In yet another change to the evolving periodic performance review (PPR) process, hospitals will be able to choose between full or limited option one or two surveys, the JCAHO announced December 2005.

The full PPR survey option will mirror the triennial inspection in duration and scope, according to the JCAHO. Organizations will be able to choose whether to undergo a limited or full PPR survey, commission spokesperson Mark Forstneger says.

The on-site surveys previously were limited to one-third of a normal evaluation, typically involving one surveyor for a couple of days. The PPR became an annual requirement January 1.

“The decision [to expand PPR surveys] is the result of communication with leaders of accredited organizations who indicated a growing recognition of the value of the on-site evaluations being performed under PPR option two and three in closing the gap between potential and actual organization performance,” Forstneger says.

The commission announced the change in the November 2005 This Month at the Joint Commission e-newsletter.

Complying with a new National Patient Safety Goal may be as simple as passing the baton.

The Defense Department developed a mnemonic known as “I PASS the BATON” to comply with JCAHO goal 2E, which requires organizations to implement a standardized approach to hand-off communication between caregivers and provide an opportunity to ask and respond to questions. The requirement took effect January 1.

The mnemonic incorporates principles that many in healthcare may already recognize, including some from the familiar SBAR (situation, background, assessment, recommendation) technique. Another take on SBAR is I-SBAR, in which the I stands for “introduction.”

SBAR was developed originally for use in the armed forces, not healthcare, says John Webster, MD, MBA, a Defense Department consultant. The department teaches SBAR and uses it for passing action-oriented critical information (e.g., on rapid response teams) and for any
Options remain the same
Organizations can choose between a full PPR, in which the hospital submits data using the JCAHO’s online PPR tool and reviews a plan of action with the JCAHO, and the following three options:

- Option one: The organization prints out the JCAHO’s PPR tool and discusses standards-related issues with the commission without giving specific results
- Option two: The organization undergoes a survey and reviews a written report of survey activities, developing a plan of action as a result
- Option three: The organization undergoes a survey and receives a verbal report from inspectors, eliminating the possibility of discovery

According to JCAHO data available at press time, 65% of accredited organizations chose the full PPR in 2005, 28.2% chose option one, 5.3% chose option two, and 1.4% chose option three.

Surveyors will not have access to the PPR reports prior to the organization’s triennial survey, and the surveyors who conduct the PPR inspection will not be a part of the hospital’s triennial survey team, Forstneger says.

The JCAHO has also said the PPR survey results would not affect an organization’s accreditation status, but an immediate-jeopardy or threat-to-life situation discovered during a PPR inspection could change an accreditation decision, Forstneger says.

Already lining up
Nearly 200 hospitals and long-term care organizations told the JCAHO that by December 2005, they would select the full option one or two surveys, reported the November 2005 This Month at the Joint Commission.

The PPR expansion could benefit hospitals, says Paula Swain, director of clinical and regulatory review at Presbyterian Healthcare in Charlotte, NC.

“Anything that will facilitate continuous survey readiness is a good thing,” Swain says. “The JCAHO expanding from a one-third [PPR] survey to a full survey is more valuable to the organization and certainly more equitable with those organizations undertaking a full scale assessment.”

Organizations will be billed for the on-site PPR survey, leading some to speculate whether the change is an attempt to generate more revenue for the JCAHO.

The commission disputes that claim.

“The PPR is an integral component of the Shared Visions—New Pathways™ accreditation process, which shifts the emphasis from survey preparation to continual systems improvement,” Forstneger says.
Baton transfer

clinical update communication.

But SBAR doesn’t always address every important part of a successful hand-off.

“It became clear that I-SBAR needed to be expanded to about eight things,” Webster says. “You can miss some of the pieces that fall under the S, the B, the A, and the R.”

Incorporate healthcare issues
The challenge was to develop a hand-off technique for healthcare within a six-month time frame, because the JCAHO mandated a January 1 implementation deadline for the new goal. Webster and others at the Defense Department spent about eight weeks reviewing literature about hand-offs and human factors in high-reliability organizations, malpractice lawsuits, root-cause analyses, and sentinel events to determine the best starting point.

