Organ donation has always been a part of the Joint Commission’s commitment to health care quality. In the 2004 hospital standards, JCAHO has continued to promote organ donation and cooperative organ procurement practices. Through its hospital accreditation standards, JCAHO has placed responsibility for organ donation squarely in the lap of hospital leadership. Standard LD.3.110 states that a hospital must implement policies and procedures developed with the participation of the medical staff for procuring and donating organs and other tissues. The 12 elements of performance associated with this standard require hospitals to, among other things, partner with an organ procurement organization (OPO), notify the OPO in a timely manner of patients who have died or whose death is imminent, work with the OPO to obtain consent from the family of each potential donor, and educate staff about donation issues and procedures.

The purpose [of the roundtable] is to identify strategies to close the gap between potential organ donors and needy recipients.

Despite JCAHO’s emphasis on organ donation in the standards and efforts of various other organizations to promote good organ donation practices, less than half of potential donors in the United States actually donate their organs. Complex issues underlie the failure of health care organizations to consistently identify potential donors and perform organ donation activities. As the issue of organ donation gains more exposure through the work of the Department of Health and Human Services (see article, this issue, page 3), the Joint Commission is also increasing its focus in this area.

Earlier this year, JCAHO launched a public policy initiative focusing on the issue of organ donation. The initiative began with an organ donation roundtable in June 2003 that brought together 30 to 40 practitioners and experts in the field of organ donation.

“The objective of the roundtable was to identify and gather information on best practices and effective practices to increase organ donation and begin to develop an action plan for increasing the rate of organ donation, as well as for improving safety in transplantation,” states Chuck Mowll, JCAHO’s executive vice president of business development and government and external relations.

In the general sense, the roundtable was created to bring multiple parties who have an interest in organ donation together in a “safe place” to discuss and analyze difficult and sensitive issues. More specifically, the roundtable was created to help understand the complex issues that surround organ donation, build upon the recommendations from the Department of Health and Human Services’ Advisory Committee on Organ Transplantation, and identify clear accountabilities for the actions necessary to achieve goals.
Joint Commission Examines Organ Donation (continued)

(Continued from page 1)

regarding organ donation and transplantation. Some key discussion points addressed in the roundtable can be seen in the sidebar below.

In October 2003 the Joint Commission again brought the same group of experts and practitioners together for another roundtable. “The purpose of this meeting was to continue the discussions around identifying strategies to close the gap between potential organ donors and needy recipients,”

(Continued on page 12)

Discussions at JCAHO’s Organ Donation Roundtable

The following issues were identified as important in the discussion of organ donation at JCAHO’s roundtable:

- Variation in donor consent rates across hospitals
- Racial and ethnic disparities in organ donation and transplantation
- Live donor care issues and complication rates
- The best practices initiative from the Health Resources and Services Administration (HRSA)
- The need to identify good measures and report performance data
- The implications of the progressive decline in trauma-related deaths
- Patient safety concerns
- Exploration of “death by neurological criteria” organ transplantation
- Live donor leave policies, providing work leave to parties donating organs

IN Sight

This column informs you of developments and potential revisions that can affect your accreditation and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they were rejected at some point in the process.

Approved

Revised “Prevention and Control of Infection” chapter applicable to ambulatory care, behavioral health care, home care, hospitals, laboratories, and long term care, effective January 1, 2005

New “Leadership” standard for hospitals and critical access hospitals requiring plans to identify and mitigate impediments to efficient patient flow throughout a hospital, effective January 1, 2005

Revision to “Environment of Care” standard and Statement of Conditions™ for hospitals requiring the replacement of existing roller latches on corridor doors with positive latching devices by March 13, 2006, effective January 1, 2004

Field Review

Revisions to waived testing standards for ambulatory care, assisted living, behavioral health care, home care, hospitals, laboratories, long term care, and office-based surgery related to growth in the number of waived testing methods and problems in the quality of testing

Revisions to infection control standard related to epidemics and infections and element of performance related to antimicrobial infections for ambulatory care, behavioral health care, home care, hospitals, laboratories, and long term care

Revisions to standards for health care networks

In Committee Review

Core measure set for international accreditation

Addition of tissue banking standards for ambulatory care and hospitals

Proposed revisions to selected Medical Staff standards for hospitals

Revisions to standards on clinical practice guidelines for hospitals

Currently in Development

Certification program for health care staffing agencies

Methodology for evaluating the impact of the SHARED VISIONS–NEW PATHWAYS initiative on the value of accreditation for health care organizations and stakeholders

International standards for primary care organizations

Revisions to organization-specific Quality Reports
A Best Practices Initiative
Each day, nearly 18 people die waiting for an organ that could save their lives. Nationally, there are more than 82,000 people currently waiting for such an organ. One of the difficulties inherent in organ donation is that individuals who need a new organ have few, if any, alternative medical options. So, barring any dramatic changes in organ transplantation technology, patients in such a situation must rely on human donors.

