Ditch old habits: Accreditation is not just a survey score

Editor’s note: This story is adapted from the fax express, sent to your facility on August 25, about the JCAHO’s first Executive Briefings seminar in Chicago on August 22.

Moving forward into 2004, forget about focusing on the survey score and Type I’s and changing systems just to please the JCAHO.

“The biggest concern that I have is that we, as well as you, will have trouble letting go,” he added.

Your colleagues who attended the seminar agreed. One of their most pressing concerns for 2004 was whether surveyors would consistently follow the major initiatives set forth in Shared Visions–New Pathways™.

Changes to National Patient Safety Goals are ‘logical’, your peers say

Two key changes to the 2004 National Patient Safety Goals are that nursing staff must read back verbal critical test results, in addition to reading back verbal and telephone orders, and hospital staff will have to pay even closer attention to infection control.

Reading back critical test results, the new requirement for Goal #2, makes sense and is consistent with requirements from the College of American Pathology (CAP) for certain specimen results, says Linda Pello, RN, MBA, CPHQ, director of quality improvement at the Hospital of St. Raphael in New Haven, CT.

St. Raphael’s staff comply with CAP requirements for documenting read back of identified specimens. Staff use a list of critical lab values which require a telephone call to a patient care unit, and for staff to document when they repeat back the results. The hospital plans to educate staff about the importance of reading back critical lab results, says Pello. The hospital will work on creating an electronic system where nurses can indicate that they read back critical test results.

The list of critical lab results > p. 3
Accreditation

One of the major initiatives of future surveys will examine whether staff at the unit level, rather than just the survey coordinator, understand the standards. “That is the model I would put in place,” Massaro said. “Disregard the current model [because], if you don’t, it will be your death sentence [in] the new process.”

At the Executive Briefings, the JCAHO discussed many topics regarding this new model. These included several tidbits of note, two of which are included below.

Periodic Performance Review (PPR)
The JCAHO issued two new options in addition to the current option of completing the self-assessment, which are as follows:

1. Organizations complete a self-assessment, and create improvement plans and measures of success as needed. You won’t have to submit this data to the JCAHO, but you must attest to the following:

   • using an introductory screen to the extranet tool, you have assessed your compliance with and developed improvement plans and measures of success. The JCAHO defines a measure of success as “a numerical or quantifiable measure, usually related to an audit, that determines if an action was effective and sustained.”

   • you have been advised by legal counsel not to participate in the PPR.

Organizations can access the PPR to print standards and their requirements, but they won’t be able to use the tool to score compliance, since the JCAHO can access this information. You can, however, submit standards-related issues for discussion with the JCAHO without revealing your own levels of compliance. Surveyors will review improvement plans and measures of success during the on-site survey.

2. Organizations undergo an on-site survey in lieu of the self-assessment. According to a JCAHO press release, if you choose this option, the JCAHO will schedule a survey 18 months into your accreditation cycle, with the duration cut by one-third and with one surveyor—at a fee yet to be decided. The JCAHO will limit the scope of the survey and conduct it primarily through tracer methodology, as the priority focus process dictates.

TIP: Perform the PPR not just for accreditation’s sake, but as a departmental audit to ensure that your hospital functions as it should, Massaro said.

Patient Safety Goals
Requirements in the first three goals will appear in the 2004 standards so the JCAHO will score you on compliance. The JCAHO will continue to score Goals #4–#7 as accreditation participation requirements.

For Goal #2 and its requirement to create a list of unacceptable drug abbreviations, the accreditor will enforce the organization’s ban on the use of certain abbreviations, acronyms, and symbols, but only for hand-written notes or orders. In 2005, organizations must eliminate all uses—including electronic—of banned abbreviations.

By early September, the JCAHO will publish on its Web site (www.jcaho.org) a “starter list” of unacceptable drug abbreviations, acronyms, and symbols that, as of January 2004, must be on your list.

In terms of the new Goal #7, regarding the Centers for Disease Control and Prevention’s (CDC) hand hygiene guidelines, the JCAHO will require organizations to comply with all of the CDC’s category I recommendations (categories A–C). The accreditor will encourage organizations to adopt the CDC’s category II recommendations as well.
to which St. Raphael’s laboratory staff will draw attention include but are not limited to the following:

- High or low potassium levels
- High or low liver functions
- High levels of acetaminophen or certain other medications
- Abnormal platelet counts
- Abnormal pH levels

At the Parkview Medical Center in Pueblo, CO, staff will focus on educating nurses about confirming critical test results with the lab before informing the physician, says Judy Sikes, PhD, Parkview’s director of accreditation and medical staff services.

