The state of JCAHO hospital surveys for 2002 and beyond

A recap of the JCAHO’s annual Executive Briefing conference

The JCAHO covered much ground regarding new standard requirements and survey processes at its first Executive Briefing seminar in Chicago on August 24 (subsequent conferences were held in Los Angeles, Dallas, and New York City).

Although the accreditor did not unveil breaking news, the JCAHO staff expanded on the many changes in 2001 and the future impacts regarding

• the Individualized Centered Evaluation (ICE) survey approach and what it means for you (i.e., double deficiencies as surveyors link systems to standards)
• the recent trend of unresolved Type I’s due to the increased window of time for random unannounced surveys (RUS)
• efforts to make the survey process easier (for example, using technology to ease the paperwork burden)

The JCAHO also updated conference attendees on

• patient safety standards compliance
• new and revised staffing standards
• the hospital standards review task force

How to survive the monthly Sentinel Event Alert requirements

Get ready to prepare more analyses on reducing the risks of specific types of sentinel events. The JCAHO will issue its Sentinel Event Alerts on a monthly basis, “so this means more work to fulfill the expectations [of standard PL4.2],” said Richard Croteau, MD, the JCAHO’s executive director for strategic initiatives, at the first 2002 hospital Executive Briefing seminar. Many conference attendees groaned aloud.

Organizations must review each Alert, consider any applicable recommendations, and implement them, or provide a reasonable explanation for not doing so or receive a Type I recommendation (see p. 1 of the May issue).

Your colleagues have said via “BOJ Talk” that the Alerts are “like a faucet that won’t turn off” and preparing monthly analyses to comply with the standard is a “bit over the top.”
Hospital surveys

• the proposed 18-month survey cycle

**ICE survey process**

If your last survey was in 1999, expect a big change for your next triennial survey, primarily a closer scrutiny of the individual patient from admission to discharge. This is because of the new ICE process, introduced at the annual surveyor training in Chicago this past January. ICE means you will have less control over what information you give to surveyors since they will follow frontline staff through the entire care process for that one patient.

Rather than assessing the process of standards compliance, surveyors will ponder information they observe, read, and hear from staff about patient care and will gauge consistency, said Kurt Patton, MS, RPh, the JCAHO’s executive director of accreditation services. “They will observe the care delivery process and then talk to the patient, nurses, and check the files to validate the patient care process,” he said (read more on ICE on p. 1 of the March issue).

And because the JCAHO wants hospitals to deliver the same level of care to all patients as part of the ICE focus, surveyors are tying standards to entire systems surrounding patient care. Surveyors will scrutinize communication, handoffs, and patterns. So you can receive multiple Type I’s on the same issue, said Carole Patterson, MN, RN, a Joint Commission Resources consultant.

In particular, surveyors link standard areas to leadership (LD) standards since the JCAHO is emphasizing more leadership accountability these days. For example, your colleagues who underwent surveys in 2001 say a Type I in areas from housekeeping to anesthesia use can also result in a LD recommendation.

**Unresolved Type I’s**

Historically, the JCAHO would not conduct a full survey if a hospital had outstanding Type I recommendations. However, the JCAHO extended the window of time to conduct a RUS from 18 months after the triennial survey to between nine and 30 months to promote continuous survey readiness. So it’s now possible to have unresolved Type I’s by the time you have your scheduled triennial survey, especially if you experience the RUS around the 30-month mark. If you haven’t cleared up the previous deficiency at the time of your triennial survey, you risk having a second generation, or unresolved Type I, Patton said.

A JCAHO source further clarified the issue with this scenario: Your official accreditation decision following your triennial survey typically becomes final after two months. Six months after that date, you have a focused survey to check on the Type I status. While the JCAHO may have cleared the Type I(s) in question, the surveyor may find a smoking violation when walking into the building, and then cite you. If you experience a RUS the next month, and you still have that smoking violation evident during survey, you now have a second generation finding.