HRSA Launches the Organ Donation Breakthrough Collaborative
As a result of the compelling statistics surrounding organ donation, Department of Health and Human Services’ Secretary Tommy Thompson has made organ donation a top priority throughout his tenure. For example, he significantly changed the roles and responsibilities of the Advisory Committee on Organ Transplantation (ACOT), which offers recommendations regarding this important topic. Thompson expanded the committee from 20 to 41 members and amended its charter to expand the scope of its responsibilities to include advising the Secretary on ways to increase organ donation nationally. (For more information on ACOT’s recommendations, please see http://www.organdonor.gov/acotrecsbrief.html.)

In addition to ACOT and its recommendations, the Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services, has launched a national initiative to generate significant increases in organ donation. Developed in conjunction with several other organizations, including the Institute for Healthcare Improvement (IHI), this initiative brings together organ procurement organizations (OPOs) and acute care hospitals to work together to improve their organ donation processes. “The Organ Donation Breakthrough Collaborative is designed to close the gap between the number of eligible donors and the number of actual donors. The learning and knowledge that results from the Collaborative will be communicated to OPOs and hospitals so that they might adopt and replicate the lessons learned in the collaborative process,” states Dennis Wagner, social marketing leader in HRSA’s Division of Transplantation.

Collaboration a Necessity Among OPOs and Hospitals
The OPO is the bridge between organ donors and patients awaiting transplantation. These organizations work with hospitals to identify eligible donors, honor donation intentions, and implement procedures to transfer donated organs to waiting recipients. Ideally, OPOs and hospitals work together to do the following:

- Establish a relationship that results in timely notification of every in-hospital death
- Assess each death for donor eligibility
- Consult and converse with families of eligible donors using trained professionals
- Evaluate and place every medically appropriate organ with a compatible transplant candidate

If any of these activities fall short, opportunities for organ donation can be missed.

The measure of how effective a hospital and OPO are at collaborating to provide organ donation services is the conversion rate, or the ratio of the number of actual donations occurring at a facility as compared to the number of eligible donors. In 2002 the 200 hospitals with the highest number of eligible donors averaged a 46% conversion rate, meaning that more than half of eligible donors did not donate their organs.

Compounding the problem is the fact that not every hospital has a substantial number of organ donors. In fact, 50% of eligible donors are found in 206 hospitals, 75% of eligible donors are found in 483 hospitals, and 90% of eligible donors are found in 846 hospitals.

With all these eligible donors, why is the conversion rate not higher across the nation’s hospitals? “In any one hospital, organ donation does not happen very often,” states Ginny McBride, public health analyst for HRSA. “Hospitals with the largest number of eligible donors at most encounter 80 eligible donors per year. Many times facilities encounter only 15 eligible donors per year. This frequency is not high enough for organizations to automatically have finely tuned donation processes.”

Support for the Collaborative
To help support and propel the Collaborative forward, a leadership council has been established made up of organizations that have an interest in seeing organ donation rates improve. The Joint Commission is an active member of that leadership council. “Because JCAHO is the preeminent accrediting organization for hospitals, it is in a great position to help support the Collaborative,” comments Wagner. Concurrently, the Joint Commission is examining the issue of organ donation through one of its public policy initiatives. (See article, page 1.)

(Continued on page 4)
How the Collaborative Works

The Collaborative encourages strong partnerships between hospitals and OPOs. It is made up of 49 teams representing 103 large hospitals and 43 OPOs. In order to participate in the Collaborative, OPOs and hospitals needed to partner, form a team, and apply to HRSA. Those accepted agree to place organ donation as a priority and complete several exercises, including readings as well as mapping and measurements of current systems. “Each team consists of OPO and hospital staff. Teams must have backing from senior leaders in their organizations and those leaders must enable participants to engage in Collaborative activities and empower participants to implement changes,” states Wagner.

