JCAHO releases proposed 2007 National Patient Safety Goals

**Learning objectives**: After reading this article, you will be able to
1. list potential 2007 National Patient Safety Goals (NPSG)
2. explain steps to take when assessing a patient’s suicide risk
3. discuss who should be members of a rapid response team

Rapid response teams, patient suicide prevention, worker fatigue, and disruptive behavior are among the topics covered by eight proposed 2007 NPSGs for hospitals and critical-access programs released November 29, 2005.

The JCAHO posted the draft on its Web site (www.jcaho.org) along with goals for its other accreditation programs. Organizations have until January 8 to comment on the proposals (go to www.jcaho.org/accredited+organizations/).

Lab accreditation decisions can affect hospital standing

**Learning objectives**: After reading this article, you will be able to
1. understand why laboratory accreditation can affect hospital accreditation
2. explain who should oversee laboratory accreditation
3. list alternative laboratory accreditors

A little-known section in the JCAHO standards manual could get hospitals into big trouble if they fail to pay attention to their laboratory compliance requirements.

The JCAHO in the March 2004 Joint Commission Perspectives amended the Comprehensive Accreditation Manual for Hospitals to mandate that if a hospital laboratory receives an accreditation decision of provisional, conditional, or preliminary denial, the hospital would receive the same decision.

“You’d better have your ducks in a row if your lab is surveyed under JCAHO standards,” says Elizabeth Di Giacomo-Geffers, RN, MPH, CNA, BC, a healthcare consultant in Trabuco Canyon, CA. “Know that your lab is prepared and can affect your hospital.”

Pathology and clinical lab services are “essential hospital services” and are mandatory for hospitals to be eligible for accreditation, according to the standards manual.

A hospital’s accreditation should not remain the same if the lab’s status is lower than the main organization’s standing, the...
2007 goals

hospitals/index.htm to view the proposed goals.

The JCAHO will consider comments from the field review after the January 8 deadline. The commission will most likely release the final goals in the spring, setting an implementation deadline of January 1, 2007.

Eight new proposals
The field review for hospitals includes eight proposed goals and requirements:

- **Goal 3E**—Reducing the likelihood of patient harm associated with the use of anticoagulants
- **Goal 15A**—Reducing the risk of patient harm from falls
- **Goal 15B**—Preventing healthcare-associated pressure ulcers
- **Goal 15E**—Identifying patients at risk for suicide
- **Goal 16**—Discouraging disruptive behavior within the organization
- **Goal 17**—Providing orientation to temporary or agency workers
- **Goal 18**—Using teams to respond to changes in a patient’s condition
- **Goal 19**—Preventing patient harm associated with healthcare worker fatigue

Missing are goals covering bar coding—which was first proposed for 2005 and rumored to be considered for 2007—and regulating a culture of safety. The umbrella Goal 15 (organizations identify safety risks inherent in their population) comes close to previous proposals on a culture of safety.

The JCAHO proposed moving the current goal 9B (regulating patient-fall programs) under Goal 15. Pressure-ulcer and suicide requirements would also fall under that goal.

Reducing the risk of pressure ulcers was first included in the 2006 long-term care goals.

“I think this goal will become too cumbersome and people will become overwhelmed by the requirements,” says **Wendy Fisher, RN, BS**, patient education coordinator at A.O. Fox Memorial Hospital in Oneonta, NY.

The JCAHO may be better served introducing the new elements of the safety-risk goal during the next two years, Fisher says. Along with patient falls, pressure ulcers could be included in 2007, with patient suicide added for 2008.

Preventing suicides, disruptive behavior
Under Goal 15E, the JCAHO would require organizations to conduct a risk assessment of specific factors that may increase or decrease suicide risk, address immediate safety and treatment needs, and provide a crisis hotline or other information for patients and their family members.

Patient suicide ranked at the top of the sentinel events reported to the JCAHO from January 1995 through June 30, 2005, with 430 cases out of 3,197 total reports, making this a much-needed goal, says **Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC**, a healthcare consultant in Trabuco Canyon, CA.