One of the greatest dangers in hand-offs is the exchange between experienced and inexperienced staff, Webster says. For example, a nurse who has had years of experience in a unit may assume that a new nurse will understand a certain aspect of a patient’s treatment or a medication’s potential side effects, he says.

Another problem lies in the contingency plans required for patient care. For example, staff need to know what will happen if a certain lab result comes back or a patient’s blood pressure drops to a certain level, Webster says.

“I PASS the BATON” incorporates information that staff normally assume and allows planning for contingencies, Webster says. Each letter—except for the word “the”—represents a critical function in healthcare hand-offs:

- **I**ntroduction—Introduce yourself and your role/job (include the patient in the introduction process, if possible)
- **P**atient—Name, identifiers, age, sex, location
- **A**ssessment—Presenting chief complaint, vital signs, symptoms, and diagnosis
- **S**ituation—Current status and circumstances, including code status, level of certainty, recent changes, and response to treatment
- **S**afety concerns—Critical lab values and reports, socioeconomic factors, allergies, alerts (e.g., falls, isolation, etc.)
- **B**ackground—Comorbidities, previous episodes, current medications, family history
- **A**ctions—Which actions were taken or are required, providing brief rationale
- **T**iming—Level of urgency, explicit timing, and prioritization of actions
- **O**wnership—Who is responsible (e.g., nurse, doctor, or team), including patient or family responsibilities
- **N**ext—What happens next (e.g., any anticipated changes in condition or care, the plan, and any contingency plans)

Although the number of steps in the mnemonic appear daunting, many healthcare workers already cover these topics daily.

“If we used ‘I PASS the BATON’ as the

**Upcoming events**

**Audioconferences:**

- **February 17**—Hand-offs: Proven Methods to Enhance Communication (Q021706)
- **February 28**—Requirements for Improvement: Before, During, and After Survey (A022806)
- **March 7**—Periodic Performance Review Management in an Unannounced Survey Climate (A030706)
- **March 16**—Medication Reconciliation: Complying with the JCAHO (Q031606)

For more information, call 800/650-6787 and mention the source code for the show.
mnemonic, it would be something everyone could remember,” Webster says. “It was developed to cover the basics of what is typically omitted.”

In fact, many physicians who have undergone Defense Department training on the mnemonic have completed all of the steps within 35 seconds, says Heidi King, MS, deputy director of the department’s patient safety program.

That time doesn’t include any clarifications or additional questions asked, King says.

**Allow for questions**
Providing time for clarification and questions is an important part of the hand-off process. Staff involved in the hand-off must assess the patient’s situation and frame it with current information, Webster says.

Staff should discuss the current status and situation, including the level of certainty regarding the circumstances of the patient’s condition, he says.

“That level of certainty is important for the person taking over care,” Webster says. “Typically, [staff currently caring for the patient] have in mind what they will do if a certain diagnosis is confirmed or labs come back, but that’s not always passed along.”

Staff also need to address safety concerns (e.g., allergies, fall risk, or other critical alerts), Webster says.

“Articulate the safety concerns,” Webster says. “It’s one of the main reasons why the Joint Commission has said we need to do this. Some of these elements are simply missed, neglected, or not addressed.”

**Tweak the process**
The Defense Department is in the process of producing posters and plastic cards that contain the mnemonic for staff identification badges to help people remember the steps.

A PowerPoint presentation and toolkit including pertinent literature and organizational recommendations are also in the works, King says.

“Everybody has the opportunity to use it,” King says of the process. “They have to take it, tweak it, and feel empowered that it’s theirs.”

Hospitals will likely develop checklists and other tools to help expedite hand-offs once they begin using the “I PASS the BATON” method, Webster says. But the Defense Department won’t mandate that hospitals use a specific tool.

“We’re in an evidence-based environment,” Webster says. “As much as we wanted to say, ‘This is what you should do,’ we can’t. There’s not enough evidence. We felt uncomfortable selling this as a solution.”