Participants in the Collaborative are learning about the best practices of the facilities with high donation rates and incorporating them into their own systems and practices. “The Collaborative uses an all-teach, all-learn philosophy,” comments Wagner. “The initiative is based on break-through collaborative methodology developed by IHI that involves a full-court press to facilitate changes in performance based on what already works.”

The Collaborative’s process is made up of a series of learning sessions and activity periods. The first learning session took place September 9–10, 2003, in Washington, DC. The main goals of the session were to share the best practices of high donor organizations and encourage teams to select initiatives to implement based on these best practices.

During the subsequent activity periods, teams returned to their institutions to design, implement, and test ideas using Plan, Do, Study, Act (PDSA) methodology. The teams will reconvene in January 2004 to review progress, assess breakthroughs, and design further changes for more testing. At this time, participants will also begin working on how to spread the effective changes that organizations have experienced to the larger pool of 846 hospitals that represent 90% of potential organ donation opportunities.

The Collaborative has set itself a challenging goal: To achieve an average organ donation rate of 75% in the nation’s hospitals with the largest number of eligible donors. “We know this goal is obtainable because there are 14 hospitals in the United States that currently have organ donation conversion rates of 75% or higher,” offers Wagner. Reaching this goal will not be an easy task; however, achieving such a conversion rate could save or enhance thousands of lives each year.

Strategies for Improving Organ Donation Conversion Rates

Although the work of the Collaborative is still very much in progress, the initiative has yielded four overarching strategies that drive it. Developed from the practices of high donor organizations as well as from input drawn from scientific literature and recent studies of organ donation processes, these strategies can apply to all hospitals and OPOs in some way. Following is a discussion of the four strategies:

- **Focus on change, improvement, and results.** The goal of this strategy is for OPOs and hospitals to create a culture of excellence and increase the number of organ donors by developing and maintaining a staff that is aware of and in tune with organ donation opportunities. Organizations can do this by defining and maintaining relationships with key stakeholders such as the medical examiner, coroner, transplant centers, and hospital physician leadership. Seamless integration of organ procurement processes must be encouraged among all staff.

- **Rapid, early referral, and linkage to potential donor families.** This strategy encourages hospitals and OPOs to communicate with one another early about a potential donation opportunity. Conversations should begin among staff well before brain death is pronounced in order for the hospital and OPO to jointly develop a plan to approach the donor’s family. To do this there should be standardized protocols between hospital and OPO staff.

- **Integrated donation process management.** This strategy encourages hospitals and OPOs to develop a process that clearly defines roles and responsibilities surrounding organ donation. For example, the OPO should provide resources for all donation-related matters, while the hospital should provide high-level leadership support and staff training.

- **Aggressive pursuit of every donation opportunity.** This strategy requires organizations to improve organ yield by applying broad criteria to evaluate every organ for donor potential, deploying resources quickly, minimizing lost recoveries and aggressively pursuing organ placement. Success at organ donation should be regularly evaluated through death record reviews.

The long term goal of the Collaborative is to encourage institutions, organizations can achieve success, allow grieving families to find comfort in their decision to donate, and ensure end-stage organ failure patients receive the life-sustaining organs they need.
Coming in your January 2004 Perspectives...

Special Issue on
SHARED VISIONS–NEW PATHWAYS

Get all the latest information about JCAHO’s new accreditation process just in time for the January 1, 2004, launch of this initiative.
JCAHO and JCR Take Action to Enhance Firewall

Since Joint Commission Resources (formerly known as Quality Healthcare Resources) was established in 1986 and began to provide consultative technical assistance, JCAHO and JCR have maintained strict policies and procedures to ensure the integrity of the accreditation process. These included the creation of a “firewall” set of guidelines that prohibits any suggestion that JCR’s services are either necessary or improperly advantageous for obtaining JCAHO accreditation, separation of JCAHO and JCR consulting by location, telephone, and computer systems and by description as a separate corporate entity, prohibition of any disclosure by JCR of the identity of its clients to JCAHO, prohibition of access by JCR personnel to JCAHO accreditation files, and separation of JCR and JCAHO staff relative to each client for three years after their involvement.

In recent years, the aftermath of several high-level corporate scandals has heightened public and corporate sensitivities to potential conflicts of interest, undermined the public trust of major corporate entities, and underscored the need for corporations to be proactive in their corporate compliance efforts.