“You know this is only the tip of the iceberg,” Di Giacomo-Geffers says of the reported suicides.

Illustration by Dave Harbaugh
The goal for discouraging disruptive behavior is also recommended, but accomplishing it may not be easy, a source close to the JCAHO says. Many organizations do not have a code of behavior, and pushing one through medical staffs may be difficult, the source says.

Measuring the policy’s effectiveness can also prove problematic, Fisher says.

“How on earth are we supposed to measure this?” Fisher asks. “You can have policies about this, and I’m sure most hospitals have those in place. I don’t see why this is a goal.”

Follow the IHI
The Institute for Healthcare Improvement (IHI) in Cambridge, MA, made rapid response teams part of its 100,000 Lives campaign, the goal of which is to save that many patients by June 14, 2006. The teams may include a respiratory therapist, intensive care nurse, and physician assistant and respond to certain triggers that show that a patient is headed for a critical code situation.

The JCAHO would require hospitals to research literature, select an intervention method most suitable for their needs, establish criteria for calling the team, and monitor intervention and rescue rates. Nearly half of the 2,900 hospitals participating in the 100,000 Lives campaign currently use rapid response teams, according to IHI officials. Implementing these teams could be a cost issue for smaller hospitals, Fisher says.

The likelihood exists that not every proposed goal will become mandatory. The JCAHO will attempt to limit to two the number of new goals each year, helping hospitals manage existing requirements, said Richard Croteau, MD, JCAHO executive director for strategic initiatives, during the Hospital Executive Briefings conference in September.

“We believe [hospitals] will accomplish more if [they] focus on a relatively small group instead of focusing on everything at once,” Croteau said.

Editor’s note: This story was sent to subscribers as an e-blast on November 30. If you did not receive it, please contact our Customer Service Department at 800/650-6787 to update your e-mail address.

2005 National Patient Safety Goals compliance data

<table>
<thead>
<tr>
<th>Goal</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. Two patient identifiers</td>
<td>96.1%</td>
</tr>
<tr>
<td>1B. Time out before surgery</td>
<td>82.9%</td>
</tr>
<tr>
<td>2A. Read-back verbal orders</td>
<td>88.4%</td>
</tr>
<tr>
<td>2B. Standardize abbreviations</td>
<td>60.5%</td>
</tr>
<tr>
<td>2C. Timely reporting of results</td>
<td>92.4%</td>
</tr>
<tr>
<td>3A. Limit concentrated electrolytes</td>
<td>98.7%</td>
</tr>
<tr>
<td>3B. Standardize drug concentrations</td>
<td>98.5%</td>
</tr>
<tr>
<td>3C. Look-alike and sound-alike drugs</td>
<td>98.1%</td>
</tr>
<tr>
<td>4A. Preoperative verification</td>
<td>94.5%</td>
</tr>
<tr>
<td>4B. Surgical site marking</td>
<td>96.2%</td>
</tr>
<tr>
<td>5A. Free-flow protection</td>
<td>99.9%</td>
</tr>
<tr>
<td>5B. CDC hand hygiene guidelines</td>
<td>96.4%</td>
</tr>
<tr>
<td>5B. Sentinel event and infection control</td>
<td>100%</td>
</tr>
<tr>
<td>8A. Medication reconciliation</td>
<td>100%</td>
</tr>
<tr>
<td>8B. Communicate medications at transfer</td>
<td>99.7%</td>
</tr>
<tr>
<td>9A. Fall-risk assessment</td>
<td>97%</td>
</tr>
</tbody>
</table>

Source: Adapted from Joint Commission Perspectives, November 2005.
Lab accreditation

The JCAHO does not maintain statistics about how many noncompliance decisions have been made since the rule took effect, JCAHO spokesperson Mark Forstneger says. The mandate can be found on p. APP-25 of the 2005 standards manual.