**Supplement hand-offs with information technology**
Information technology can play a role in any hand-off solution, Webster says. Using a computer database can help aggregate all information for a patient, he says.

Some hospitals may rely on fax or e-mail to transmit information about a patient at a hand-off, but face-to-face interaction or a phone call must also occur to allow for questions and clarifications to comply with the JCAHO goal, Webster says.

**Train early, often**
Training staff early will help instill the importance of proper hand-offs, King says. The Defense Department will implement “I PASS the BATON” training at Uniformed Services University of the Health Sciences, the military physician training school in Bethesda, MD.

“We [believe] it’s important to catch [healthcare workers] at the earliest level,” King says. “Educate them while they’re still students.”
Learning objectives: After reading this article, you will be able to
1. describe how to write a plan of correction
2. explain the process for receiving and responding to deficiencies
3. define the follow-up process after submitting a plan of correction

The devil is in the details, and when it comes to responding to deficiencies after a Centers for Medicare & Medicaid Services (CMS) survey, providing detail will put the hospital in a position to get the citation overturned.

“You can be as innovative as you want to be,” says Jeffrey Coleman, a former CMS surveyor in New York state. “[Responding to survey deficiencies is] not just correcting the deficiency—it’s preventing it [from occurring in the future].”

Hospitals must outline in their plans of correction that they will fix the deficiency by a certain date and describe the steps they will take to fix it, Coleman says.

After a CMS survey, hospitals will receive a statement of deficiencies, which outlines areas in which surveyors may have found a hospital to be noncompliant. Hospitals then have 10 calendar days from the date they received the statement to respond with a plan of correction.

If the state survey agency contracted by CMS to conduct the evaluation is satisfied with the plan of correction, it will overturn the deficiency (see p. 6 for a sample plan of correction).

Back it up
Part of the innovation required to correct a deficiency includes providing support materials when submitting a plan of correction.

Judy Sikes, PhD, CPHQ, director of accreditation and medical staff services at Parkview Medical Center in Pueblo, CO, includes attachments with her plans of correction to provide additional proof that the hospital has fixed the problem and will prevent it from occurring again.

For example, if a deficiency is related to chart review, Sikes will say that a plan of correction includes education with nurses and weekly chart monitoring for the next three months, she says.

To provide proof for CMS, Sikes includes a copy of the sign-in sheet from the education session and talking points from the presentation, she says. She also includes a copy of the data-collection tool she uses to monitor the charts.

Sikes puts the attachments in a folder and notes the related deficiencies. “It’s an issue of being able to have the tools with you to express your views,” says Sikes. “If [survey agencies] can’t put it in context, I believe you have a lot less of a chance of being successful.”

Tip: Keep in mind that hospital responses could be subject to public review because they entail correspondence with government agencies, Coleman says. Provide enough information to prove the hospital’s point and eliminate the possibility of the surveyors returning for a follow-up visit, he says.

Providing additional documentation will also help hospitals clarify requirements for improvement after a JCAHO survey, Sikes says.

Keep in touch
After submitting a plan of correction, calling the state survey agency helps keep the hospital’s case in the foreground, Coleman says. The move paints the hospital in a good light from the survey agency’s standpoint, and also keeps the process moving forward, he says.
Sample CMS plan of correction for hospitals

Following is a sample statement of deficiency and the requisite plan of correction that would follow, courtesy of Jeffrey Coleman, a former Centers for Medicare & Medicaid Services (CMS) surveyor in New York state:

Sample statement of deficiency: On January 20, 2005, at 1:30 p.m., surveyors reviewed the record of patient #4, who was an inpatient on the second floor, east nursing unit. Interviews were also conducted at that time with the patient and patient’s sister.

The patient’s sister stated that the patient had developed several bed sores (i.e., decubitus ulcers) since her admission to the hospital for pneumonia January 15, 2005. The nursing surveyor observed several red areas on the patient’s heels and back, one of which had perforated and developed into a decubitus ulcer.