With these sensitivities in mind, the chairs of the JCAHO and JCR Boards met with the chief executive officers of both organizations to discuss ways to further enhance the separation and independence of JCAHO and JCR activities. Representatives of both organizations agreed to engage outside consultants to assist in a full and independent review of this issue, utilizing the passage of the Sarbanes-Oxley Act and the various regulatory standards being promulgated by the Securities and Exchange Commission to put both JCAHO and JCR at the cutting edge of governance and management self-scrutiny.

The consultant recommendations centered on the furthering of a strong corporate compliance framework, with revised policies of conflict and duality of interest, and an enhanced firewall that further demonstrates independence of operations.

The restructuring changes approved by JCAHO’s Board of Commissioners and JCR’s Board of Directors provide for the following:

- Changes in the number and composition of JCR’s Board of Directors so that a majority of the members are “outside” directors
- Creation of a JCR Board Firewall Oversight Committee, which reports directly to the JCAHO Audit Committee to review all descriptions and documentation of the firewall between JCAHO and JCR for the purpose of assuring that JCR’s institutional-specific domestic consulting services do not jeopardize the integrity of JCAHO’s accreditation process
- Creation of a JCAHO Corporate Governance Committee with overall responsibility for corporate compliance and governance
- Changes in officer selection that prevent simultaneous service with JCAHO and JCR
- Improved procedures that require JCAHO and JCR directors, officers, board members, and employees to attest to protecting confidential information and agree to guidelines for avoiding conflicts and dualities of interest
- Protocols for JCR field staff
- Limitations on the scope of JCR services, including prohibition of the following:
  - Specific postsurvey assistance in challenges to accreditation decisions or JCAHO findings
  - Resolution of JCAHO findings of deficiencies in accreditation standards compliance
  - Preparation of root cause analysis for sentinel events
  - Preparation of organizations that have been denied accreditation by JCAHO for future accreditation surveys
- Policy regarding use of Joint Commission name and logo on JCR products

JCAHO also announced a policy change in late 2002 addressing JCAHO surveyors’ conflict-of-interest policy (see January 2003 Perspectives, page 7). Under this change, also effective January 1, 2004, all JCAHO surveyors are prohibited from providing any JCAHO accreditation-related consulting services to health care organizations. JCAHO determined that a perceived conflict of interest could arise if a JCAHO surveyor provides presurvey consultation independently to organizations seeking or maintaining JCAHO accreditation. Under this policy, all JCR consultants are prohibited from serving as surveyors.

To support this change, JCAHO approved an Accreditation Participation Requirement (APR) precluding health care organizations from hiring Joint Commission surveyors to consult on accreditation-related issues. This APR appears in the 2004 comprehensive accreditation manuals and becomes effective January 1, 2004.
Errata to 2004 Accreditation Manuals

This article contains corrections to material recently published in the accreditation manuals effective January 1, 2004, for ambulatory care, behavioral health care, home care, hospitals, laboratories, and long term care. These errata, which will be effective February 1, 2004, are provided to address the following:

- Typographical or wording errors that could lead to misinterpretation or scoring errors
- Ambiguous language that could lead to misinterpretation or scoring errors
- Standards or elements of performance that were effective in 2003 and continue to be effective in 2004 but were inadvertently omitted from the 2004 manuals
- An element of performance that was inadvertently and incorrectly moved to an inappropriate standard

These errata are provided in the box below by accreditation program. Language to be added is shown in underline and language to be deleted is shown in strikethrough.

Questions about these changes should be addressed to JCAHO’s Standards Interpretation Group at 630/792-5900 or through its online question form at http://www.jcaho.org.

Errata to Standards and Elements of Performance in 2004 Manuals

1. Evaluating patients/clients/residents before performing moderate or deep sedation and anesthesia.
2. Performing the moderate or deep sedation and anesthesia, including rescuing patients/clients/residents who slip into a deeper-than-desired level of sedation or analgesia. These include the following:
   a. Moderate sedation—are qualified to rescue patients/clients/residents from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation
   b. Deep sedation—are qualified to rescue patients/clients/residents from general anesthesia and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation
   - Appropriate equipment for care and resuscitation
   - Appropriate monitoring of vital signs including, but not limited to, heart and respiratory rate and oxygenation using pulse oximetry equipment, respiratory frequency and adequacy of pulmonary ventilation, the monitoring of blood pressure at regular intervals, and cardiac monitoring (by EKG or use of continuous cardiac monitoring device) in patients/clients/residents with significant cardiovascular disease or when dysrhythmias are anticipated or detected
   - Documentation of care
   - Monitoring of outcomes

Definitions of four levels of sedation and anesthesia include the following: [Note, only the definition of one level is provided here as changes are only applicable to that definition.]