A few hospitals have experienced issues with this JCAHO mandate, and at least one has received a denial of accreditation as a result. Several hospitals declined to comment for this article.

Get on the same page

Lab surveys occur every two years and may not fall at the same time as a triennial hospital survey, Di Giacomo-Geffers says. That cycle variation means that hospitals must know when each survey is and place importance on each.

Labs also usually have their own quality control coordinators who are responsible for knowing the JCAHO standards relevant to lab accreditation, says Di Giacomo-Geffers.

With a survey coordinator responsible for hospital accreditation standards and lab staff responsible for lab standards, compliance issues can become lost between departments.

Hospital leadership must work with lab and hospital accreditation officials to address any issues that may overlap between the two areas, Di Giacomo-Geffers says.

Other options exist

An alternative solution would be to obtain lab accreditation from the College of American Pathologists (CAP), which could prevent the hospital from being adversely affected, Di Giacomo-Geffers says.

“At least you’re not going to cripple your hospital,” Di Giacomo-Geffers says.

The JCAHO recognizes CAP and Clinical Laboratory Accreditation and Education—a physician-directed organization in Columbia, MD—as alternative accreditation providers. CAP surveys will be unannounced starting in 2006, according to its Web site, www.cap.org.

CMS corner

Get ready for a CMS hospital survey

Although Centers for Medicare & Medicaid Services (CMS) surveys are unannounced, there are reasonable ways to ensure that you are ready for them, just as you now have to be for JCAHO surveys.

First, note that unaccredited hospitals can expect a routine CMS survey every three years, which is CMS’ goal for its state survey agencies. As your three-year mark approaches or once a decision to become unaccredited is made, take immediate action to familiarize facility leadership and staff with the Conditions of Participation (CoP).

Even if the CoPs are not up to date, they will be the benchmark for measuring your compliance. The most effective plan for this survey is having well-prepared staff who can offer a summary of their area’s organization, its staffing and daily operation, and most importantly, its quality assurance and performance improvement program.

Editor’s note: Want more information on CMS surveys and CoPs? Check out future issues of BOJ for more CMS corner features. Have ideas for future CMS articles? Contact Matt Bashalany at mbashalany@hcpro.com. This article was excerpted from The CMS Survey Guide by Jeffrey T. Coleman. ©2005, HCPro, Inc. For more information, visit www.hcmarketplace.com.
Problematic standards—MM.4.10

Include contrast media in monthly inspections

Learning objectives: After reading this article, you will be able to
1. list six steps to take when handling oral contrast media
2. identify the pharmacist’s role in contrast media handling
3. explain when a pharmacist should review a contrast order

Pharmacists do not need to review most oral contrast media orders, but they should apply other medication management principles and standards to meet JCAHO requirements.

Among the tasks pharmacists should perform regarding contrast media are inspecting expiration dates, labels, and security issues when conducting monthly floor-stock checks.

“That is something that should be an ongoing standard,” says Doug Wong, PharmD, senior executive consultant for the Grapevine, TX–based Pharmacy Healthcare Solutions. “That shouldn’t be the exception. That should be the rule.”

Meet six standards
JCAHO standard MM.4.10 requires hospitals to review all prescriptions and medication orders for appropriateness. Contrast media are considered medications, according to the commission.

But the accreditor does not require a pharmacist’s prior review of oral contrast orders, according to an article in the June 2005 Joint Commission Perspectives. However, according to the newsletter, organizations should adhere to the following standards and safeguards:

- The hospital must have procedures to prevent retrieval errors
- A pharmacist must be available to answer questions if necessary
- The hospital must evaluate its system by sampling records of patients who received contrast media without prior pharmacy review

According to data from the U.S. Pharmacopeia MEDMARX error-reporting database for a five-year period ending in 2003, 912 reports listed radiology as the location of the error. Of those reports, 27% were wrong-dose errors, and 22% were the wrong drug.