A review of the patient’s medical record indicated that on January 16, 2005, there was a physician order issued to turn the patient every four hours and obtain a dietary consult. Nurse notes for the days which followed the orders do not indicate that the patient was turned at all on January 17, 19, or 20, up until 1:30 p.m. There was a brief note from the dietician on January 17 that states, “patient diet to be discussed with PMD.” This case is cited because the

- patient was not turned in accordance with the physician’s orders and has developed both red areas on the heels and a stage 1 decubitus ulcer on the back.

- interview with nursing staff at 1:55 p.m. on January 20, 2005, revealed that the order had been signed off but was not part of the nursing care plan.

- interview with the dietician at 3 p.m. on January 20, 2005, indicated that she had planned to confer with the physician concerning the patient’s lack of nutrition prior to admission and her laboratory results, but could not reach the physician. The patient’s laboratory results in the medical record on January 21, 2005, reveal that she was mildly malnourished.

Sample plan of correction: The patient’s needs were immediately addressed on the day of the survey. The nutritional consult was completed, and the skin-care team assessed the patient and placed her on an individualized skin-care protocol. The patient was discharged to her home on February 3, 2005, with all conditions treated successfully.

In addition, the medical director, nursing director, and chief dietician have conducted a root-cause analysis of this case on February 1, 2005. The following corrective action has been implemented:

- On February 2, 2005, the nursing staff on the affected unit were reinserviced by the nursing director regarding the transfer of the physician’s orders, the need to ensure that nursing care plans contain all elements of care needed by the patient, and the implementation of all necessary nursing care for patients.

- The nursing quality-assurance program will evaluate overall nursing compliance on this unit and throughout the hospital during the next 90 days. Corrective action will be taken when problems are found in this area. Date of correction: February 10, 2005.

- The dietician and medical director have determined that the dietician review was not completed promptly, due in part to miscommunication and problems with the physician’s answering service. The attending physician was out of town, and his partner covered his cases. The dietician has been advised to follow through in the future with the physician’s service.

- The dietician will establish an indicator in the quality-assurance program for timeliness of consults and their completion and will complete the first study in 30 days. The attending physician’s service will now automatically refer all calls to the covering physician when the partner is not available. Date of correction: March 7, 2005.

Editor’s note: For more information about The CMS Survey Guide, visit www.hcmarketplace.com.
Informing the public about JCAHO with ease
Simple ways to meet new notification requirement

**Learning objectives:** After reading this article, you will be able to
1. explain the new public information interview process
2. list how to meet the JCAHO’s new requirement

Unannounced surveys have marked the end of the public information interview, but organizations must still provide the community with appropriate JCAHO contacts to air safety or quality concerns.

Organizations must now show surveyors how they inform the public about contacting the JCAHO with patient-safety or quality concerns, according to the September 2005 *Joint Commission Perspectives*.

The new accreditation participation requirement, APR 8, took effect January 1.

Under the announced survey process, hospitals had to give the public 30 days’ notice prior to a survey, offering a chance to speak about the perception of care during a scheduled meeting during the inspection.

The JCAHO removed the information interview from survey agendas because organizations will not be able to notify the public in advance due to the unannounced inspections.

**Benefit from technology**

Hospitals should allow patients the opportunity to discuss or resolve issues of safety or quality with the organization and its leadership. If those efforts prove futile, patients may then contact the JCAHO, says Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, a healthcare consultant in Trabuco Canyon, CA.

The most common place to post contact information is on a hospital Web site, Di Giacomo-Geffers says. The Web site can list all regulatory agencies that patients can contact, including the JCAHO, Occupational Safety and Health Administration, state health department, and others, she says.

“Keep it simple, but just enough to demonstrate [compliance],” Di Giacomo-Geffers says.

Hospitals can also put the information in a safety brochure to give to patients, in patients’ admissions paperwork, or in a flier mailed to the community each year, Di Giacomo-Geffers says.

**Spread the word**

Many hospitals also have newsletters that are distributed throughout the community during the year.