- Moderate sedation/analgesia (“conscious sedation”) A drug-induced depression of consciousness during which patients/clients/residents respond purposefully to verbal commands (note, reflex withdrawal from a painful stimulus is not considered a purposeful response)—either alone or accompanied by...
light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Ambulatory Care, Behavioral Health Care, Home Care, Hospital, Long Term Care

**Standard MM.4.30**

Medications are appropriately labeled.

**Elements of Performance for MM.4.30**

4. When preparing individualized medications for multiple specific patients/clients/residents or the person preparing the individualized medications is not the person administering the medication, the label also includes the following:
   - Patient/client/resident name
   - Patient/client/resident location
   - Directions for use and any applicable cautionary statements either on the label or attached as an accessory label (for example, “requires refrigeration,” “for IM use only”)

**Standard LD.3.10**

The leaders engage in both short-term and long-term planning.

**Elements of Performance for LD.3.10**

2. Planning for care, treatment, and services addresses the following:
   - The needs and expectations of patients/clients/residents and, as appropriate, families and referral sources
   - Staff needs
   - The scope of care, treatment, and services needed by patients/clients/residents at all of the organization’s locations
   - Resources (financial and human) for providing care and support services
   - Recruitment, retention, development, and continuing education needs of all staff
   - Data for measuring the performance of processes and outcomes of care

**Standard LD.3.20**

Patients/clients/residents with comparable needs receive the same standard of care, treatment, and services throughout the organization.

**Elements of Performance for LD.3.20**

3. Planning for care, treatment, and services addresses the following:
   - The needs and expectations of patients/clients/residents and, as appropriate, families and referral sources
   - Staff needs
   - The scope of care, treatment, and services needed by patients/clients/residents at all of the organization’s locations
   - Resources (financial and human) for providing care and support services
   - Recruitment, retention, development, and continuing education needs of all staff
   - Data for measuring the performance of processes and outcomes of care

**Ambulatory Care**

**Standard PC.9.10**

Blood and blood components are administered safely.

**Elements of Performance for PC.9.10**

For Medicare-Certified Ambulatory Surgical Centers

13. Only physicians or registered nurses administer blood and blood products.

**Standard PC.13.20**

Operative or other procedures and/or the administration of moderate or deep sedation or anesthesia are planned.

**Elements of Performance for PC.13.20**

1. Sufficient numbers of qualified staff (in addition to the LIP performing the procedure) are available to present to evaluate the patient, assist with the procedure, provide the sedation and/or anesthesia, monitor, and recover the patient.

2. Individuals administering moderate or deep sedation and anesthesia are qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

For Medicare-Certified Ambulatory Surgical Centers

18. If a nonphysician administers the anesthesia, the anesthetist must be under the supervision of the operating physician, and in the case of an anesthesiologist’s assistant, under the supervision of an anesthesiologist.

**Standard PC.13.40**

Patients are monitored immediately after the procedure and/or administration of moderate or deep sedation or anesthesia.

**Elements of Performance for PC.13.40**

5. Patients who have received sedation or anesthesia are discharged in the company of a responsible, designated adult.

**For Medicare-Certified Ambulatory Surgical Centers**

6. Each patient is evaluated by a physician for proper anesthesia recovery before discharge from the ambulatory surgery center.

**Standard MM.2.10**

Medications available for dispensing or administration are selected, listed, and procured based on criteria.

**Elements of Performance for MM.2.10**

3. A list of medications for dispensing or administration (including strength and dosage form) is maintained and readily available.

**Note:** Sample medications are not required to be on this list.

(Continued on page 8)
Errata to Standards and Elements of Performance in 2004 Manuals (Continued)

Standard MM.3.20
Medication orders are written clearly and transcribed accurately.

**Elements of Performance for MM.3.20**

For Medicare-Certified Ambulatory Surgical Centers

12. Orders given orally for drugs and biologicals are followed by a written order, signed by the prescribing physician.

Standard HR.4.10
There is a process for ensuring the competence of all practitioners permitted by law and the organization to practice independently.