According to a “BOJ Talk” group user, it was difficult to get nurses to consistently write down “rb” when they read back a verbal order. Instead, the facility trained nurse managers to monitor conversations at different nursing stations to determine how often the nurses follow the read-back policy. Managers keep a log of how many times they watch a nurse take a verbal order and how well the nurse follows the procedure. The managers note if the verbal order was confirmed, notice how receptive physicians are to nurses who read back orders, and contact one of the facility’s leaders if a physician refuses to cooperate with a nurse during a read-back.

“Reading back critical values is something that everybody should be doing and probably [is] doing,” says Pello. “The hard part is coming to consensus on what to include in the read-back requirements because, as I understand this goal, it applies to all tests, not just lab results,” says Pello. “That is a very realistic goal and should be part of our everyday practice.”

Trim your nails

Reducing health-care associated infections (HAIs)—now JCAHO’s Goal #7—was a focus at the Parkview Medical Center even before the JCAHO added it to the goals, says Sikes. Several years ago, for example, the center adopted a policy restricting artificial fingernails and limiting nail length because of the role they can play in spreading infections, she says.

When patients are admitted to the hospital, they receive a list of safety tips, which includes asking health care workers if they have washed their hands and applied antiseptic gel. See the related policy on handwashing and fingernail length on p. 4 and a proper attire policy on p. 5.

Staff at Parkview have already made the switch to antiseptic waterless hand gels and installed hand gel dispensers throughout the facility. One of the requirements of the goal is to comply with the Centers for Disease Control and Prevention hand hygiene guidelines, which emphasize using antiseptic hand gels. The JCAHO will also start requiring facilities to treat as sentinel events any unanticipated deaths or major permanent loss of function as a result of HAIs.

At St. Raphael’s, staff placed waterless alcohol hand sanitizer dispensers throughout patient care areas and now rely on extensive education programs to encourage better hand hygiene. Posters reminding staff to wash their hands are located throughout the facility, and infection control practitioners routinely monitor how well staff comply with the hand hygiene policies, says Pello.

A policy on artificial nails will be in place by the end of October, she says. “Nail hygiene might be problematic, because many people wear nail polish and spend money to get their nails done,” says Pello. “If we say they can’t wear artificial nails, we will be impacting their personal lives as well as their professional lives. However, it has long been recognized that [some] of the best ways of preventing infections are washing hands and having shorter fingernails.”

“Improving hand hygiene definitely has significant value, but changing behavior to comply 100% of the time will be very difficult,” says Pello. “I think people feel a sense of frustration and urgency because we only have a year to completely change behavior for all of the goals.”
Sample handwashing and hand hygiene policy

Policy
Hospital personnel will use appropriate hand hygiene to prevent the spread of infections to themselves and others. Staff will wash their hands with soap and water when they are visibly dirty or contaminated. If hands are not visibly soiled, use an alcohol-based, waterless antiseptic agent for routinely decontaminating hands.

At minimum, staff will wash hands during the following times:
- When coming on duty
- Before applying and after removing gloves
- When hands are obviously soiled
- Between handling of individual patients
- Before contact about the face and mouth of patients
- Before and after personal use of toilet
- After sneezing, coughing, blowing, or wiping the nose or mouth
- On leaving an isolation area or after handling articles from an isolation area
- After handling used sputum containers, soiled urinals, catheters, and bedpans
- Before eating
- On completion of duty

All direct care providers and others who have contact with patients (i.e., environmental technicians), supplies, equipment, or food must not wear artificial nails and must keep natural nails short. The hospital does not permit chipped nail polish. Staff must also limit jewelry.

Surgical hand antisepsis—either an alcohol-based handrub or an antimicrobial soap—is necessary before donning sterile gloves. When performing surgical procedures, decontaminate your hands without using a brush to minimize skin damage and the bacteria that may be released from damaged skin.

