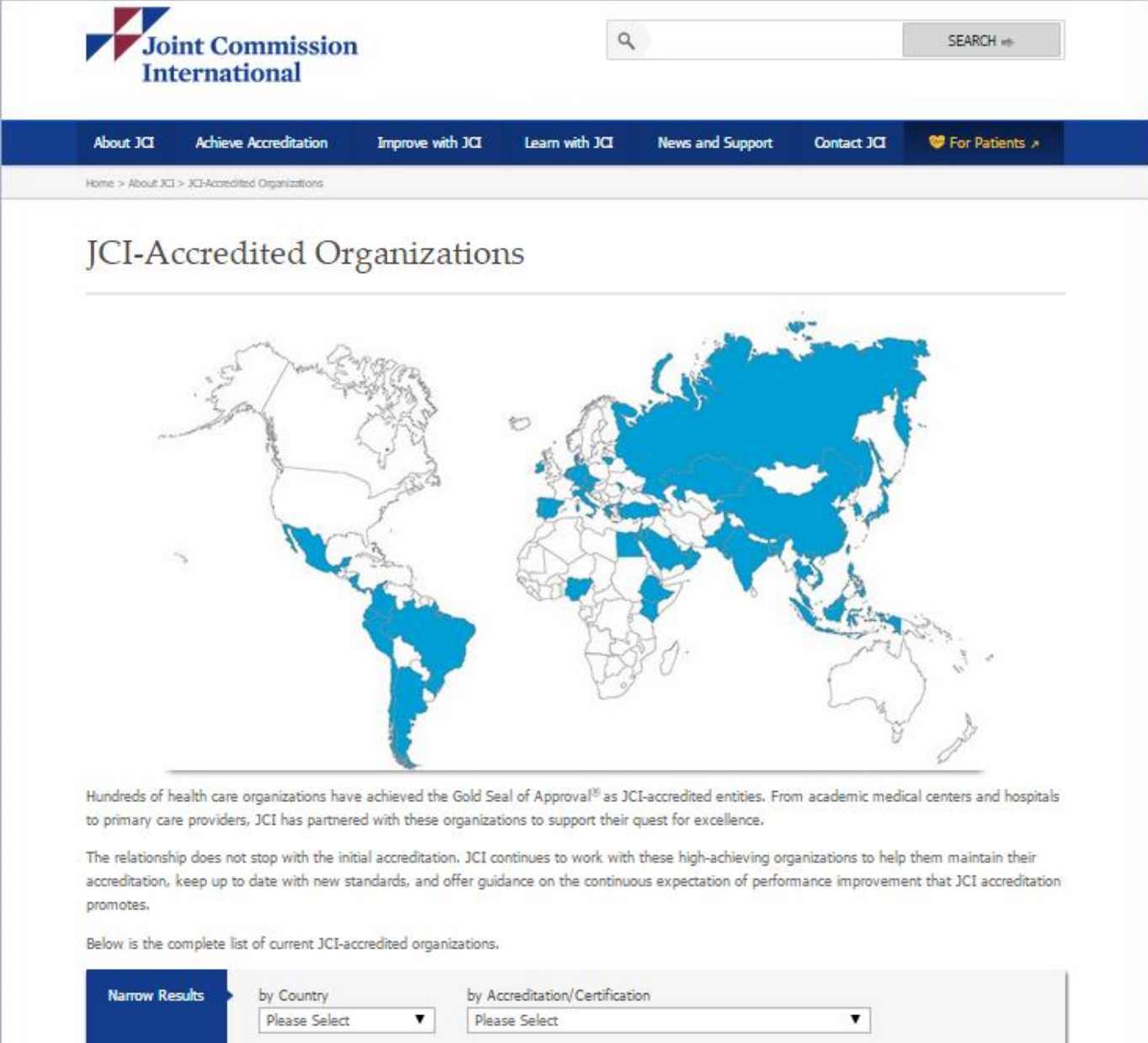
Accreditation Canada International's list of accredited organizations below is updated quarterly.