The JCAHO will meet you half way by allowing your organization to clear the deficiency in two ways. You can suspend the written progress report if it’s due within 60 days of the scheduled full survey. If the written progress report deadline is after the survey date, surveyors can evaluate the unresolved Type I at the time of survey. If corrected, they will clear the finding. If not, surveyors will reapply the deficiency as a first generation with the same follow-up time frame (six months). If the written progress report deadline is before the full survey, surveyors will evaluate the deficiency at the time of survey. “It’s complicated, but we wanted to clear up the Type I’s [more easily],” Patton said.
Simplifying the survey process

Although the JCAHO will stringently hold you to your policies and what you tell surveyors about patient care, it will strive to simplify the mechanics of the survey process. The accreditor will begin the electronic survey application system in 2002 to eliminate application paperwork. By March 2002, all hospitals will have a password-protected Web site containing their data.

As part of the electronic application, the JCAHO hopes to build in some logic that will tailor the survey better. The JCAHO wants to be more flexible with surveyor days since many hospitals complained that they had too many of them. Thus, the JCAHO will provide you with the exact number of surveyors needed. However, don’t get nervous if you see an extra body come survey day. To stay on top of surveyor performance, the JCAHO will randomly send out a regional associate director from the central office to evaluate them. At one time every surveyor will be evaluated, but it may not happen during your survey.

The JCAHO has assigned each hospital in the country an account representative. Your representative is not a standards expert, but serves as a liaison or case manager and can refer you to the appropriate party when you have questions, Patton said.

Patient safety standards

Regarding the new patient safety standards, the JCAHO will look for a compliance track record starting in July 2002. But if you undergo a survey next month, surveyors will ask what you have done thus far since the standards took effect July 1. Key patient safety survey elements are

- an increased focus on patient safety throughout the survey
- leadership interviews to understand standard intents
- patient unit visits and staff interviews to understand the actual practice
- the implementation of Sentinel Event Alert recommendations or alternative explanations within 90 days of publication

The accreditor requires hospitals to pick one high-risk process to analyze by October 1, said Richard Croteau, MD, the JCAHO’s executive director for strategic initiatives. At press time, the JCAHO had not yet published the October 1 deadline, and one JCAHO insider questioned how surveyors will score on the October 1 date, since surveyors—as well as hospitals—had not yet received scoring guidelines.

The complete failure mode analysis—or root-cause analysis of a near-miss—is due in July 2002. Hospitals surveyed after that date must share the completed failure mode and effects analysis, along with any resulting process redesigns, said JCAHO spokesperson Mark Forstnegler. Look to the November issue for tips on how to conduct the analysis.

Staffing standards

The new and revised staffing standards go into effect in July 2002. Prepare now to analyze your staffing levels based on your selection of several of the 21 new human resources and clinical screening indicators, posted at www.jcaho.org/standard/stds2002_mpfbrm.html. “We are looking for your organizations to start using these indicators and to be more descriptive in your variance reports to see how effective you are with staffing,” Patterson said. “Is staffing effective to meet patient needs?”

During leadership interviews, for example, surveyors will ask leaders why they chose the indicators that they did and how they assessed them, Patterson said. Link patient outcomes with judging how you deliver patient care. If staff do not administer a patient’s medications on a timely basis, is this due to understaffing in that area? You should ask this question first.

Standards review task force

Remember the standards review task force that started to overhaul the Comprehensive Accreditation Manual for Hospitals (CAMH) this past spring? The task force has completed revising the Rights of Patients, Leadership, and Governance chapters, but the final revised version of the CAMH will not be published until about 2004. The JCAHO promised a more readable, understandable accreditation manual minus some irrelevant standards (see p. 1 of the June issue).

The accreditor also announced a new CAMH standards format for 2003 (see p. 12 of the September issue). Some chapters will contain an introduction for > p. 4
Hospital surveys < p. 3

standards sets, similar to the recent addition of the TX.2 anesthesia standards that have a shaded introduction explaining the four new anesthesia definitions, Patterson said.