Procedure
1. Stand far enough back from the sink so that you do not touch it and contaminate your clothing.
2. Turn on the water to a comfortable temperature.
3. Wet your hands up to the wrists.
4. Apply one squeeze of disinfectant soap (soap provided by the hospital). Work into a lather and wash all surfaces of your hands and fingers for 10-15 seconds. Rub your hands together briskly to create friction and develop a lather. Friction is important to dislodge dirt and microorganisms.
5. Work the soap under your fingernails by rubbing them against the palm of your hand. Also, interlace your fingers and scrub the spaces between each finger.
6. If you are wearing a wedding band, slide it down the finger slightly and scrub the skin underneath it.
7. Cleanse your wrists by grasping one wrist and rubbing around it vigorously with the other hand.
8. Rinse well, keeping your hands pointing down. Complete removal of soap helps to prevent excoriation of the hands.
9. Dry your hands well with paper towels, then use a dry paper towel to turn off the faucet. If you use a wet towel, micro-organisms from the faucet handle can contaminate your hands.
10. Dispose of paper towels properly.

Procedure for using a waterless antiseptic agent (alcohol gel)
1. Apply to clean, dry hands and nails.
2. Dispense one pump into the palm of one hand.
3. Rub your hands together, covering all surfaces of your hands and fingers, especially under the fingernails and up to the wrists.
4. Rub lotion into your hands until dry without wiping. It should take 15 seconds for your hands to dry.

Hand lotion
You may use lotions after washing hands to help alleviate dermatitis. Hand lotions that contain petroleum products or other oil emollients may affect the integrity of gloves and should not be used. Use the lotion provided by the hospital for health care workers.

Source: Parkview Medical Center, Pueblo, CO. Reprinted with permission.
Sample professional dress and appearance policy

Policy
Our customers expect to see staff members who look professional. Directors and supervisors ensure that employees present a professional image and appearance at work.

Procedure
1. The medical center requires uniforms in many areas. Supervisors make certain that employees know what kind of uniform the organization requires, where to find uniforms, and how to assist with group purchases and payroll deductions when possible. If the organization requires that a staff member wear a uniform, doing so is a condition of employment.
2. When the organization does not require a staff member to wear a uniform, the employee wears conservative business attire appropriate for his or her work. The organization requires that staff wear hose or socks.
3. The following items of clothing are unacceptable: Blue jeans (except for hospital-approved dress down days), T-shirts, sweatshirts or sportswear tank tops.
4. Makeup should blend with the person’s complexion and not be theatrical. Perfume, cologne, and aftershave are inappropriate in the health care setting. Wear minimal jewelry in patient care areas.
5. Because of increased scientific reports (see sample handwashing/hand hygiene procedure on p. 4) linking higher numbers of micro-organisms and fungi with artificial nails, artificial nails will not be worn by anyone, with the following exceptions:
   • Staff in the business office, admitting, and information services
   • Medical records department staff
   • Other clerical staff who do not work in patient care areas

Keep natural nails clean and short, no more than one-quarter inch past the tip of the finger. Do not pierce the natural nail (with or without jewelry). If a staff member wears nail polish, it cannot be chipped, cracked, or peeling because this increases the bacterial count on the nail.
6. Department directors have the authority and responsibility to counsel employees who do not conform to these guidelines. The second time an employee requires counseling will result in the employee leaving and returning in appropriate attire.
7. Exceptions to the dress requirements as a result of individual departmental needs may be approved by the director. When the director approves an exception, it is put into departmental policy format and reviewed by the vice president of human resources.
8. When an employee changes into scrubs that the medical center provides, the scrubs must remain at the medical center and may not be worn home.
9. The hospital requires that staff wear name tags at all times.

Signed by_________________
Effective________ Document owner_______

Source: Parkview Medical Center, Pueblo, CO. Reprinted with permission.

Questions? Comments? Ideas?

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2004 standard advice

JCAHO is now more consistent with HIPAA requirements with the 2004 IM standards

Even though all health care organizations must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the JCAHO cannot technically enforce the security rule. The fact that the accreditor cannot make people comply should not make your facility lax, or it could cause problems at your next survey.

JCAHO’s updated information security and continuity of information standards (IM.2.20 and IM.2.30) for 2004 are more consistent with security rule requirements than those in previous years. These standards are generally the best practices for information management, says Shawn P. O’Reilly, CISA, CISM, information security coordinator at Upstate Medical University, in Syracuse, NY. If you comply with HIPAA, you’ll also meet many of the JCAHO standards, he says.