Work with the hospital’s communications department to include the regulatory agency contacts in that newsletter, Di Giacomo-Geffers says.

Hospitals should also notify local patient-advocacy groups about the proper ways to contact the JCAHO and other regulatory agencies, she adds.

**Work with staff**

Staff should also receive education about how to contact the JCAHO with safety concerns, Di Giacomo-Geffers says. That education can be done during new employee orientation and annual staff updates, she says.

APR 17 requires hospitals to educate their staff about reporting safety concerns to the commission free of retribution or disciplinary action—the so-called “whistleblower” requirement.

**File it away**

The hospital’s JCAHO coordinator should maintain a file with public notification information, Di Giacomo-Geffers says. Placing in the file any brochures, fliers, or Web site printouts that include the contact information will help staff explain to surveyors how the organization meets the notification requirement, she says.

Leadership should also be aware of the hospital’s public-notification methods, she adds.
E-mails help hospital train, get perfect survey score

Multiple training methods lead to success

Survey tracker

Learning objectives: After reading this article, you will be able to
1. describe staff training methods for unannounced surveys
2. explain how to use the periodic performance review (PPR) to prepare for survey
3. identify other tools used to train for surveys

A perfect survey was a click of the mouse away for one Florida hospital.

Staff at Naval Hospital Jacksonville each week received e-mails containing basic JCAHO information, survey questions and answers, and challenging standards to help them prepare for the hospital’s July 2005 survey, says Cmdr. Carola Miner, the hospital’s performance improvement coordinator.

Miner’s department created the e-mails—or “survey savvies,” as she called them—which helped staff learn about the JCAHO at their leisure. The e-mails combined with the PPR and other preparation methods gave the 60-bed hospital no requirements for improvement and only a few supplemental suggestions during its survey.

“All that information prepared us for what to expect,” Miner says. “It was just planning ahead.”

Training for the 21st century

Miner culled the e-mails from any available source of information about the JCAHO, including periodicals, she says. The e-mails began circulating in January 2005, and staff received them either weekly or biweekly.

“We used whatever source[s] we could come up with,” Miner says.

When the e-mails first started seven months prior to survey, staff received basic information about tracer methodology to get them up to speed, Miner says.

The July survey was the hospital’s first since the new survey process began.

Staff enjoyed receiving the e-mails, Miner says, and supervisors used them as educational cues during meetings. Miner also posted the e-mails on the hospital intranet so staff could view past issues whenever they chose.

PPR trains staff

The PPR also prepared the hospital by helping it determine areas of noncompliance. The hospital submitted its PPR to the JCAHO in February 2004, but it also conducted another one in 2005 to evaluate where it stood, Miner says.

“It was just to kind of keep the momentum going and do a clean sweep of the standards,” Miner says.

Survey focus areas

Surveyors focused on the following areas during a July 2005 survey of Naval Hospital Jacksonville (FL):

- Medication management
- Environment of care
- Plan of care
- Patient education
- Transferring care to outpatient services

Tell us about your unannounced survey experience!

Has your hospital had its unannounced triennial survey yet? BOJ wants to know about it. What happened when the surveyors showed up? How did staff handle the surprise?

Contact Managing Editor Matt Bashalany at 781/639-1872, Ext. 3726, or mbashalany@hcpro.com, and your experiences may be featured in a future article.
Miner also distributed to committees (e.g., pharmacy and therapeutics) standards that related to their areas and had them evaluate compliance, she says.

“They really took ownership of those standards,” Miner says of the committees.

**Videos highlight tracers**

In addition to the PPR and e-mails, the hospital showed a video about tracers to teach staff about the new surveys, Miner says. Staff also conducted mock tracers that focused on patients.

“That was really the crux of getting staff involved [in survey preparation],” Miner says. “It made people more comfortable.”

**Plan for unannounced visits**

Naval Hospital Jacksonville volunteered to be part of the unannounced survey pilot in 2005, so the organization only received a three-day notice that surveyors would be arriving, Miner says.

