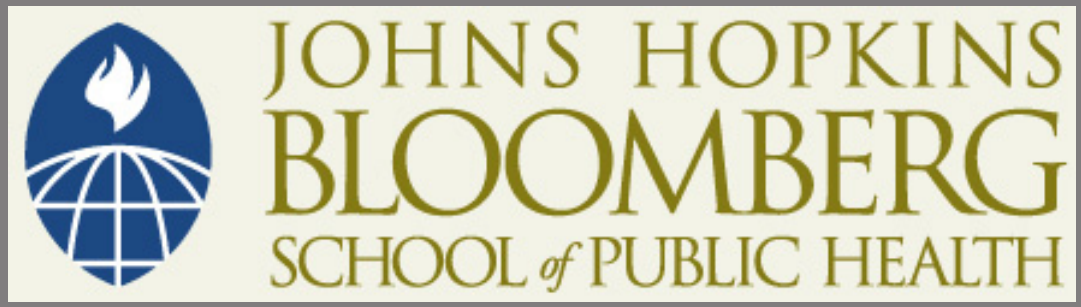

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The Joint Commission and Patient Safety

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Section A

Background

The Joint Commission Is …

- … the new (2007) name of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

- … an independent, not-for-profit organization that accredits and certifies more than 16,000 health care organizations and programs in the U.S.

Entities Receiving Joint Commission Certification

- General, psychiatric, children's, rehabilitation, and critical access hospitals
- Medical equipment services, hospice services, and other home care organizations
- Nursing homes and other long-term care facilities
- Behavioral health care organizations and addiction services
- Rehabilitation centers, group practices, office-based surgeries, and other ambulatory care providers
- Independent or freestanding laboratories

Putting the "Mission" in Joint Commission

- Mission: To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations

History of the Joint Commission

- 1910: Ernest Codman, MD, proposes the "end result system of hospital standardization." Under this system, a hospital would track every patient it treated long enough to determine whether the treatment was effective. If the treatment was not effective, the hospital would then attempt to determine why so that similar cases could be treated successfully in the future.

History of the Joint Commission

- 1913: American College of Surgeons (ACS) is founded at the urging of a colleague of Dr. Codman. The “end result” system becomes an ACS stated objective.

- 1917: The ACS develops the Minimum Standard for Hospitals. Requirements fill one page.

- 1918: The ACS begins on-site inspections of hospitals. Only 89 of 692 hospitals surveyed meet the requirements of the Minimum Standard.

History of the Joint Commission

- 1951: The American College of Physicians, American Hospital Association, American Medical Association, and Canadian Medical Association join with ACS to create the Joint Commission on Accreditation of Hospitals (JCAH)

- 1952: The ACS officially transfers its Hospital Standardization Program to JCAH, which begins offering accreditation to hospitals in January 1953

History of the Joint Commission

- 1964: JCAH begins charging for surveys

- 1965: Congress passes the Social Security Amendments of 1965 with a provision that ***hospitals accredited by JCAH are "deemed" to be in compliance with most of the Medicare Conditions of Participation for Hospitals and, thus, able to participate in the Medicare and Medicaid programs***

- 1987: The organization name changes to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to reflect an expanded scope of activities

History of the Joint Commission

- 1994: Quality Healthcare Resources, Inc., and the Joint Commission form Joint Commission International (JCI) to provide education and consulting to international clients

- 1997: JCAHO launches ORYX: The Next Evolution In Accreditation to integrate the use of outcomes and other performance measures into the accreditation process

- 1999: The Joint Commission's mission statement is revised to explicitly reference patient safety

Sidebar: What Is ORYX?

- According to the Joint Commission Web site …

  "ORYX relates to the ORYX Performance Measurement Initiative that The Joint Commission initiated in the 1980s. With as much as The Joint Commission uses acronyms, surprisingly enough, this is not one of them. Why 'ORYX'? An oryx is a swiftly moving and graceful gazelle-like animal by definition. This information, along with the fact that it is a short, unique catch word, comes together to provide an explanation as to how the initiative received its name."