“We want fewer words to read and succinct and shorter sentences,” she said. “We want this to be easy to understand.”

Alert requirements < p. 1

“It almost seems like a conflict of interest; we must use their product in order to avoid a Type I error,” points out another talk group user.

How to simplify the process

Don’t let the Alert analysis overwhelm you. Check out how staff at Beaver Dam (WI) Community Hospital simplified the Alert response. Sue Williams, MT, the hospital’s quality improvement director, created a simple form (see p. 5) to record Alert analysis information. When Williams receives each Alert, she records the Alert number and title in the top left box on the form and then sends it along with a hard copy to the appropriate persons for review. For example, she forwarded the Alert concerning the threats of kernicterus in newborns to the nurse director of the OB/Women’s Health Center.

The appropriate staff members have two weeks to review the Alert and complete the response form. If staff members identify an opportunity for improvement, they appoint someone to lead the effort and note a target date. On a quarterly basis, Williams shares an Alert summary with the medical staff to keep them informed of patient safety measures. And she files the Alerts and response forms in a three-ring binder so at any time hospital staff—or surveyors come survey time—can easily obtain and review the Alert information, and how the hospital has addressed each one.

“Using the form makes the process very simple,” she says. “It has worked for us so far.”

18-month survey cycle

Don’t hold your breath waiting for an 18-month survey cycle. This proposed process is still in the pilot stage (see p. 1 of the April issue).

The JCAHO is investigating the cost impact (your colleagues cry more ramp-up costs), so any change will happen in 2003 at the earliest.

Does this make sense?

By the way, some of your colleagues were confused by Sentinel Event Alert #22 (read the full list of Alerts at www.jcabo.org/ptsafety_frm.html) on preventing needlestick and sharps injuries for health care workers.

According to the JCAHO’s policy, sentinel events relate only to patients and not staff. While needlestick and sharps injuries involving patients are less frequent, the JCAHO’s sentinel event database includes two cases—one involving an infant and the other a child, says JCAHO spokesperson Charlene Hill. “The definition for sentinel events has not changed,” she says. “The techniques suggested in the Alert to protect health care workers from needlestick and sharps injuries can also protect patients.”

One West Coast physician feels that the JCAHO is “stretching here,” although there have been more patient needlesticks than just two children. “But I am not sure it’s enough to make everyone scramble,” the physician says.

Also, the physician feels the JCAHO’s Alerts have moved toward the “if it saves just one life, it’s worth it” mentality. “But at a one-a-month rate, I think we will no doubt see more of these that affect few people, but cost us a lot.”

Note: The JCAHO will start to repeat Alerts if sentinel event statistics on a past topic—such as wrong site surgery or restraint deaths—increase, Croteau said.
Sentinel Event Alert Response

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**Outcome of Review** (check all appropriate and document – use additional sheet if necessary)

- **Measures in Place** – list policies and practices

- **Suggestions or Alternate Ideas To Be Implemented** – please list

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- **Chose Not to Implement Suggestions** – list and reason

- **Suggestions are not relevant to the services that we provide at BDCH**

Source: Beaver Dam (WI) Community Hospital. Reprinted with permission.
Too busy to attend the JCAHO’s annual hospital Executive Briefing series? BOJ attended and offers the following portion of the question and answer segment:

**Q** Can the JCAHO conduct the long-term care portion of a tailored survey on different days than the hospital survey?

**A** Our focus is to connect surveys. Yes, this can be done, but you need to ask us first.

**Q** Will surveyors come conduct an off-shift survey prior to the official start of the triennial? For example, could they show up at 3 a.m. on Monday when the survey officially commences at 9 a.m.?

**A** No. However, on rare instances, for-cause surveys can occur prior to the full triennial.

**Q** Has the JCAHO included the Health Insurance Portability and Accountability Act of 1996 requirements in the survey application?