With the move to unannounced surveys for all organizations, hospitals no longer receive advance notice, the JCAHO has said. The only facilities that will receive notice are those in the Defense Department and Federal Bureau of Prisons due to security reasons, according to the commission.

To prepare for the unannounced visit, Miner’s team evaluates staffing every month to ensure that the appropriate administrators, staff, and backups would be present if surveyors arrived that month, she says. A monthly evaluation is critical because turnover can leave key positions vacant, she says.

Miner also had to secure rooms for the surveyors and compile critical documents and policies. “We planned as best we could,” Miner says. “At the drop of the hat, you’re supposed to come up with meeting rooms and schedules.”

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### Sample patient tracer training e-mail

You have a new admission from the emergency department who came to your unit an hour ago with nausea, vomiting, and dehydration.

The patient suddenly developed acute abdominal pain, and you suspect an acute obstruction with the need for surgical intervention.

If a JCAHO surveyor approached you, how would you answer the following questions?

1. How does the patient-assessment process begin?
2. Who determines whether an NG tube is needed?
3. How do you get a stat computed tomography (CT) of the abdomen performed?
4. How do you get the CT results to the physician and how do you verify critical results?
5. What is your process for getting a patient to the operating room in an emergency?
6. What is your role in preparing a patient for surgery?

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**E-mail learning topics**

Following are five topics staff at Naval Hospital Jacksonville (FL) read about in survey-preparation e-mails:

- ABCs of patient safety
- Pointers on patient rights
- Sentinel event basics
- Challenging standards
- Tracer methodology

*Editor’s note: This sample survey training e-mail was excerpted from j-mail, 2006 Edition: JCAHO Survey Prep for the Whole Staff. Get more information at www.hcmarketplace.com. j-mail provides 130 new JCAHO-related questions and answers to help you maintain a state of continuous survey readiness.*
Eight expert tips for medication labeling success

Cases of unintentional medication and solution swaps are widely covered in the media. Unfortunately, many of these cases are devastating and result in fatal complications. They include:

- high-concentration epinephrine mistaken for low-concentration epinephrine
- Formalin mistaken for spinal fluid
- prep solution mistaken for radiocontrast dye
- muscle relaxant mistaken for antibiotic

Despite the frequency of cases, the Institute for Safe Medication Practices reports that during a 2004 survey of 1,600 hospitals, only 41% reported that they consistently label medication containers (e.g., syringes and basins) on the sterile field. Although it has increased from the 25% reported in its 2000 survey, 41% is a far cry from even half of the hospitals reporting.

A new JCAHO National Patient Safety Goal addressing this topic took effect January 1. The goal requires hospitals to label all medications, medication containers (e.g., syringes and basins) on and off of the sterile field in perioperative and other procedural settings.

Extension of the five ‘rights’ of medication use
This goal reaffirms the five “rights” of medication use. In other words, staff ensure that they have the right:

- patient
- medication
- dose
- time
- route

However, the following pitfalls may occur and lead to poor habits:

- Assuming that the medication is correct
- Submitting to production pressure
- Relying on memory
- Normalizing deviance

Tips for compliance
Following are eight tips for medication labeling:

1. Make it easy on yourself. Make sure that sterile markers, preprinted labels, blank labels, and nonsterile markers are readily available in the perioperative area. Consider placing markers and labels in your sterile packs.

   **Tip:** Conduct usability testing before final purchase of your markers and labels (i.e., check to make sure that labels will stick on basins and that markers don’t smear too much). Also notify your purchasing department staff so they know that the markers and labels you have selected have undergone usability testing and that changing buyers will require new usability testing prior to purchase.

2. Create an explicit policy and process for drawing up medications in the perioperative setting. A frequent failure point occurs when a medication is poured into a medicine bowl or cup and then drawn up into a syringe. The two-step process can lead to one of the two containers not being labeled.

   Redesigning the process to remove the extra step (e.g., drawing the drug directly into the syringe) reduces the potential for harm and error.