### BAHRAIN

Manama



# JCI: Accredited Organizations



The screenshot shows the JCI website's 'Accredited Organizations' page. At the top is the JCI logo and a search bar. A navigation menu includes links for 'About JCI', 'Achieve Accreditation', 'Improve with JCI', 'Learn with JCI', 'News and Support', 'Contact JCI', and 'For Patients'. The breadcrumb trail reads 'Home > About JCI > JCI-Accredited Organizations'. The main heading is 'JCI-Accredited Organizations'. Below this is a world map with blue-shaded regions indicating accreditation. Text below the map states that hundreds of health care organizations have achieved the Gold Seal of Approval as JCI-accredited entities, and that JCI continues to work with these organizations to maintain their accreditation and improve performance. At the bottom, there is a 'Narrow Results' section with two dropdown menus: 'by Country' (set to 'Please Select') and 'by Accreditation/Certification' (set to 'Please Select').


**Joint Commission International**

SEARCH

About JCI Achieve Accreditation Improve with JCI Learn with JCI News and Support Contact JCI For Patients

Home > About JCI > JCI-Accredited Organizations

## JCI-Accredited Organizations



Hundreds of health care organizations have achieved the Gold Seal of Approval<sup>®</sup> as JCI-accredited entities. From academic medical centers and hospitals to primary care providers, JCI has partnered with these organizations to support their quest for excellence.

The relationship does not stop with the initial accreditation. JCI continues to work with these high-achieving organizations to help them maintain their accreditation, keep up to date with new standards, and offer guidance on the continuous expectation of performance improvement that JCI accreditation promotes.

Below is the complete list of current JCI-accredited organizations.

**Narrow Results**

by Country

by Accreditation/Certification



التدريب

سلامة المرضى

تصميم المنشآت الصحية

التأهيل والتصنيف

الاعتماد

عن المركز

الرئيسية

## دليل المستشفيات المعتمدة من المركز السعودي

Accredited Government Hospitals المستشفيات الحكومية المعتمدة		
Hospital Name	Certificate Expiration Date تاريخ انتهاء صلاحية الشهادة	اسم المستشفى
Central Region		
1. Hospital of King Fahd Medical City - Riyadh	October, 2017	١. مستشفى مدينة الملك فهد الطبية - الرياض
2. Central Security Hospital in Haair Prison - Riyadh	September, 2017	٢. مستشفى الأمن المركزي بسجن الحائر - الرياض
3. King Saud Medical City - Riyadh	May, 2017	٣. مدينة الملك سعود الطبية - الرياض
4. AL Quwayiyah General Hospital - AL Quwayiyah	June, 2016	٤. مستشفى القويحية العام - القويحية
5. Wadi Al-Dawasir General Hospital - Wadi Al-Dawasir	October, 2015	٥. مستشفى وادي الدواسر العام - وادي الدواسر
6. Dawadmi General Hospital - Dawadmi	October, 2015	٦. مستشفى الدوامي العام - الدوامي
7. Alafraj General Hospital - Alafraj	September, 2015	٧. مستشفى الأفلاج العام - الأفلاج
8. King Khalid Hospital - Al Kharj	September, 2015	٨. مستشفى الملك خالد ومركز الأمير سلطان للقلب - الخرج
Madinah Region		
1. Royal Commission Medical Center - Yanbu	April, 2017	١. المركز الطبي للهيئة الملكية - ينبع
Eastern Region		
1. Security Forces Hospital - Dammam	February, 2016	١. مستشفى قوى الأمن - الدمام


# What hospitals are looking for in a candidate?

- Credentials
- Experience & Training
- Competencies/ Skills: Communication, Teamwork, Bilingual: Arabic/English, Computer and internet literacy, LEADERSHIP?