**A** No. But we are working on two fronts. We are trying to remove the JCAHO from the business associate category. We also added additional language for the Management of Information standards related to the issue that all medical record information is secure. The revisions will be forthcoming in the near future.

**Q** How is it best to demonstrate records compliance when a majority are computerized?

**A** Invite the surveyor to sit at the computer with you, and you can show them. But just as they don’t let you play with their laptops, they are not supposed to play with your computers.

**Q** What is the JCAHO doing about the rising costs of accreditation and the momentum to not be JCAHO-accredited?

**A** The JCAHO has done a lot of work to increase the value of your fees. We have been investigating ramp-up costs, for example. Under the Accreditation Process Improvement initiative, we try to increase the triennial value. You should also note that there were no fee increases this year, and last year you only had a modest increase. So there was one small increase in the past four years. About the momentum, it’s hard to define. I define momentum differently from the four hospitals identified in the media out of the 4,800 nationwide. Our accredited facilities ask whether the JCAHO is keeping up with the times. That’s a good dialogue, and that drives much of our change. But I don’t see a momentum of moving away from the JCAHO.

**Q** How do we resolve the different answers we get from the standards interpretation group?

**A** We are developing an extensive frequently asked questions (FAQ) database. Most questions for the standards interpretations group can be answered by looking at the FAQ’s that we post on our Web site (www.jcaho.org). We’ve also had a backlog of questions, which we have resolved. We are trying to use technology to help with this. While most people prefer to talk to another person than look on the Web, the Web site may be quicker. More complex questions can be answered by phone.

**Q** Can the two-year reappointment be extended if all parts of the process are complete, but the board has not met yet?

**A** Our current standards don’t address extensions. But we have a level of tolerance for individual cases in which the physician can’t be reappointed because of factors beyond the medical board’s control. The reappointment process is likely to change, and we are looking into that, but any changes won’t happen quickly. Some organizations get around this issue by staggering reappointments because they can do this earlier than every two years.
History and physicals 101: A refresher course on the basic requirements

The many requirements for history and physical (H&P) documentation and procedures have historically tripped up hospitals. And it shows in how the JCAHO rates H&P standards compliance. Many of the consistently top problematic JCAHO standards deal with H&P requirements (see box below).

This month BOJ examines the basic H&P requirements and who can perform them. In the November issue, we will conclude with recommendations. John Rosing, MHA, FACHE, senior consultant for The Greeley Company, a division of HCPro, in Marblehead, MA, prepared the following H&P criteria.

Basic requirements
You must perform an H&P for each patient and place it in the record within 24 hours of admission, including weekends and holidays. Staff must dictate, transcribe, authenticate, and place the H&P in the medical record based on hospital policy. This policy may allow for authentication of the H&P to occur sometime beyond 24 hours of admission (e.g., at the time of the next visit or prior to discharge).

When a transcription delay beyond 24 hours occurs, a licensed independent practitioner (LIP) can submit a signed handwritten note and place it in the medical record. The note must contain pertinent findings or sufficient patient information within 24 hours of admission so that clinicians can manage the patient and guide the plan of care.

Medical staff rules, regulations, or policies should define the H&P contents, including the time frame for currency and procedures or interventions (in addition to the admission of an inpatient) requiring either a complete or short form H&P and the disciplines privileged to perform the H&P.

H&P elements
The full or complete H&P must include the following items:

- Chief patient complaint
- Details of the present illness or condition including, when appropriate, assessment of the patient’s emotional, behavioral, and social status
- Relevant past social and family histories appropriate to the patient’s age
- Inventory of body systems
- Physical examination
- Diagnosis or problem list with a plan of care

For children and adolescents, the history should also include the following:

- An evaluation of the patient’s developmental age
- Consideration of educational needs and

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Some top problematic standards that cover history and physical (H&P) requirements