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History of the Joint Commission

- 2002: The Joint Commission announces the Shared Visions-New Pathways initiative, designed to progressively sharpen the focus of the accreditation process on care systems critical to the safety and quality of patient care (ultimately launched 2004)
  - Unannounced inspections
  - Tracer patients

History of the Joint Commission

- 2003: First set of National Patient Safety Goals take effect
- 2005: The Joint Commission and Joint Commission Resources (JCR) establish the Joint Commission International Center for Patient Safety

History of the Joint Commission

- 2006: The Joint Commission begins conducting ***on-site accreditation surveys and certification reviews on an unannounced basis***, with certain exceptions

- 2007: Name changes to "The Joint Commission"

- 2007: The Joint Commission is awarded a contract by the WHO to oversee global field testing of the International Classification for Patient Safety

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Section B

JC—National Patient Safety Goals

National Patient Safety Goals (NPSG)

- The purpose of the NPSG is to promote specific improvements in patient safety
- Highlight problematic areas in health care and describe evidence and expert-based solutions to these problems
- Focus on system-wide solutions, where possible

Surveying and Scoring the National Patient Safety Goals

- All applicable Goals and Requirements, or acceptable alternative approaches, must be implemented
- Surveyors evaluate the actual performance, not just the intent of meeting the Goals and Requirements
- NPSG Requirements are scored as either “Compliant” or “Not Compliant”
- Failure to comply with a NPSG Requirement will result in a “Requirement for Improvement” (RFI)

2009 Goal No. 1

- 2009 Goal No. 1: Improve the accuracy of patient identification
  - Use at least two patient identifiers when providing care, treatment, and services
  - Prior to the start of surgical or invasive procedures, individuals involved in the procedure conduct a final verification process (e.g., “time-out”) to confirm the correct patient, procedure, and site
  - Eliminate transfusion errors related to patient misidentification

2009 Goal No. 2

- 2009 Goal No. 2: Improve the effectiveness of communication among caregivers
  - For verbal or telephone orders or for telephone reporting of critical test results, the individual giving the order verifies the complete order or test result by having the person receiving the information record and "read back" the complete order or test result
  - There is a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization

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  - The organization measures, assesses and, if needed, takes action to improve the timeliness of reporting and the timeliness of receipt of critical tests, critical results, and values by the responsible licensed caregiver
  - The organization implements a standardized approach to hand-off communications, including an opportunity to ask and respond to questions

2009 Goal No. 3

- 2009 Goal No. 3: Improve the safety of using medications
  - The organization identifies and, at a minimum, annually reviews a list of look-alike/sound-alike medications used by the organization and takes action to prevent errors involving the interchange of these medications
  - Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field
  - Reduce the likelihood of patient harm associated with the use of anticoagulation therapy

2009 Goal No. 7

- 2009 Goal No. 7: Reduce the risk of health care–associated infections
  - Comply with current WHO or CDC hand hygiene guidelines
  - Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function related to a health care–associated infection
  - Implement evidence-based practices to prevent health care–associated infections due to multiple drug–resistant organisms in acute-care hospitals

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  - Implement best practices or evidence-based guidelines to prevent central line–associated bloodstream infections
  - Implement best practices for preventing surgical-site infections

2009 Goal No. 8

- 2009 Goal No. 8: Accurately and completely reconcile medications across the continuum of care
  - A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the organization
  - When a patient is referred or transferred from one organization to another, the ***complete and reconciled list of medications is communicated to the next provider*** of service and the communication is documented. Alternatively, when a patient leaves the organization's care directly to his home, the complete and reconciled list of medications is provided to the patient's known primary care provider or the original referring provider or a known next provider of service.

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  - When a patient leaves the organization's care, a complete and reconciled list of the patient's medications is provided directly to the patient, and the patient's family as needed, and the list is explained to the patient and/or family
  - In settings where medications are used minimally or prescribed for a short duration, modified medication reconciliation processes are performed

2009 Goal No. 9

- 2009 Goal No. 9: Reduce the risk of patient harm resulting from falls
  - The organization implements a fall reduction program that includes an evaluation of the effectiveness of the program

2009 Goal No. 10

- 2009 Goal No. 10: Reduce the risk of influenza and pneumococcal disease in institutionalized older adults
  - The organization develops and implements protocols for administration of the flu vaccine
  - The organization develops and implements protocols for administration of the pneumococcus vaccine
  - The organization develops and implements protocols to identify new cases of influenza and to manage outbreaks