**Elements of Performance for HR.4.10**

12. In addition to the above criteria, the organization collects and verifies information on restriction of privileges at other health care organizations.

Standard HR.4.30
The organization has a process for granting temporary clinical privileges, when appropriate.

**Elements of Performance for HR.4.30**

4. To grant temporary privileges for new applicants, the results of the NPDB query have been obtained and evaluated.

5. To grant temporary privileges for new applicants, the applicant has the following:
   - A complete application
   - No current or previously successful challenge to licensure or registration
   - Not been subject to involuntary termination of professional or medical staff membership at another organization, when applicable to the discipline
   - Not been subject to involuntary limitation, reduction, denial, or loss of privileges, when applicable to the discipline.

6. The administrator or designee grants temporary privileges for meeting important patient needs and for new applicants, upon recommendation of clinical leadership or the medical director.

Standard HR.4.50
Clinical privileges and appointments/reappointments are reviewed and revised at least every two years.

**Elements of Performance for HR.4.50**

4. The reappraisal addresses current competency and includes the following:
   - Confirmation of adherence to organization policies and procedures, rules, or regulations
   - Relevant information from organization performance improvement activities when evaluating professional performance, judgment, and clinical or technical skills
   - Any results of peer review of the individual’s clinical performance
   - Clinical performance in the organization that is outside acceptable standards
   - Relevant education, training, and experience, if changed since initial privileging and appointment
   - Verification of current licensure, including all actions against the license
   - A statement that the individual can perform the care, treatment, and services he or she has been providing
   - Evaluation of restrictions on privileges at a hospital(s) or other health care organization(s)
   - A query of the NPDB for information on adverse privilege actions taken by a health care entity, when appropriate to the discipline

**Behavioral Health Care**

Standard PC.13.20
Operative or other procedures and/or the administration of moderate or deep sedation or anesthesia are planned.

**Elements of Performance for PC.13.20**

1. Sufficient numbers of qualified staff (in addition to the LIP performing the procedure) are available, present to evaluate the client, perform assist with the procedure, provide the sedation and/or anesthesia, monitor, and recover the client.

2. Individuals administering moderate or deep sedation and anesthesia are qualified* and have the appropriate credentials to manage clients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

Standard PC.13.40
Clients are monitored immediately after the administration of moderate or deep sedation or anesthesia.

**Elements of Performance for PC.13.40**

5. Clients who have received sedation or anesthesia are discharged in the company of a responsible, designated adult.

Standard MM.2.10
Medications available for dispensing or administration are selected, listed, and procured based on criteria.

**Elements of Performance for MM.2.10**

3. A list of medications for dispensing or administration (including strength and dosage form) is maintained and readily available.

**Note:** Sample medications are not required to be on this list.

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* qualified: The individuals providing moderate or deep sedation and anesthesia have at a minimum had competency-based education, training, and experience in the following:

1. Evaluating patients before moderate or deep sedation and anesthesia
2. Performing the moderate or deep sedation and anesthesia, including rescuing patients who slip into a deeper-than-desired level of sedation or analgesia. This includes the following:
   - Moderate sedation—are qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation
   - Deep sedation—are qualified to rescue patients from general anesthesia and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.
Errata to Standards and Elements of Performance in 2004 Manuals (Continued)

Standard HR.4.10
There is a process for ensuring the competence of all practitioners permitted by law and the organization to practice independently.

Elements of Performance for HR.4.10
3. In addition to the above criteria, the organization collects and evaluates information on restriction of clinical responsibilities at other health care organizations, when appropriate.

Standard HR.4.30
The organization has a process for assigning temporary clinical responsibilities, when appropriate.

Elements of Performance for HR.4.30
4. To assign temporary clinical responsibilities for new physicians, the results of the NPDB query have been obtained and evaluated when appropriate to the discipline’s practice.
5. To assign temporary clinical responsibilities for new LIPs, the LIP has the following:
   - A complete application
   - No current or previously successful challenge to licensure or registration
   - Not been subject to involuntary termination of professional or medical staff membership at another organization, when applicable to the discipline
   - Not been subject to involuntary limitation, reduction, denial, or loss of clinical responsibilities, when applicable to the discipline.
6. The administrator or designee assigns temporary clinical responsibilities to meet important client needs and for new LIPs, upon recommendation of clinical leadership.

Standard HR.4.50
Clinical responsibilities are reviewed and revised at least every two years.