JCAHO v. HIPAA

The JCAHO standards address data integrity, safeguarding data, authentication, and other issues covered by the HIPAA security rule. The continuity of information standard directly relates to the security rule’s contingency plan standard, although HIPAA is more flexible than the standards created by the accreditor, says O’Reilly.

“The JCAHO’s continuity of information standard actually gives more detail. There are bullet points listing what the JCAHO wants to see. Although it is implied, there is nothing in the security rule’s standard about plans for scheduled and nonscheduled interruptions.”

Despite the many similarities, there are some differences between the two. Complying with HIPAA doesn’t automatically mean your facility complies with the JCAHO standards because the Joint Commission only surveys compliance with its standards, says Charlene Hill, spokesperson for the JCAHO.

“While our standards are consistent with HIPAA, they do not possess the specificity of HIPAA.”

The JCAHO standards don’t give you much leeway, says O’Reilly. “HIPAA’s addressable specifications give you some flexibility, but the JCAHO standards just tell you what’s required.”

Under the JCAHO’s security standard, organizations have to develop and implement policies for determining when it is permissible to remove records. “That sounds more to me like taking a paper record out of a file,” says O’Reilly.

“The security rule only covers electronic information, and [permitted removals] will likely involve some form of user ID and password.”

Analyze standard overlap

Avoid duplicating compliance efforts by doing a crosswalk analysis to determine where HIPAA and JCAHO standards overlap, says O’Reilly. “Doing the analysis will help you map some compliance efforts together.”

Use your risk analysis to determine what you need to do to comply with both sets of standards, he says. Upstate Medical University recently began its HIPAA assessment process and will also look at what the organization needs to do to prepare for the next JCAHO survey in November 2004.

“We’ll work on JCAHO and HIPAA compliance at the same time,” says O’Reilly. “I’m starting to determine what we need to do now. There may be a few things we put off until the beginning of 2005.”

Editor’s note: See p. 7 for the JCAHO’s 2004 information security and continuity of information standards, with their corresponding elements of performance.
IM.2.20: Maintain information security, including data integrity
1. Develop a written process (in one or more policies) based on and consistent with applicable law that addresses information security, including data integrity.
2. Communicate effectively the facility’s policy, including significant changes, to applicable staff.
3. Have an effective process for enforcing the policy.
4. Monitor compliance with the policy.
5. Monitor information and developments in technology to improve information security, including data integrity.
6. Develop and implement controls to safeguard data and information (including the clinical record) against loss, destruction, and tampering. Controls include the following:
   • Developing and implementing policies for when removal of records is permitted
   • Protecting data and information against unauthorized intrusion, corruption, or damage
   • Preventing falsification of data and information
   • Developing and implementing guidelines to prevent the destruction of records

IM.2.30: Have a process for maintaining continuity of information
1. Have a business continuity/disaster recovery plan for information systems, which includes identification of the most critical information functions for patient care, treatment, and services and business processes.
2. Test the plan periodically to ensure that the business interruption backup techniques are effective.
3. Have a process for disaster recovery and business continuity for electronic systems, as they would impact the management of information, including the following:
   • Plans for scheduled and unscheduled interruptions, which includes end-user training with downtime procedures
   • Contingency procedures for operations interruptions (hardware, software, or other system’s failure)
   • Plans for minimal interruptions as a result of scheduled downtime
   • An emergency service plan
   • Back-up system (electronic or manual)
   • Retrieval and what it will address, including retrieval from storage and information presently in the system, retrieval of data in the event of system interruption, and backup of data.

Source: The JCAHO’s 2004 Hospital Accreditation Program Standards. Go to www.jcaho.org to download a PDF of the standards.
Survey monitor
Navy hospital raises its score with continuous readiness plan

During its last JCAHO survey in December 2000, the Naval Hospital in Twentynine Palms, CA, received a score of 89. But in its February survey, the hospital raised its score to 97—currently one of the highest scores in the Navy, according to the facility’s staff.

They attribute the hospital’s success and improvement to a shift in philosophy, from preparation only in the months before the survey to continuous survey readiness. Hospital leadership instituted this shift just after their December 2000 survey.

Other hospitals may want to consider a similar strategy. The JCAHO will place more emphasis on continuous readiness with the changes to its survey process that take effect in January 2004—and the shift to unannounced surveys that will take place in 2006.

The following are five ways the Naval Hospital worked toward a system of being ready for a survey at any time:

1. Formed “JCAHO functional teams.” To make sure the hospital was following various standards. Each team focuses on a chapter of the Comprehensive Accreditation Manual for Hospitals. Members perform an assessment in their designated area and address any problems they find.