Control it as a medication
Although contrast media are considered medications, many hospital pharmacies do not control the media beyond the initial purchase, Wong says. Once the media are purchased, pharmacy usually transfers them to radiology, he says.

The materials management department

Audioconferences:

- January 17—The JCAHO’s National Patient Safety Goal on Hand-Off Communications (Q01706)
- January 19—Off-label: A Discussion of Changes, Regulatory Risks, and Impact under Part D
- January 26—IM Standards: What You Need to Know for Your Next JCAHO Survey (A012606)
- January 26—Discharge Planning from an Operations Point of View (N012606)

For more information, call 800/650-6787 and mention the source code for the show.
Contrast media

at Tennessee Christian Medical Center in Madison, purchases contrast media, says David Kellogg, DPh, MS, the hospital’s pharmacy director.

Pharmacy staff—mainly technicians—check the labels, expiration dates, and security of contrast media when conducting monthly inspections of the hospital’s floor stock, he says.

Tip: Keep contrast media locked if they are stored in an area where no staff are present.

“All the different things you do with any medication, just apply them to contrast media,” Kellogg says. “You have to interact with other departments involved. Make sure this process is in place.”

Some reviews may be necessary
Pharmacy should review contrast orders that are for an area outside of radiology (e.g., a patient care unit), Wong says. Pharmacists must look for drug-drug interactions, allergies, and other issues that could arise with other medications, he says.

However, in the radiology department, radiologists usually control the ordering and administration, avoiding the need for a pharmacist’s prior review, Wong says.

Ensure practitioner oversight
The pharmacy department at Fairview and Lutheran hospitals in Cleveland tries to ensure pharmacy oversight when licensed independent practitioners are not supervising the ordering and administration of contrast media, says pharmacy director Michael Hoying, RPh, MS.

For example, if a floor nurse administers contrast media, a pharmacist should review the order, Hoying says. The hospital created a protocol for echocardiograms to turn that process into a drug order, he says (see a sample order sheet on p. 7).

Hospitals also must be aware of IV contrast. Pharmacists should review those orders if a licensed independent practitioner does not oversee the process.

“The question that is always out there is, ‘Is there a licensed independent practitioner reviewing the process?’ ” Hoying says.

The radiology department at Fairview and Lutheran hospitals maintains a protocol book listing the contrast media appropriate for use, and the pharmacy and therapeutics committee approves those protocols, Hoying says.

Standard MM.4.10

This standard mandates that hospitals review prescriptions or medications for appropriateness.

Elements of performance for MM.4.10
1. A pharmacist checks all medication orders before dispensing them unless a licensed independent practitioner orders and gives out the drugs or any delay would cause harm to the patient
2. Not applicable
3. A qualified staff member reviews orders when an on-site pharmacy is not open 24 hours a day
4. The pharmacist reviews the order once he or she is available or the pharmacy opens
5. The hospital reviews all prescriptions for

- the dose, frequency, and administration methods
- therapeutic duplication
- allergies or sensitivities
- possible interactions between the drug and other medications, food, or laboratory values
- other impairments to treatment
- any variation from hospital policy regarding medication use
- other relevant issues

6. The person prescribing the medication addresses all concerns, issues, or questions before a pharmacist fills the order
Sample contrast protocol order form

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**PHYSICIAN’S ORDER RECORD**

**PHYSICIAN’S ORDERS AND SIGNATURE**

**ECHOCARDIOGRAM WITH CONTRAST PROTOCOL ORDER**

- **Current patient weight:** kg

**Contraindications/precautions assessment**

- Both products: Patient has a known cardiac shunt, congenital heart defect
- Both products: Patient is pregnant (patient interview)
- Both products: Patient has severe emphysema, pulmonary vasculitis, history of pulmonary emboli, known or suspected liver disease, or ARDS
- **Optison** Patient has allergies to blood, blood products or albumin
- **Optison** Patient is a Jehovah’s Witness and doesn’t have a durable power of attorney document authorizing use of blood fractions
- **Definity** Known hypersensitivity to octylfluorocarpane