- **PE.1.7.1**—Hospitals must perform the H&P and other necessary screening assessments within 24 hours of admission
- **PE.1.8**—Staff must record the H&P, diagnostic tests, and preoperative diagnosis in the medical record prior to surgery
- **IM.7.6**—The hospital analyzes medical record data and information in a timely manner
- **PE.1.7.1**—If staff perform the H&P 30 days prior to surgery, a copy must be in the medical record

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H&P refresher

- daily activities, as appropriate
- The parents’ report or other documentation of the patient’s immunization status
- The family/guardian expectations for, and involvement in, the assessment, treatment, and continuous care of the patient

The short form H&P typically includes the above six elements for adults and additional four elements for children, with a provision that the information may be abbreviated to include only that which is relevant to the procedure to be performed. The medical staff rules or policy must also outline the circumstances, such as specific procedures or interventions, where a short form H&P is allowable.

Moderate or deep sedation requirements

In cases involving moderate or deep sedation, the hospital may incorporate (into the short form H&P) documentation required for a preanesthesia/presedation assessment and reassessment. Typically, this would include the following:

- Pertinent medical and surgical history
- Personal and family history of sedation/anesthesia complications
- Physical exam of airway, heart, and lung, and level of consciousness
- Clinical impression or preop diagnosis
- Operative and other invasive procedure plan
- Pertinent lab or test results
- Current medications and dosages—including over-the-counter medications and herbal supplements—allergies, and all past medication reactions
- Sedation risk assessment, such as the American Society of Anesthesiologists score
- Plan for moderate sedation (e.g., intravenous sedation with monitoring)
- A note recording a second evaluation just prior to inducting or administrating the sedative/anesthesia

If staff complete an H&P within 30 days prior to admission, it can be used to fulfill the above requirements, provided staff place a legible copy into the medical record, and note there are no changes from the previous H&P. Or, a staff member can detail any changes that may have occurred since the earlier H&P. This is known as the interval note.

Note: The Centers for Medicare and Medicaid Services’ (Formerly the Health Care Financing Administration) Condition of Participation and some state laws specify that an H&P may be no more than seven days old. Since caregivers often find this impractical, many hospitals choose to risk a citation on this issue from one or more of these government-sponsored payers.

Who can perform the H&P?

Qualified nonphysician LIPs, such as podiatrists or dentists, can now perform complete H&Ps as long as they are privileged to do so. Other non-LIPs—such as physician assistants and nurse practitioners—can now perform H&Ps as long as state law and medical staff policy permit it and a qualified physician supervises them. The hospital must grant specific privileges to these individuals through the medical staff credentialing process.

If a nonphysician, non-oral, and maxillo-facial surgeon LIP perform a high-risk procedure they must have a qualified physician endorse their findings, conclusions, and assessments prior to performing the procedure. The medical staff must clearly define in their policies exactly which procedures qualify as high-risk. For instance, thyroid ablation, endoscopy, elective cardioversion, cancer chemotherapy or radiotherapy, pain clinic assessment and therapy, and any procedure involving moderate sedation likely qualify as “high-risk” procedures.

On the other hand, properly trained oral and maxillo-facial surgeons, in addition to holding privileges to perform a basic H&P, may also hold privileges to assess the medical, surgical, and anesthetic risks of the proposed operation or other procedures, regardless of whether it is defined as “high-risk.”
Medical staff standard **MS.5.11** requires that hospitals not grant privileges for more than a two-year period. When it comes to the recredentialing process, however, time and paperwork issues and uncooperative physicians can often cause a foul-up, warranting a request for temporary privileges to extend the original appointment.

However hospitals can’t extend an original appointment beyond the two-year time period, says **John Rosing, MHA, FACHE**, a senior consultant for The Greeley Company, a division of HCPro, in Marblehead, MA. “Institutions that find themselves in that situation should carefully review their reappointment process.”

Many of your colleagues struggle with this issue, as 8% of hospitals received a poor score on this standard in 2000 (see the full chart of the top JCAHO problematic standards for 2000 on p. 4 of the June issue).