2. Hired JCAHO consultants. To train the functional teams, clinicians, and other key members of hospital staff.

3. Performed multiple mock inspections. For instance, leaders of different units would inspect one another.

“Medical would check nursing and nursing would go in and check OB/GYN and optometry. Everybody got involved,” says Lieutenant Commander Mary Martin, the hospital’s former organizational performance improvement coordinator.

Staff from other Navy hospitals also stage mock inspections two to four times a year. In addition, Martin herself performed several mock inspections, looking at patient care standards and working with the “troops,” as she calls them. The hospital also hired a JCAHO consultant in June 2002 to perform an unannounced mock survey.

4. Had leadership attend seminars and audio-conferences. “It was very well supported by leadership, and that’s a key point,” says Martin.

5. Cooperated with other Navy hospitals. “In the Navy, we have what’s called ‘organizational performance improvement networking,’ ” says Martin. During surveys at Navy hospitals, scribes carefully record information and questions that surveyors ask, so that they can help their brother and sister facilities better prepare.

About the facility

The Naval Hospital in Twentynine Palms, CA, is located on the Marine Corps Air Ground Combat Center, the largest Marine Corps base in the world. The hospital’s 15-bed multi-service ward, 15-bed obstetrics ward, large outpatient area, and additional satellite clinic for active-duty military personnel underwent a survey in February. The JCAHO sent a Navy medical inspector general and his team—including a physician surveyor, who happened to be a retired Navy admiral, and a retired Army nurse surveyor—to inspect the hospital for three days.
When the hospital received its 30-day notice, a “ready team” went into action, fulfilling duties such as posting the 30-day notice, dealing with public affairs, and arranging badges and parking spaces for surveyors.

Patient safety scrutiny
As has been the case at many hospitals lately, surveyors showed great interest in how the hospital promoted patient safety—particularly regarding the 2003 National Patient Safety Goals. The following are some of the questions the nurse surveyor asked staff during the patient safety and medication management interview:

- Have you been oriented to the Patient Safety Goals?
- Do you know what processes you put in place for patient identifiers?
- What type of device do you use to put initials on body parts?
- Have you tested your labor and delivery alarms?
- How does the medical staff get involved with medication safety issues?
- If patients come in with a food or drug allergy, do you start their medications right away?

Tip: Staff had put together a binder containing evidence of their compliance with each of the goals. “It was almost ‘failure-proof.’ The surveyor looked at it, and at that time, we had a home run,” says Jeanette von Gunten, the hospital’s patient safety specialist. The surveyor even flipped through the binder during the interview, asking questions based on the materials included in it.

Tip: Train everyone. The entire military system went on an aggressive campaign for patient safety training last fall, says Commander Rita Sullivan, risk manager at Twentynine Palms. As part of the campaign, every staff member—including providers, nurses, housekeepers, and administrative personnel—received instruction on the hospital’s patient safety program.

“The staff may have gotten tired of hearing about patient safety, but it has paid off. When JCAHO came...[surveyors] could stop anyone here in the hospital and that person could speak intelligently about patient safety,” she notes.

Von Gunten also says she was pleasantly surprised by the results of extensive training. For instance, she felt a little nervous when a nurse who had joined the patient safety/medication management interview at the last minute spoke up after a surveyor asked whether anyone knew the National Patient Safety Goals. But her fears proved unfounded—the staff member explained all of the goals from memory.

Follow your policies for pain management
Surveyors also educated staff on pain management. Standard PE.1.4 in the assessment of patients chapter of the Comprehensive Accreditation Manual for Hospitals instructs hospitals to assess all patients for pain, but Twentynine Palms’ also required clinicians to assess the intensity, quality, and quantity of the pain.

When reviewing records, surveyors “could find that pain was assessed in all patients, but not to where we’d raised the benchmark,” says Martin.

Survey at a glance

**Hot spots:** National Patient Safety Goals, pain management, medication management.

**Critical advice:** Always be prepared for a survey. That way, staff will be used to any revisions to policies by the time surveyors visit, you won’t get surprised by a random unannounced survey, and you’ll save yourself a headache in the months leading up to your survey.