**Establish peripheral IV access with 20 gauge angiocatheter or larger**

- Methods of administration include a short extension tubing, saline lock, or intravenous line, all with a three-way stopcock

**Before any drug administration, flush line with 10ml 0.9% sodium chloride**

- **Definity** ml (10 microliters/kg) over 30 to 60 seconds

**RN may repeat dose, at technician’s discretion, 30 minutes after initial dose. Do not exceed two bolus doses of Definity**

**Follow each injection of Definity with a flush of 10ml of 0.9% NaCl injection**

- **Optison** injection 0.5 ml IV push over no less than 1 minute

**May repeat 0.5 ml dose, at the technician’s discretion, up to a total of 5 ml over a 10 minute period**

**Do not exceed a dose of 8.7 ml for any one patient study**

**Follow each injection of Optison with a flush of 10 ml of 0.9% sodium chloride injection**

**For nausea/vomiting:** Compazine 10 mg IV one time

**Allergic reaction:** Stop drug administration and inform physician immediately.

- If approved by prescriber, administer Benadryl 25 mg IV and dexamethasone 4 mg IV one time.

**Order set initiated in accordance with hospital policy**

**Echocardiogram technician signature:**

**Physician’s orders:**

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*Source: Fairview Hospital, Cleveland. Reprinted with permission.*
MD hospital wins award for flow improvements

Hospital reduces ambulance diversion, increases satisfaction

Learning objectives: After reading this article, you will be able to
1. identify the JCAHO standard regulating patient flow
2. list staff responsible for improving patient flow
3. identify how to use data to improve flow

Shady Grove Adventist Hospital in Rockville, MD, was suffocating.

A backlog of patients clogged the 269-bed hospital from the emergency department (ED) all the way through to discharge. The logjam forced the second-busiest ED in Maryland (behind The Johns Hopkins Hospital in Baltimore) to divert ambulances to other Montgomery County hospitals. Those four other county hospitals then had to divert ambulances as well, placing patients at greater risk.

“It [became] very clear to us that we couldn’t keep our hospital open unless we looked at the issues affecting us,” Shady Grove Adventist President Deborah Yancer says. “We didn’t feel that [diverting ambulances] was acceptable.”

That attitude won Shady Grove Adventist the 2005 Ernest A. Codman Award from the JCAHO for its use of outcome measurement to improve patient flow. The hospital received the award November 9, 2005, in Chicago.

The hospital began evaluating patient-flow data and implemented several changes, including hiring a clinical bed coordinator, implementing computerized bed tracking, creating earlier discharge times, and adding a short-stay unit for patients who would be in the hospital for less than 24 hours, says Debra Foshee, vice president of quality and medical staff services.

Thanks to those and other changes, length of stay (LOS) in the ED fell from 397 minutes to 372 minutes in little more than a year. The number of ambulance diversions fell by 72%.

JCAHO standard LD.3.15 requires leadership to develop and implement plans to allow efficient flow throughout the hospital, and scrutiny could intensify even more in the future under revised leadership standards proposed for 2007.

Think outside the ED

The ED often takes the brunt of the blame for a patient-flow problem, but leaders at Shady Grove Adventist realized that the problem involved the entire hospital, Yancer says. If patients were not discharged until later in the day, their beds would be occupied longer, leaving fewer beds for new patients.

The hospital created three teams to evaluate patient flow. The teams looked at the ED, the discharge process, and throughput for the entire organization, Yancer says.

The teams consisted of ED physicians, hospitalists, intensivists, radiologists, staff nurses, and staff from the laboratory, housekeeping, patient transport services, admitting, pharmacy, case management, and discharge planning, hospital spokesperson Marisa Lavine says.

The hospital also involved community-based physicians on the teams to obtain their cooperation with discharge issues, Lavine says.

“We challenged them to think about any changes we could make to create more capacity,” Yancer says.