# Interviews & Job Offers

- Honest and Professional CV
- CPHQ Code of ethics

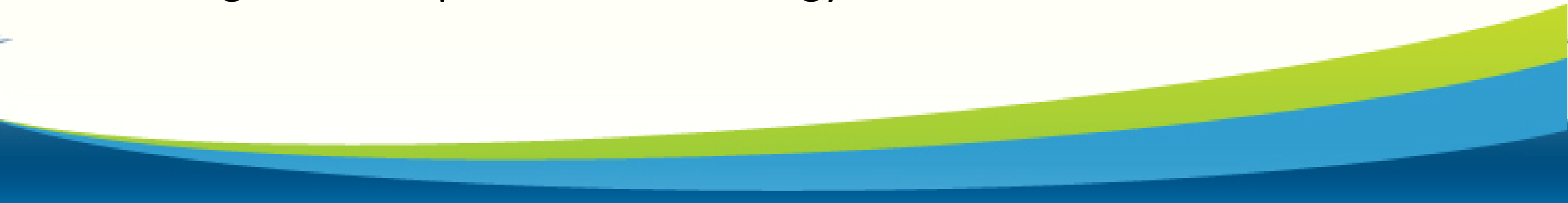
# Job Description & Confidentiality Agreement

- **Don't forget:**
  - Hospital Orientation: then sign
  - Departmental orientation: then sign
  - Hospital departments visit
  - Quality Manual understanding
- 


# Now: Quality Departmental CHART

- Director
- Accreditation staff
- Patient safety/ Clinical Risk management staff: Incidents, complaints, initiatives.
- Document Control: policy, forms, checklists, surveys, etc.
- Medical Audit: Open, Close
- Statistics
- Clerks, data entry, etc.
- Health education, Infection Prevention & Control, Safety????

# Quality structure in the hospital

- Position of Quality Department to the leadership
  - Quality Council
  - Scope of service
  - Integrated QPS plan with the strategy
- 

# Is it a must to have JCI or CBAHI to practise Quality?

- WHO Patient Safety Friendly Hospital Initiative: Arabic/English
  - IFC (World Bank) Assessment Tool
- 



# Patient safety assessment manual

PROMOTING STANDARDS  
IN THE PRIVATE HEALTH SECTOR

## A Self-Assessment Guide for Health Care Organizations



QUALITY, SAFETY, ETHICS



# PART II



# Literature Review: Regional

BMJ

BMJ 2012;344:e832 doi: 10.1136/bmj.e832 (Published 13 March 2012)

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RESEARCH

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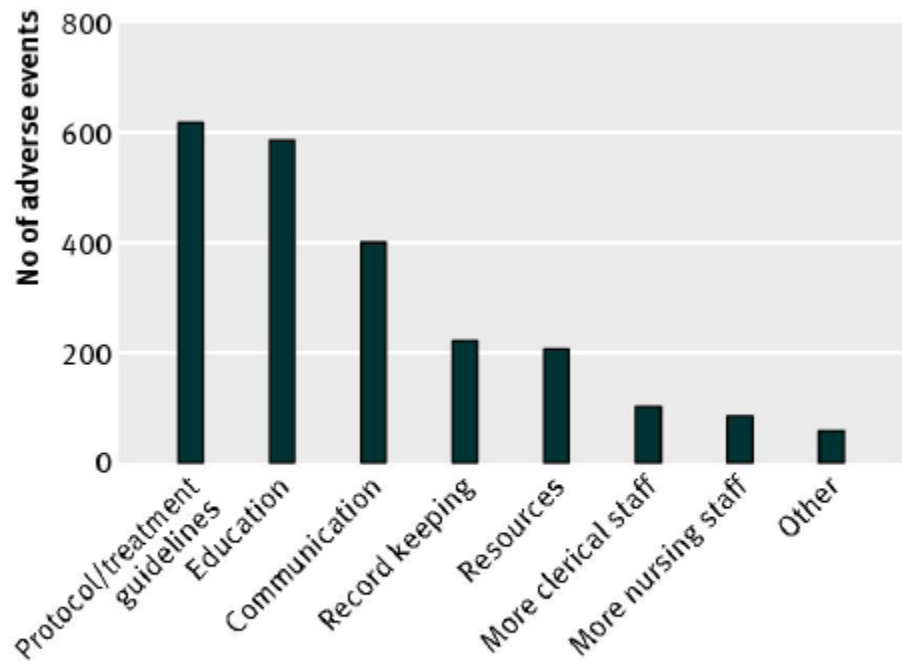
**Patient safety in developing countries: retrospective estimation of scale and nature of harm to patients in hospital**