**Quote of note:** “The staff may have gotten tired of hearing about patient safety, but it has paid off. When the JCAHO came...[surveyors] could stop anyone here in the hospital and that person could speak intelligently about patient safety,” says Commander Rita Sullivan, risk manager at the Naval Hospital in Twentynine Palms, CA.
Although they did not issue a Type I, surveyors did counsel the organization to lower its policy requirements.

“If you spell it out in your instructions that you’re going to do 10 different things, you have to do those 10 different things on each patient,” she notes.

Medication management insight
Surveyors also gave a hint as to what they may look for as part of the new medication management standards that will go into effect in January 2004. They asked the pharmacy director to complete a form on the facility’s most high-profile patient, tracking the patient’s medications for three days through charts and electronic files and noting any discrepancies or missing information.

However, other hospitals will probably not receive the same form. The JCAHO tells BOJ that surveyors distributed the form only as a one-time tool to hospitals that volunteered to pilot the medication management standards.

“It looked like [they were interested in] continuity of care as far as the date of admission . . . diagnosis, whether allergies were identified in the computer system, orders that were written, discrepancies in abbreviations, transcription errors, [and] dosing delays,” says Martin.

Use periodic performance reviews to resolve problems before surveyors arrive at your facility

One of the big changes hospitals will notice when the JCAHO starts its new survey process in January 2004 is how fast the accreditor expects them to correct problems.

Once an organization completes its triennial survey, staff will have 90 days to submit plans of action to address noncompliant elements of performance. Hospitals should start working on the related measures of success at the same time, says Russell Massaro, the JCAHO’s vice president of accreditation operations, who spoke during the JCAHO’s Executive Briefings conference in Chicago on August 22.

Four months after submitting the plans of action, facilities will have to turn in the measures of success with substantial data proving that the plans corrected any problems. If the problems remain, the facility could lose its accreditation status.

Fix problems in advance
To avoid jeopardizing their accreditation status, hospitals should complete their periodic performance

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**Upcoming Events**

**Audioconferences:**

**November 1**—Completing your periodic performance review

**November 13**—Disaster preparedness planning and patient surge

**November 18**—Information management compliance guide to JCAHO standards

**November 19**—How to use FMEAs to identify areas of risk in your medication management system

Call Customer Service at 800-639-8511 to register.
review (PPR) as accurately as possible and correct problems before the triennial survey, says Bud Pate, BA, REHS, an executive consultant for Kaiser Permanente in Pasadena, CA. If there are concerns about discoverability, hospitals must either complete a PPR (previously called a self-assessment) halfway through their survey cycle or pay the JCAHO to conduct a smaller, on-site survey at the halfway point to identify substandard areas.

Although facilities will still have to develop corrective plans and measures of success after the PPR, they will have more time to iron out the problems before the accreditation survey. However, hospitals will need to demonstrate a 12-month compliance track record prior to the next triennial survey, says Massaro.

“The best strategy is to find any problems and work on them before the surveyor arrives,” says Pate. “That is the intent of the PPR. If you really complete that accurately and honestly, it may be the case that you find a lot of ways you do not comply with the standards. But it is better to find that out before your survey.”

Tip: Don’t wait until halfway through your accreditation cycle before you conduct the PPR. Instead, start as soon as possible to leave plenty of time to work on the corrective plans and related measures of success. The JCAHO will work with organizations to prioritize the plans of actions.

Tip: To make it easier to carry out corrective plans, educate staff about the new policies while the medical executive committee reviews and adopts the plans, says Kathryn Chamberlain, CPHQ, a self-employed JCAHO consultant from Gloucester, MA.

Buried with plans of action? The JCAHO’s 2004 standards contain more than 1,300 elements of performance. Some people might be afraid that they could have to write up hundreds of plans of action, but that shouldn’t be the case, says Chamberlain.

Although the accreditor updated the standards for 2004, facilities should be familiar with many of the elements of performance, which replaced the intent statements of the old standards. The main difference is that these elements are the only items surveyors will score.

An organization that has not kept up with JCAHO compliance might have to create approximately a dozen plans of action. Hospitals that did not have major difficulties during their last surveys should not have significant problems as a result of the new survey process, says Chamberlain.

“Unless an organization gets taken by surprise or staff don’t understand the intent of the elements, they really shouldn’t have a big laundry list of things to work on at the end of the survey,” says Chamberlain.