**Get time on your side**

Consider the following tips to resolve recredentialing procedure timing issues:

- Make the privileges run from January to January, but start the approval process in November (or similar time frames).
- Make the approval date effective though the end of the month regardless of when your board meets during the month to vote on the approval. The date on reappointments is for the two-year window, not the date of the board meeting.
- Send physician credential files to the board the month before they expire rather than the month they do expire.
- Start the credentialing process earlier, but stay within the time frames you have identified in your policies and procedures.

**Forge solutions with docs, the paper trail**

When it comes to dealing with paperwork processing issues and uncooperative physicians, consider the following:

- Take the file to the physician personally, and wait in his or her office until the paperwork is completed. **Cathy Alversteffer**, medical staff coordinator at North Ottawa Community Hospital in Grand Haven, MI, says “the physician is usually embarrassed,” but in the long run it saves time because she uses the face time to educate the physician on credentialing and reappointments. The one-on-one time also gives the physician the opportunity to ask questions.
- Use correspondence to clearly explain the credentialing process. **Malee Maurer CMCS, CPCS**, medical staff coordinator at Holy Spirit Hospital in Camp Hill, PA, uses correspondence to explain the credentialing procedure and tells physicians that they have the burden of follow-up on any verification items not received. Maurer also faxes a three-column checklist with all the credentialing documentation to the physician’s office administrator.
- Use teamwork to accomplish your credentialing goals. One New England medical staff coordinator works with the chair of the credentialing committee. The medical staff coordinator is not afraid to have the credentialing chair step in to help enforce the rules.
- Don’t tolerate physicians who “forget” to reapply. “Establish a firm policy that requires the receipt of a reappointment application prior to the two-year deadline,” Rosing says. “If the medical staff office does not receive the application prior to that date, clinical privileges and appointment will expire, and the institution will no longer permit the physician to practice.”
Your “BOJ Talk” colleagues recently asked for a policy for communicating medical errors. What you may not know is this information is posted at the National Patient Safety Foundation’s Web site, www.npsf.org/statement.htm. (If the link is not working, go to the home page at www.npsf.org, and click on the “Talking to Patients about Healthcare Injury Statement of Principal” on the bottom right hand side of the page.)

The policy states that “when a health care injury occurs, the patient and the family or representative are entitled to a prompt explanation of how the injury occurred and its short- and long-term effects. When an error contributed to the injury, the patient and the family or representative should receive a truthful and compassionate explanation about the error and the remedies available to the patient.”

One of your colleagues says the statement is short, simple, and can be adapted at your hospital with revisions appropriate to specific facilities. Almost every malpractice carrier says caregivers must be honest with patients, tell them about an event, and how it could never happen again, and thus usually decrease the amount awarded to the plaintiff in a court case by doing so, comments an industry expert. -dea-
**Trends & tips**

**Preliminary hot buttons for 2001**
Heads up on the preliminary hot buttons for 2001. The following standards are in the top problematic standards list for the first quarter of this year:

1. **IM.7.3.2.2**—(11.2%) Staff must immediately write a progress note after surgery if they have not placed the operative note into the medical record.

2. **PF.3**—(7.8%) Staff must educate patients on their assessed needs, abilities, and learning preferences.

3. **EC.1.5.1**—(6.2%) Staff members design and maintain newly constructed and existing environments of care according to the *Life Safety Code*.

4. **EC.2.1**—(5.4%) The hospital implements its safety plan.

These standards may drop out of the hot button roster since the JCAHO had only surveyed 205 hospitals at that point, Carole Patterson, MN, RN, a Joint Commission Resources consultant, said at the first Executive Briefing seminar in Chicago on August 24.

Where did hospitals go wrong? Concerning **IM.7.3.2.2**, physicians often fail to perform dictation in time, said Patterson. “The information must go on the medical record as a patient moves to different areas of care,” she said. “If a patient is in the [recovery area] for two hours and staff have not yet written a progress note, that’s not good.” *Note: This standard was the top 6th problematic standard in 2000.*

With **PF.3**, surveyors often can’t find this assessment in patient records, Patterson said. This standard is new to the troublesome list.