OPEN ACCESS




**Fig 5** Factors contributing to the adverse events. Coding was not possible for all adverse events and multiple codes could be used for same event



**Fig 6** Strategies for preventing recurrence of 1277 adverse events from eight countries in adverse event study. Coding was not possible for all adverse events and multiple codes could be used for same event

# 3 Golden Rules in QPS

- 1- Just Culture (The Secret).
  - 2- PDSA
  - 3- Teamwork
- 

# Medical Errors Video

- <https://www.youtube.com/watch?v=i3PN8V4-slU>





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[Quality & Patient Safety](#)

[▶ AHRQ's Healthcare-Associated Infection Program](#)

[▶ Comprehensive Unit-based Safety Program \(CUSP\)](#)

[▶ Partnership for Patients](#)

[▶ Patient and Family Engagement](#)

[▶ Patient Safety Measure Tools & Resources](#)



## Hospital Survey on Patient Safety Culture

In 2004, the Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture, a staff survey designed to help hospitals assess the culture of safety in their institutions. Since then, hundreds of hospitals across the United States and internationally have implemented the survey.

In response to requests from hospitals interested in comparing their safety culture survey results to other hospitals, AHRQ funded the development of a comparative database on the survey in 2006. The database comprises voluntarily submitted data from U.S. hospitals that administered the survey. Comparative database reports were produced in 2007, 2008, 2009, 2010, 2012, and 2014.

### Hospital Survey Toolkit

### UPDATE ON HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

AHRQ is proposing a pilot test and bridge study data collection effort to test a revised Hospital Survey on Patient Safety Culture (Version 2.0) and new supplemental item set on Health Information Technology Patient Safety.

[Read more.](#)

### RESOURCE LIST

Improving Patient Safety in Hospitals: A Resource List for Users of the AHRQ Hospital Survey on Patient Safety Culture

# HSOPS, AHRQ

- Measure the Culture..

## Hospital Survey on Patient Safety

### Instructions

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

- An *“event”* is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.
- *“Patient safety”* is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.

### SECTION A: Your Work Area/Unit

In this survey, think of your “unit” as the work area, department, or clinical area of the hospital where you spend most of your work time or provide most of your clinical services.

What is your primary work area or unit in this hospital? Select ONE answer.

- a. Many different hospital units/No specific unit
- b. Medicine (non-surgical)       h. Psychiatry/mental health       n. Other, please specify:
- c. Surgery       i. Rehabilitation
- d. Obstetrics       j. Pharmacy
- e. Pediatrics       k. Laboratory
- f. Emergency department       l. Radiology
- g. Intensive care unit (any type)       m. Anesthesiology

Please indicate your agreement or disagreement with the following statements about your work area/unit.

Think about your hospital work area/unit...	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. People support one another in this unit .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. We have enough staff to handle the workload.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. When a lot of work needs to be done quickly, we work together as a team to get the work done .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. In this unit, people treat each other with respect .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. Staff in this unit work longer hours than is best for patient care .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

# First: Just Culture: The Secret

- Deming Theory: 85/15; for Complexity of Healthcare

## **Fair and just culture** (non-punitive and accountable):

- **Medical errors are inevitable.**
- **All events and near misses to be reported.** It can make the system safer.
- **Competent professionals make mistakes and develop unhealthy norms (shortcuts or routine rule violations), but it has zero tolerance for reckless behavior.**