Elements of Performance for HR.4.50
8. The reappraisal addresses current competency and includes the following:
   - Confirmation of adherence to organization policies and procedures, rules, or regulations
   - Relevant information from organization performance improvement activities when evaluating professional performance, judgment, and clinical or technical skills
   - Any results of peer review of the person’s clinical performance
   - Clinical performance in the organization that is outside acceptable standards
   - Relevant education, training, and experience, if changed since initial responsibilities
   - Verification of current licensure, including all actions against the license
   - A statement that the person can perform the care, treatment, and services he or she has been providing
   - Evaluation of restrictions on clinical responsibilities or privileges at a hospital(s) or other health care organization(s)
   - For physicians, a query of the NPDB for information on adverse clinical responsibility or privilege actions taken by a behavioral health care entity.

Home Care
Standard MM.2.10
Medications available for dispensing or administration are selected, listed, and procured based on criteria.

Elements of Performance for MM.2.10
3. A list of medications for dispensing or administration (including strength and dosage form) is maintained and readily available.

Note: Sample medications are not required to be on this list.

Hospital
Standard PC.13.20
Operative or other procedures and/or the administration of moderate or deep sedation or anesthesia are planned.

Elements of Performance for PC.13.20
1. Sufficient numbers of qualified staff (in addition to the LIP performing the procedure) are available, present* to evaluate the patient, perform assist with the procedure, provide the sedation and/or anesthesia, monitor, and recover the patient.
2. Individuals administering moderate or deep sedation and anesthesia are qualified† and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

Standard MM.2.10
Medications available for dispensing or administration are selected, listed, and procured based on criteria.

Elements of Performance for MM.2.10
3. A list of medications for dispensing or administration (including strength and dosage form) is maintained and readily available.

Note: Sample medications are not required to be on this list.

Standard MM.3.20
Medication orders are written clearly and transcribed accurately.

Elements of Performance for MM.3.20
6. The hospital specifies the required elements of any of the following types of orders that it deems acceptable for use:
   - “As needed” (PRN) orders
   - Standing orders

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* For hospitals providing obstetric or emergency operative services, this means they can provide anesthesia services as required by law and regulation.
† qualified: The individuals providing moderate or deep sedation and anesthesia have at a minimum had competency-based education, training, and experience in the following:
1. Evaluating patients before moderate or deep sedation and anesthesia;
2. Performing the moderate or deep sedation and anesthesia, including rescuing patients who slip into a deeper-than-desired level of sedation or analgesia.
   This includes the following:
   a. Moderate sedation— are qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation.
   b. Deep sedation— are qualified to rescue patients from general anesthesia and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.
Corrections to 2004 Standards and EPs (continued)

(Continued from page 9)

Hold orders
Automatic stop orders
Resume orders‡
Titrating orders—orders in which the dose is either progressively increased or decreased in response to the patient’s status
Taper orders—orders in which the dose is decreased by a particular amount with each dosing interval
Range orders—orders in which the does or dosing interval varies over a prescribed range, depending on the situation or the patient’s status
Order for compounded drugs or drug mixtures not commercially available
Orders for medication-related devices (for example, nebulizers and catheters)
Orders for investigational medications
Orders for herbal products
Orders for medications at discharge

Laboratory and Point-of-Care Testing

Standard LD.3.10
The leaders engage in both short-term and long-term planning.

Elements of Performance for LD.3.10
26. Planning for care, treatment, and services addresses the following:
   • The needs and expectations of patients and, as appropriate, families and referral sources
   • Staff needs
   • The scope of care, treatment, and services needed by patients at all of the organization’s locations
   • Resources (financial and human) for providing care and support services
   • Recruitment, retention, development, and continuing education needs of all staff
   • Data for measuring the performance of processes and outcomes of care

Standard LD.3.20
Patients with comparable needs receive the same standard of care, treatment, and services throughout the organization.

Elements of Performance for LD.3.20
3. Planning for care, treatment, and services addresses the following:
   • The needs and expectations of patients and, as appropriate, families and referral sources
   • Staff needs
   • The scope of care, treatment, and services needed by patients at all of the organization’s locations

‡ Note: See EP 10.9 —A blanket reinstatement of previous orders for medication is not acceptable.

• Resources (financial and human) for providing care and support services
• Recruitment, retention, development, and continuing education needs of all staff
• Data for measuring the performance of processes and outcomes of care

Long Term Care

Standard PC.2.120
The organization defines in writing the time frame(s) for conducting the initial assessment(s).