Quick fix not a final solution

The hospital began the patient-flow evaluation

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process in mid-2002, Foshee says. But flow problems got so bad during winter 2003–2004 that the hospital applied for an emergency certificate of need with the state of Maryland to license 15 beds at the campus’ rehabilitation facility, Yancer says.

The emergency license allowed the hospital to put less ill patients in those 15 beds for six months.

“That got us through that winter,” Yancer says. “[But it] cost us more because we had to staff it.”

But as the evaluation process picked up more momentum, the hospital was able to service the same number of patients the following year without the extra 15 beds, Yancer says.

From measurement to improvement
The hospital measured LOS for ED and admitted patients, Foshee says. It also calculated total LOS.

Staff tracked bed turnaround time, and the hospital soon implemented a pager system for housekeeping, Yancer says. Using this system, case managers walked the floors looking for empty beds, and staff could page housekeeping if a bed needed to be prepared for another patient, she says.

The hospital also studied patient census at certain times of the day to determine when the greatest need for staffing occurred, Yancer says.

Keep staff updated
Top leaders weren’t the only ones evaluating the data once it was collected. The hospital published the measures in a scorecard for all staff to see, Foshee says. Staff were also updated during meetings and in the employee and physician newsletters, she says.

“A lot of it was about communication,” Foshee says. “What we thought was so remarkable was that we really got buy-in from the [entire] organization.”

Plan for early discharges
Many of those who bought into the effort to discharge patients before noon were staff, physicians, and even patients, Foshee says. Patients had more time to fill prescriptions at a pharmacy or more access to their physician’s office than if they left the hospital late in the day, she says.

“In addition, the bed is open to patients in the ED who are waiting,” Foshee says.

And Shady Grove Adventist often had several patients waiting for a bed. The busiest ED in Montgomery County, it logged 85,000 visits in 2004.

The second busiest hospital the county logged 40,000 ED visits that year, Yancer says.

Use administrative power
The hospital also began having an administrator from Yancer’s executive team on call every day. The administrator was able to use the executive power of the president’s office to remove any barriers that could impede patient flow, Yancer says.

For example, if there was a shortage of housekeeping staff on a particular day, the administrator could bring in more help, Yancer says. Or if a particular floor failed to call in admissions, the administrator could find out why.

The hospital also created a grid to track staffing at any given time.

“Most problems have to be solved at the point of care, but you need to be creative,” Yancer says.

Editor’s note: Talk about patient-flow issues with colleagues on BOJ Talk. To join this subscriber-only forum, e-mail owner-boj_talk@hcpro.com.

Questions? Comments? Ideas?
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JCAHO increases accreditation thresholds for 2006

Hospitals in 2006 will have a slight cushion in the number of requirements for improvement necessary to trigger preliminary denial of accreditation, according to the JCAHO.

The preliminary denial threshold will increase from 13 noncompliant standards to 15 for hospitals surveyed on or after January 1, according to the October 2005 This Month at the Joint Commission, the JCAHO’s online newsletter.

The JCAHO increased the preliminary denial threshold for critical-access hospitals from seven to eight noncompliant standards for 2006. The threshold for conditional accreditation will remain at 10 noncompliant standards, according to the JCAHO. The critical-access cutoff will remain at five.

A source close to the JCAHO says pressure from hospital leaders may have forced the commission to increase the cutoff. As of press time, 15 hospitals had been placed in preliminary denial of accreditation in 2005, JCAHO spokesperson Mark Forstneger says, which would fall in line with commission data from past years.

The JCAHO updates accreditation thresholds annually based on the average number of requirements for improvement from the previous year, Forstneger says.

New fixed performance areas for 2006 surveys

The JCAHO also released the fixed performance areas for 2006 random unannounced surveys.

They include:

- assessment and care
- medication management
- patient safety
- 2006 National Patient Safety Goals applicable to hospital services.

Random unannounced surveys will continue through at least 2008, the JCAHO has said.