# An Introduction to Just Culture

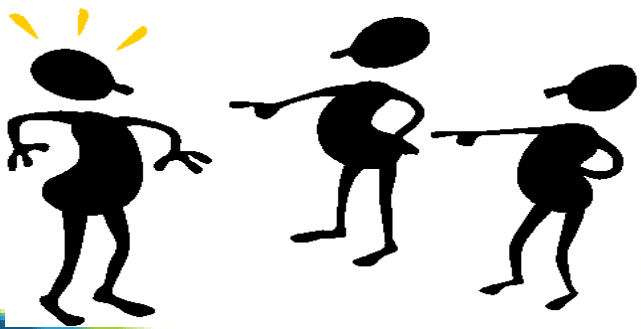
“People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

Don Norman  
Author, *The Design of Everyday Things*

# An Introduction to Just Culture

The single greatest impediment to error prevention in the medical industry is  
“that we punish people for making mistakes.”

*Dr. Lucian Leape  
Professor, Harvard School of Public Health  
Testimony before Congress on  
Health Care Quality Improvement*

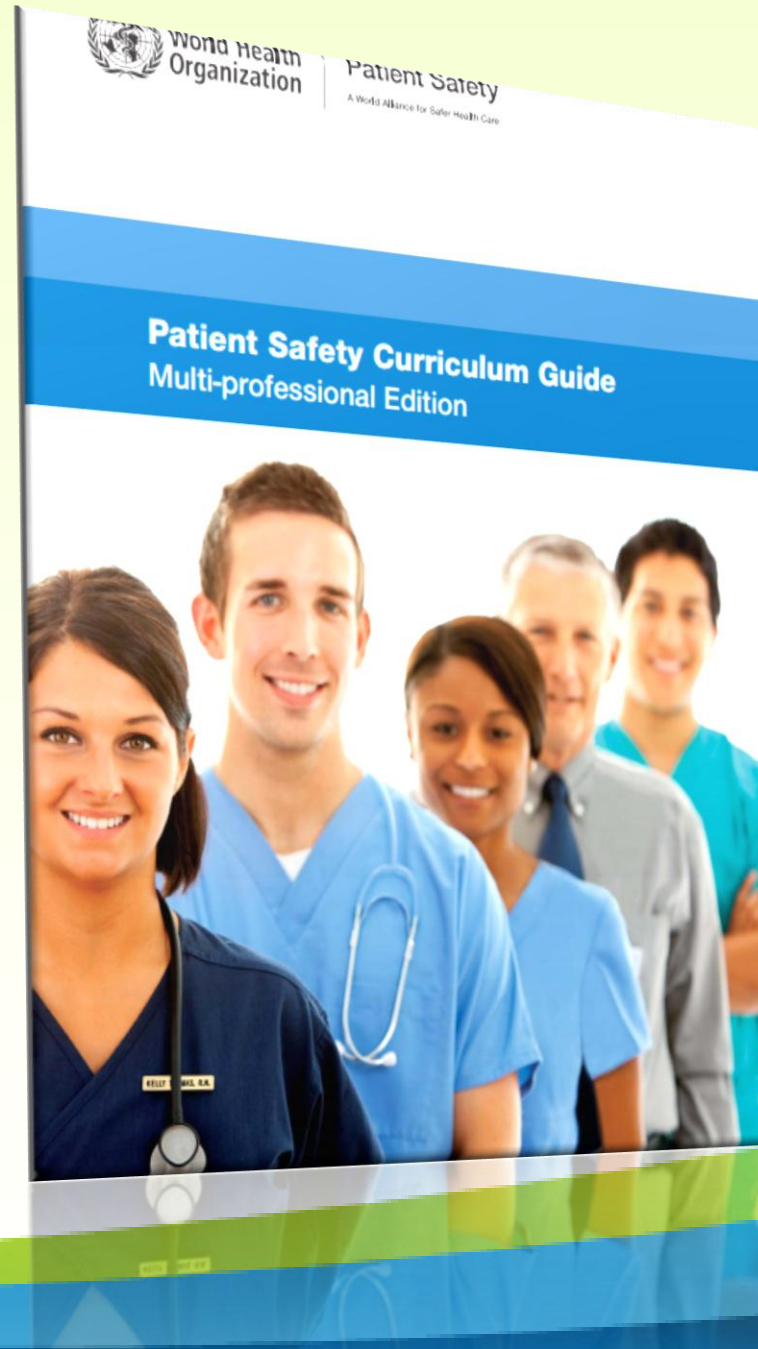


# Human Factor Engineering



- It is the study of human interactions with others, equipments, technology, surrounding environment. It discusses the human ability and limitations.
- Human factors to be considered in healthcare (**NPSF**):
  - 1- sleep deprivation
  - 2- Interruptions