Regarding **EC.1.5.1**, surveyors have stumbled upon blocked exits or insufficient notes regarding exits in the emergency plans. *Note: This was the top 26th problematic standard last year.*

For **EC.2.1**, many hospitals fail to hold sufficient unannounced fire drills, Patterson said. *This standard was the 28th problematic standard last year.*

Percent of hospitals surveyed during the first quarter of 2001 received scores of 3, 4, or 5, which can lead to a Type I finding.

**Hospitals score well on pain management**
Speaking of troublesome areas, you’d think that pain management standards would climb up the problematic list ladder. But the JCAHO data from the first quarter of 2001 shows that hospitals scored well on pain standards. “The impact is minimal,” Patterson said.

**Is the JCAHO or health care getting tougher?**
There’s been a lot of talk on the streets about JCAHO surveyors being much tougher on hospitals. Also, the average survey score dropped from being 92.3 in 1997 to 90.8 in 2000. JCAHO insiders told *BOJ* that surveyors are not necessarily getting tougher, but are paying closer attention to systems while still offering educational advice. Patterson said at the Executive Briefing conference that since the JCAHO scrutinizes systems more these days, surveyors have seen more system/record flaws and omissions.

“The moral of this story is that the JCAHO identified its standards as being risk points in the patient care management process,” Patterson said. “Health care is getting more risky, especially with an aging population. There are a lot more societal issues. The Joint Commission is not getting tougher, but health care is getting tougher. So you need to protect yourself in [top problematic standard] areas.”

**CAMH update**
The third quarter *Comprehensive Accreditation Manual for Hospitals (CAMH)* update is in! Don’t forget to remove the appropriate pages from your *CAMH*, and replace them with the update, as outlined in the instructions.

Some highlights in the update, effective January 1, 2002, include the following:

- Clarifications regarding JCAHO requirements in *Sentinel Event Alerts*.
- Scoring cap changes for Assessment of...
Patients, Leadership, and Medical Staff (MS) standards.

- Revisions to restraint and seclusion standards, including to standard TX.7.5.3, which clarifies the use of individual orders. A revised definition for restraint standards in acute medical and surgical care states that “restraint is the direct application of physical force to a patient, with or without the patient’s permission, to restrict his or her freedom of movement.”

- Revisions to MS standards regarding supervision of residents (visit www.jcaho.org/standards_frm.html).

**Another pain management lawsuit**

Not adequately treating patients for pain can be pretty costly. A California jury on June 14 ordered a physician to pay $1.5 million to the family of a man who suffered what the jury said was unbearable pain before he died of lung cancer (see story on p. 1 of the September issue).

Another California pain lawsuit that hit the press on August 18 involved a judge issuing a final ruling against Dr. Wing Chin of the Eden Medical Center in Alameda County of elder abuse for under-medication of the pain of an 85-year-old cancer patient.

William Bergman was reportedly suffering from bone fractures and possible lung cancer at the time of his death in 1998. The judge awarded Bergman’s children $250,000, based on California’s elder abuse law. In 1994, the California State Medical Board issued guidelines on how to best treat pain to physicians across the state.

**Concurrent survey pilot update**

Remember the controversy over the pilot test of concurrent Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, and JCAHO surveys? During the first quarter of this year, the JCAHO and CMS performed concurrent validation surveys at hospitals with 150 beds or more to assess and monitor the JCAHO deeming status process (read full story on p. 1 of the February issue).

The dust seems to have settled, and there are no more concurrent surveys scheduled at this time, said Kurt Patton, MS, RPh, the JCAHO’s executive director of accreditation services at the Executive Briefing seminar. Several hospitals in California and Illinois participated in the pilot (read how one hospital survived the joint survey on p. 4 of the March issue). 

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**Briefings on JCAHO**

**Editorial Advisory Board**

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</tr>
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