Even though there are many elements, not all of them require measures of success, says Pate. Each element will have an A, B, or C next to it. Category A elements are scored on a yes or no (2 or 0) basis, for example, because the facility either has the policy or not. Category B elements are also a yes or no evaluation, but surveyors will judge them subjectively to see whether the organization considered performance improvement processes when designing a process. Category C elements are rate-based—zero for noncompliant, one for partially compliant, and two for compliant. Surveyors will determine compliance based on how often a facility does what the element of performance requires.

Elements that carry a measure of success will have an M marked next to them in the standards manual. During the PPR or on-site survey, the surveyor will mark which element(s) of performance the facility did not comply with, says Pate.

Tip: Don’t overanalyze your measures of success. It’s just an audit, Massaro said. And know you can call the JCAHO’s standards interpretation group if you have any questions while writing up the measures of success or if you simply need help developing them.
Quick tip: Understand 2004 EC standard changes

The current environment of care (EC) standards detail training requirements to orient and educate employees about the EC, followed by a laundry list of areas with which people must be familiar (see standard EC.2.8).

But heads up: In 2004, those requirements will shift over to the human resources (HR) chapter under HR.2.20.

The JCAHO felt the HR chapter was a more appropriate spot for the requirement, and the new language under HR.2.20 is very general compared to the current EC.2.8.

That’s not to say that safety folks will relinquish their training responsibilities; you still must provide training and education even if the chapter is different, says consultant Susan McLaughlin, MBA, CHSP, MT(ASCP), SC.

Seasoned safety professionals won’t flinch too much under the changes.

However, this switch could create a problem for new safety officers who may have no idea what should happen with orientation and training, she says.

To avoid confusion, consider mentioning in your seven EC plans the activities you use to educate and train staff members about the EC, McLaughlin suggests.

“Make sure you help out the new guys on the block in your organization,” Mills says.
Directions:

• Complete this continuing education (CE) quiz by writing the letter corresponding to the correct choice for each question on the answer sheet found on p. 4. There is only one correct answer for each question. You can find the answers to each question in the specific issues of BOJ, and you may refer to them as you take the quiz. (Back issues of BOJ are available. Send $15 per issue with your request, and we’ll mail them to you.)

• Send only the answer sheet (p. 4) back to us by November 15, with a $39 payment for each person completing the quiz. To qualify for CE credits, you must answer at least 75% of the questions correctly—that’s 22 out of 30.

• We’ll send you a certificate of completion that you may use for display and documentation of three credits toward Certified Professional in Healthcare Quality (CPHQ) recertification by the Healthcare Quality Certification Board (HQCB). Approval of CE hours for CPHQ recertification by the HQCB is pending.

• If you’d like to purchase and take your CE quiz online, please check our e-learning Web site at www.hcprofessor.com. Quizzes taken online contain the same series of questions included in the print version, but will be scored instantly and offer immediate access to your certificate of completion.

Editor’s note: CE quizzes are now offered on a quarterly basis. Therefore, instead of offering two CE quizzes per year based on six months of BOJ, you now have four quizzes per year, each based on three issues of BOJ. Further, you can receive three credits for each quarterly quiz rather than six credits for the biannual quiz.

July 2003

1. Unapproved abbreviations only apply to drug order sheets, not to any other patient information records.
   a. true
   b. false

2. The Institute for Safe Medication Practices created a dangerous drug abbreviation list. Which of the following have many organizations stopped using?
   a. “U” for units
   b. zero after a decimal point
   c. both
   d. neither

3. If a hospital needs to keep high-alert medications on a specific unit and not just in the pharmacy, staff must
   a. separate them from other medications
   b. prominently label the high-alert medications
   c. limit access to them
   d. all of the above
   e. none of the above; high-alert medications belong in the pharmacy and not on patient care units

4. Tracer methodology will be a key part of the JCAHO’s Shared Visions–New Pathways™ survey process, which starts next year. For a 300-bed hospital, expect surveyors to trace approximately 30 patients.
   a. true
   b. false
5. To prevent wrong-site surgery, facilities must mark sites that involve right/left distinction, multiple structures such as fingers and toes, or levels (i.e., the spine).
   a. true
   b. false

6. The preoperative verification process should include which of the following?
   a. a reminder to check all appropriate medical records
   b. checking all imaging studies before operating
   c. taking a “time-out” to verify correct patient, procedure, and surgical site
   d. all of the above

7. If infusion pumps do not have free-flow protection devices, it is never acceptable to use add-on devices.
   a. true
   b. false