# WHO Patient Safety Curriculum





# Individual factors that predispose to error *(WHO, Patient Safety Curriculum, Mod. 2)*

- limited memory capacity
- further reduced by:
  - fatigue
  - stress
  - hunger
  - illness
  - language or cultural factors
  - hazardous attitudes



# Accountability for Our Behaviors



85%

15%

## 3 basics:

1. It **doesn't reduce the personal accountability** and discipline. It emphasizes the learning from the errors and near misses to reduce errors in the future.
2. The **greatest error not to report a mistake**. Thereby prevent learning.
3. **All in the organization to serve as safety advocates.**
  - Both providers and consumers will feel safe and supported when they report medical errors, near misses and voice concerns about patient safety.

- Q Solutions, 2<sup>nd</sup> ed., Module 5

# Josie King: Lessons Learned



JOSIE KING FOUNDATION  
*creating a culture of patient safety, together*



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## About

### What Happened

From Sorrel King's speech to the IHI Conference in 2002

Josie was 18 months old...In January of 2001 Josie was admitted to Johns Hopkins after suffering first and second degree burns from climbing into a hot bath. She healed well and within weeks was scheduled for release. Two days before she was to return home she died of severe dehydration and misused narcotics...

Josie spent ten days in the PICU. I was by her side every day and night. I paid attention to every minute detail of the doctors' and nurses' care, and I was quick to ask questions. I bonded with them and was in constant awe of the medical attention she received. Every time Josie moved or fussed someone would be quick to push her pain button. I tried rubbing her head and found that often this would settle her. Much to our relief, Josie was experiencing a quick recovery. Her burns were healing beautifully. She was sent down to the intermediate care floor with expectations of being sent home in a few days. Her three older siblings prepared for her welcome home celebration. We were told that no one had ever been sent back up to the PICU.

## ABOUT

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[Josie's Story: The Book](#)

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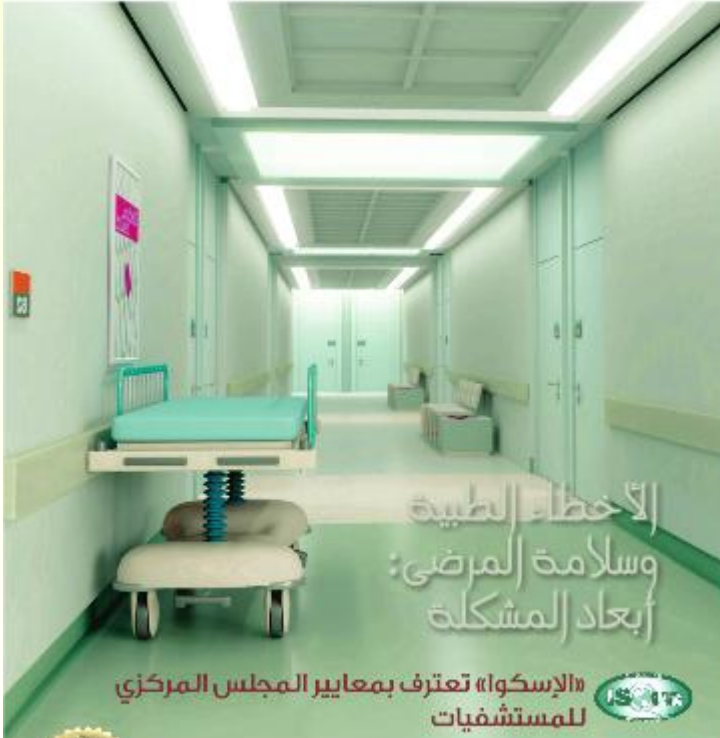
[Donate](#)