2009 Goal No. 11

- 2009 Goal No. 11: Reduce the risk of surgical fires
  - The organization educates staff, including licensed independent practitioners who are involved with surgical procedures and anesthesia providers, on how to control heat sources, how to manage fuels while maintaining enough time for patient preparation, and establish guidelines to minimize oxygen concentration under drapes

2009 Goal No. 13

- 2009 Goal No. 13: Encourage patients' active involvement in their care as a patient safety strategy
  - Identify the ways in which the patient and her family can report concerns about safety and encourage them to do so

2009 Goal No. 14

- 2009 Goal No. 14: Prevent health care–associated pressure ulcers (decubitus ulcers)
  - Assess and periodically reassess each resident's risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks

2009 Goal No. 15

- 2009 Goal No. 15: The organization identifies safety risks inherent in its patient population
  - The organization identifies patients at risk for suicide
  - The organization identifies risks associated with home oxygen therapy, such as home fires

2009 Goal No. 16

- 2009 Goal No. 16: Improve recognition and response to changes in a patient's condition
  - The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening

The Organization Meets Expectations

- The organization meets the expectations of the Universal Protocol
  - Conduct a pre-procedure verification process
  - Mark the procedure site
  - A time-out is performed immediately prior to starting procedures

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Section C

What Does the Joint Commission Do?

Results

The Joint Commission

National Patient Safety Goal compliance trends by program
2008 Ambulatory Care Accreditation Program (January 1 – December 31, 2008)

The numbers represent percentages, except the second row, which represents the number of surveys conducted. Rates for the current year are not considered final until all surveys for the year have been completed and reviewed.

Goal	2008	2007	2006	2005	2004	2003
Number of surveys	459	452	434	403	448	397
1A Two patient identifiers	94	94	93	96	92	93
2A Read back verbal orders	98	96	91	89	92	94
2B "Do not use" abbreviations	90	88	76	82	84	80
2C Reporting critical test results	79	79	92	99	n/a	n/a
2E Hand-off communication	100	100	97	n/a	n/a	n/a
3A Restrict concentrated electrolytes	n/a	n/a	n/a	98	99	97
3B Standardize drug concentrations	n/a	100	99	100	100	98
3C Look-alike, sound-alike drugs	92	87	91	96	n/a	n/a
3D Labeling medications & solutions	82	85	96	n/a	n/a	n/a
3E Anticoagulation therapy	98	n/a	n/a	n/a	n/a	n/a
5A Infusion pump free-flow protection	n/a	n/a	n/a	100	100	99
6A Maintain & test alarm systems	n/a	n/a	n/a	n/a	100	97
6B Alarms set properly & audible	n/a	n/a	n/a	n/a	100	97
7A CDC hand hygiene guidelines	87	90	88	93	98	n/a
7B Health-care associated infection	100	100	100	98	100	n/a
8A Medication list & reconciliation	89	84	76	99	n/a	n/a
8B Transfer/discharge reconciliation	81	73	74	99	n/a	n/a
11A Surgical fire prevention	98	98	99	98	n/a	n/a
13A Patient involvement	93	95	n/a	n/a	n/a	n/a
UP* 1A Pre-operative verification	99	99	98	95	98	98
UP* 1B Surgical site marking	94	95	92	94	96	96
UP* 1C "Time-out" before surgery	86	81	76	86	93	94

* Universal Protocol

Organizational Policy vs. Individual Action

The Joint Commission

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Additional Joint Commission Patient Safety Efforts

- Patient safety-related standards
- Sentinel event policy (and Sentinel Event Alert)
- Patient Safety Advisory group
- Office of Quality Monitoring
- Patient safety research, education, and resources
- Legislative efforts and patient safety coalitions
- Quality Check and Quality Reports
- “Speak Up” initiatives

Effect of the Joint Commission?

- Grade = A
  - Impact of regulation on patient safety in last 5 years
  - Why? Because physicians are individualistic and hospitals lack robust incentives to drive patient safety

Limitations of the Joint Commission

- Hard to regulate less “black and white” things, such as creating a positive safety culture and implementing appropriate information technology

- Regulation can pick off the “low hanging fruit”

Conclusion

- The Joint Commission represents a powerful force in the patient safety movement

- Organizations aiming to meet the spirit of the NPSG (as opposed to deploying “work arounds” only during Joint Commission surveys) are the most likely to create and sustain safer environments