3. Have an explicit process to cross-check and verify. All medications and solutions handed over to...
the sterile field should have a two-person verification process. This process should involve verbal read-backs and should include the drug, concentration, dose, and expiration date. During each hand-off (e.g., relief break, shift change), all solutions and medications should be cross-checked and verified between staff.

4. **Use friendly competition within your procedural areas and operating rooms (OR) to provide constant awareness, feedback, and goals for compliance.** With the huge number of policies, procedures, and documentation requirements in healthcare facilities, providing constructive competition in a non-punitive manner can encourage compliance.

5. **Take this time to review other safe medication practices.** Implementation of this policy provides a good opportunity to recheck the following other parts of the National Patient Safety Goal for improving medication safety:

- **Look-alike/sound-alike solutions and medications:** Your prior reviews may not have considered chemicals and solutions, but misidentifying these non-IV solutions can be a significant risk for patients. Colored solutions that look dangerously alike may need to be reviewed for purchasing through a different vendor. Tinting solutions (e.g., cocaine solutions) may help differentiate between them, but this process does not remove the requirement for consistent labeling.

- **Standardizing medication concentrations:** Review if multiple concentrations and dosage containers of medications/solutions need to be in the procedure rooms. Examples of standardization include:
  - **epinephrine:** multidose vials of epinephrine can be standardized to 1 cc.-unit-dose ampules or vials. Opening three to five ampules for a case may take a few more seconds, but it removes the risk of mistaking a multidose vial of epinephrine for another drug.
  - **heparin:** another common standardization is limiting the number of heparin solutions available in the hospital and perioperative areas.

6. **Don’t forget solutions that look like medications.** This goal is not limited to medications. Therefore, don’t forget solutions that look like medications (e.g., irrigation solutions, formalin solutions, and other pathology-fixating preparations). These solutions should be marked and labeled. The only rare exception when a solution need not be marked and labeled is when it is poured, immediately used, and discarded without a break by one person.

7. **Better to be safe than sorry.** Your policy should adhere to and articulate several other practices as well. Implement and practice the following:

- **When in doubt, throw it out**—if there is any question regarding a solution’s contents, discard it.
- **Even if it’s the only one**—using only one medication in the field does not justify failing to label it. The case of the prep solution being mistaken for radiographic dye is an example of something other than a drug being mistaken for a drug.
- **Keep all containers until the end of the case**—both the original containers and the labeled containers should be accessible for review until the end of the case. At that point, discard all containers.

8. **Don’t forget the areas outside the operating room.** Medications and solutions in procedure areas are just as vulnerable as those in the OR setting. Thus, this goal applies to all areas. Remember to include such areas as invasive radiology and the cardiac catheterization laboratory.

Illustration by Dave Harbaugh

“Well, we finished your survey. Thank you for adding to our sentinel events database.”
Random unannounced surveys will end December 31, 2007, a change from previous JCAHO announcements, which said the inspections would continue through 2008.

The December 2005 Joint Commission Perspectives said the current random unannounced survey process would continue at a 5% sample of all surveyed organizations through December 31, 2007.

The JCAHO Web site in early December 2005 said random unannounced surveys would continue through 2008, and commission officials made similar statements earlier in 2005.

JCAHO spokesperson Mark Forstneger confirmed that the end of random unannounced surveys would come by December 31, 2007, and said the Web site would be updated to reflect the correct date. The Web site had been corrected as of presstime.

Random unannounced surveys have become outdated with the advent of unannounced triennial surveys, forcing the need to restructure the process.

The JCAHO will begin phasing in random unannounced validation surveys of organizations required to submit evidence of standards compliance.

Organizations would not be charged for the visit, and most inspections would last one day, according to Perspectives.

The primary purpose of the visit is to validate statements made in the evidence of standards compliance submitted for a requirement for improvement received during its triennial survey, Perspectives noted.

Organizations required to submit evidence of standards compliance would face a validation survey after the JCAHO accepts the statements, the commission said.

Hospitals submitting evidence of standards compliance and a measure of success (MOS) would face an inspection after the MOS is submitted.