# Josie King

مملكة بوجهه تخدم من الطمس  
التركيز لامتداد الكفالة الحميمة

## الاعتماد الصحي

العدد 1 / أيلول - أيلول 2013



الأخطاء الطبية  
وسلامة المرضى:  
أبعاد المشكلة

«الإسكوا» تعترف بمعايير المجلس المركزي  
للمستشفيات

رئيس المجلس المركزي د. محمد خفيم:  
السلامة أولاً والجودة دائماً في المنشآت الصحية



## جوسى كينج.. قبلة الوداع الأخيرة في أفضل مستشفى للأطفال

في يناير 2001 تم إدخال (جوسى كينج) ذات الثمانية عشر شهراً إلى العناية المركزة للأطفال بمستشفى جون هوبكنز للأطفال، بسبب حروق من الدرجة الأولى والثانية. بعد عشرة أيام في العناية المركزة تم نقلها إلى الرعاية المتوسطة، بينما أخذت حروق جوسى تلتئم بصورة طيبة، وبدأت الطفلة تتمثل للشفاء في أسابيع، وتم بالفعل تحديد موعد خروجها من المستشفى.



بقلم الدكتور

**أحمد يحيى**

طبيب بشري واستشاري الجودة - ماجستير  
الصحة العامة - الجامعة الأمريكية - لبنان

## دينيس كويد..

# الهيبارين كاد أن يقتل فرحتي بالتوائم



يقدم الدكتور  
أحمد يحيى  
استشاري الجودة - ماستر الصحة العامة  
- الجامعة الأمريكية - بيروت

في منتصف ليل الثامن عشر من نوفمبر (2007م) تعرض توأمين في اليوم العاشر من حياتهما للذرف بشدة بينما كنا بجالغان من عدوى في رعاية حميتي الأطفال مركز سيناي الطبي (Cedars-Sinai) في لوس أنجلوس. كانت المريضة تقوم بوجئنا بنفخية التوصلات الوريدية للتوأمين (وي و توماس) باستخدام الهيبارين بتركيز (10) وحدات معيارية (USP 10) وهو مستحضر مخصص لهذا الإجراء خفياً غير أنه للمرة الثانية في هذا اليوم - على سبيل الخطأ - استخدام الهيبارين بتركيز (10000) وحدة معيارية (والتي يستخدم في علاج الجلطات والاحشاءات) أي بما يعادل الجرعة المطلوبة بألف مرة ما تسبب في نزيف التوأمين بصورة كادت أن تودي بحياتهما.



في الواقع تضرر طفلي لثالث في نفس الوحدة وينس الخطيئة التي حدثت للتوأمين غير أنه ربما لسن الخط كان التوأمين هما أنا لثالث الأمريكي (دينيس كويد) وهذا ما رغم أن حوادث شبيهة حدثت من قبل بسبب الهيبارين بين عامي (2007م إلى 2008م) - وأقول لسن الخط لأن التقنية تصيرت بصورة كبيرة في وسائل الإسلام ومن طريق ذلك المثل الأمريكي لتأخذ التقنية منحنى آخر سيؤد فيما بعد بقاتلة كبيرة على النظام الصحي الأمريكي بل والعالم أجمع.

### الهداية

بدأت التمسدة بخطأ في تمرير الهيبارين من الصيدلية من دون تحقق من طرف ميدلتي فإن ليح بعد ذلك في يد الممرضة والتي لم تتبه للخطأ ولأنست لم يتم التحقق مرة أخرى في هذه المسلة الهامة من قبل أية ممرضة أخرى قبل إعطاء الهيبارين للتوأمين وهو دواء سائي الخطورة كما هو معلوم في الأوساط العلمية.