8. To guarantee regular preventive maintenance of clinical alarm systems, test that the alarm
   a. is on
   b. is set with the proper parameters
   c. will sound when it is supposed to
   d. is loud enough to hear
   e. all of the above
   f. none of the above

9. If you want to use an alternative to any of the National Patient Safety Goal recommendations, you can wait until your survey for approval. Surveyors can approve alternative approaches while at your facility.
   a. true
   b. false

10. JCAHO surveyors will not look at any documents during the new survey process since there will no longer be a formal document review.
    a. true
    b. false

August 2003

1. Which of the following is essential to rewriting your medication policies?
   a. looking at your scope of services
   b. examining how you greet patients
   c. assessing what makes the best clinical sense
   d. all of the above

2. How did the JCAHO expand its current definition of a medication?
   a. The accreditor clarified the definition of security.
   b. The JCAHO fleshed out the current term “any substance.”
   c. none of the above
   d. all of the above

3. Which of the following must you consider when adding or subtracting a drug from the formulary?
   a. indications for use
   b. effectiveness
   c. risks
   d. all of the above

4. In requiring hospitals to properly and safely store medications, the JCAHO incorporated the Centers for Medicare & Medicaid Services’ definition of secure.
   a. true
   b. false
5. How did the JCAHO clarify informed consent in the new RI.2.40?
   a. Only the direct caregiver can obtain informed consent.
   b. The new standard states who can obtain informed consent.
   c. The JCAHO did not make changes to the informed consent process.
   d. none of the above

6. Which of the following should you do during the informed consent process?
   a. Take down the patient's height, weight, and age.
   b. Discuss discharge plans.
   c. Discuss the potential risks and benefits of a procedure.
   d. all of the above

7. When patients understand their procedure and staff educate them about it, it helps to reduce their anxiety level.
   a. true
   b. false

8. The failure to obtain informed consent can get hospitals into legal trouble.
   a. true
   b. false

9. Which of the following characteristics are important to guarantee strong physician leadership?
   a. They must speak in a nonjudgmental or nonpunitive manner.
   b. They must set the stage for quickly delegating responsibilities.
   c. all of the above
   d. none of the above

10. Many physician leaders are used to working under the traditional hierarchal model that thwarts open communication.
    a. true
    b. false

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September 2003

1. The JCAHO accepts predrawing medications into a syringe, as long as you label them.
   a. true
   b. false

2. When it comes to creating range orders, which of the following is sound advice?
   a. Create policies that standardize the initial drug dose ranges.
   b. Create a common and predictable manner for nurses and physicians to issue and carry out range orders.
   c. all of the above
   d. none of the above

3. Which of the following did the JCAHO change for the use of blanket orders?
   a. Hospitals are not allowed to use blanket orders.
   b. Hospitals must minimize blanket reinstatements of previous medication orders.
   c. Caregivers can only reinstate blanket orders when there's an urgent need.
   d. none of the above

4. Non-staff members who administer medications must monitor the drug's effects.
   a. true
   b. false

5. The JCAHO now requires hospitals to remove all concentrated electrolytes from all units, with no exceptions.
   a. true
   b. false
6. Which of the following is a new Patient Safety Goal for 2004?
   a. Hospitals must create a list of at least 10 unacceptable drug abbreviations, acronyms, and symbols.
   b. Hospitals must reduce the occurrence of surgical fires.
   c. Hospitals must reduce the risk of hospital-acquired infections.
   d. none of the above

7. The JCAHO says it is optional for hospitals to comply with the Centers for Disease Control and Prevention’s hand-hygiene guidelines.
   a. true
   b. false

8. How did the JCAHO modify Goal #2?
   a. Staff can no longer accept telephone orders.
   b. Staff read back only critical lab values.
   c. Staff must take a 10-minute time-out prior to surgery to clear their minds.
   d. none of the above

9. Which of the following is a reason why hospitals may not report health care–acquired infections (HAIs)?
   a. They are difficult to track.
   b. Hospitals do not experience HAIs.
   c. The JCAHO may punish hospitals.
   d. Too many reports of HAIs result in conditional accreditation status.

10. The JCAHO will change the term “recommendation” for goals compliance to “requirement” in 2004.
    a. true
    b. false

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### Answer sheet

Please write the letter corresponding to the correct answer next to the question numbers below.

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