ومن حسن الطالع أيضاً أن التوأمين تماثلنا لشقاء مما حدا باتصال الأمريكي الفهور بلا يرفع قضية ضد المستشفى غير أن أحداثنا أثر في الواقعين ليتخذنا خطوات عملية مع المستشفى وشركة باكستر الشهيرة للأدوية لتتلف فيما يلي:

- قامت المستشفى بدأ من اليوم التالي الموالي (19 نوفمبر 2007م) بعملية تدريب تطالغ الممرضين بأبوابه والتي تجاوزت عدده (1000) ممرض وممرضة إضافة إلى طاقم



الصيدية والتبالغ منعدم قرابة (200) شخص.  
• راجعت المستشفى كافة التواريخ والمعاملات المتعلقة بالأدوية في المستشفى.

• اجبرت التواريخ الجديدة أن يتم تحقيق الأدوية عالية الخطورة في الصيدلية من طريق هي ميدلتي لأن كما أقرت المستشفى أثناء امتداد كبير الأخطاء من هذه المعاملة بأنه خطأ دوائي كان يمكن تلافه Preventable Adverse Drug Event.

- قامت المستشفى باستثمار يُقَدَّر بملايين الدولارات في إنشاء نظام الماركوكو والذي يحد من مخزون من مستوي سلامة المرضى بالمستشفى.
- قام دينيس كويد بعمل هيتم وثائقي مدته (55) دقيقة من هذه الحادثة بعنوان مغاردة تصفر: الفوز في معركة الأخطاء الطبية (Cheating Zero Winning the War on Healthcare Errors).
- صادقاً رجع وصي الأمر كيجين وفهرم من صوب العالم لخطوة الأخطاء الطبية والتي يمكن تجنبها بسهولة - لزامن تمنحها أغلبها بسهولة - لزامن

حينما نبار  
جعل النظام  
الصحي أكثر أمناً  
منع الأخطاء قبل  
حدوثها. وحينما  
نعلم من الأخطاء  
التي حدث بالفعل  
حتى لا نكرر مرة  
أخرى من دون اللجوء  
إلى الإنكار أو دفن  
رؤسنا في الجبال.  
تكون في طريقنا نحو  
تحقيق مبدأ  
'النظمة للتعلم'



## الاعتماد الصحي في العالم إلى أين؟

دينيس كويد، الهيبارين كاد أن يقتل فرحتي بالتوأمين

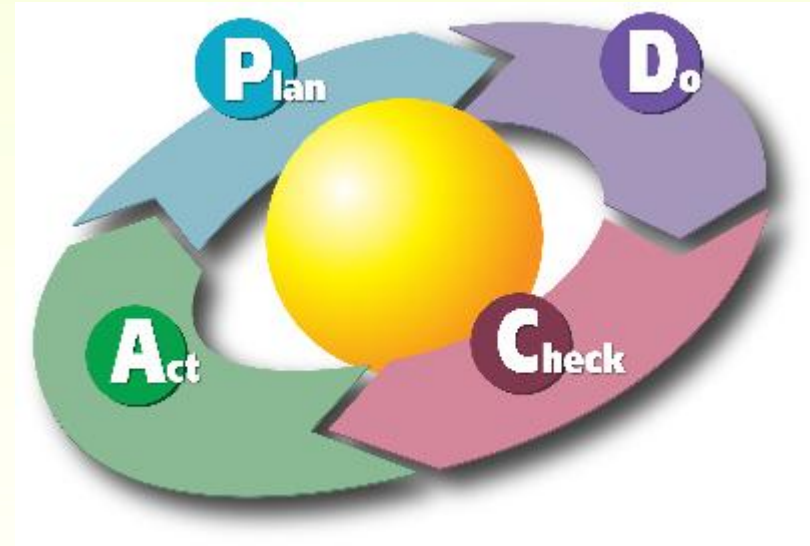
أمين عام المجلس المركزي:  
المجلس دخل مرحلة جديدة من التحديات



# Second: 4-Step Success Formula

PDCA (PDSA)

- It is continuous: Kaizen



# Third: Teamwork

Delos Cosgrove

Systems Thinking..









Keep Your Patients Safe



**Thank You**