Elements of Performance for PC.2.120
9. For subacute services, the organization initiates assessments within 24 hours before admission and completes them within 48 hours after admission for all disciplines pertinent to the reason for admission.

Standard PC.13.20
Operative or other procedures and/or the administration of moderate or deep sedation or anesthesia are planned.

Elements of Performance for PC.13.20
2. Individuals administering moderate or deep sedation and anesthesia are qualified* and have the appropriate credentials to manage residents at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

Standard PC.13.40
Residents are monitored immediately after the procedure and/or administration of moderate or deep sedation or anesthesia.

Elements of Performance for PC.13.40
5. Residents who have received sedation or anesthesia are discharged in the company of a responsible, designated adult.

Standard MM.2.10
Medications available for dispensing or administration are selected, listed, and procured based on criteria.

Elements of Performance for MM.2.10
3. A list of medications for dispensing or administration (including strength and dosage form) is maintained and readily available.

Note: Sample medications are not required to be on this list.

* qualified The individuals providing moderate or deep sedation and anesthesia have at a minimum had competency-based education, training, and experience in the following:
1. Evaluating patients before moderate or deep sedation and anesthesia.
2. Performing the moderate or deep sedation and anesthesia, including resusciting patients who slip into a deeper-than-desired level of sedation or analgesia.
   This includes the following:
   a. Moderate sedation—are qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation.
   b. Deep sedation—are qualified to rescue patients from general anesthesia and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.
Errata to Standards and Elements of Performance in 2004 Manuals (Continued)

Standard HR.4.10
There is a process for ensuring the competence of all practitioners permitted by law and the organization to practice independently.

Elements of Performance for HR.4.10
12. In addition to the above criteria, the organization collects and verifies information on restriction of privileges at other health care organizations.

21. The governing body does the following:
   - Reviews recommendations made by the medical director
   - Reviews documentation on which recommendations are based
   - Reviews records of any hearings or appeals addressing adverse decisions
   - Grants appropriate clinical privileges

15. The LIP is notified in writing of the governing body’s decision.

Standard HR.4.20
Individuals permitted by law and the organization to practice independently are granted clinical privileges.

Elements of Performance for HR.4.20
2. The governing body does the following:
   - Reviews recommendations made by the medical director
   - Reviews documentation on which recommendations are based
   - Reviews records of any hearings or appeals addressing adverse decisions
   - Grants appropriate clinical privileges

8. The applicant is informed in writing of the governing body’s decision.

Standard HR.4.30
The organization has a process for granting temporary clinical privileges, when appropriate.

Elements of Performance for HR.4.30
4. To grant temporary privileges for new applicants, the results of the NPDB query have been obtained and evaluated.

5. To grant temporary privileges for new applicants, the applicant has the following:
   - A complete application
   - No current or previously successful challenge to licensure or registration
   - Not been subject to involuntary termination of professional or medical staff membership at another organization, when applicable to the discipline
   - Not been subject to involuntary limitation, reduction, denial, or loss of privileges, when applicable to the discipline.

6. The administrator or designee grants temporary privileges for meeting important resident needs and for new applicants, upon recommendation of clinical leadership or the medical director.

Standard HR.4.50
Clinical privileges and appointments/reappointments are reviewed and revised at least every two years.

Elements of Performance for HR.4.50
4. The reappraisal addresses current competency and includes the following:
   - Confirmation of adherence to organization policies and procedures, rules, or regulations
   - Relevant information from organization performance improvement activities when evaluating professional performance, judgment, and clinical or technical skills
   - Any results of peer review of the individual’s clinical performance
   - Clinical performance in the organization that is outside acceptable standards
   - Relevant education, training, and experience, if changed since initial privileging and appointment
   - Verification of current licensure, including all actions against the license
   - A statement that the individual can perform the care, treatment, and services he or she has been providing
   - Evaluation of restrictions on privileges at a hospital(s) or other health care organization(s)
   - A query of the NPDB for information on adverse privilege actions taken by a health care entity, when appropriate to the discipline

Medicare/Medicaid Certification Based LTC Accreditation Standards
Standard PI.3.20 was inadvertently omitted from the Medicare/Medicaid Certification Based LTC Accreditation Standards in the back of the 2004 CAMLTC. This standard and its intent will be reinstated and surveyed in 2004.

Standard PI.3.20
An ongoing, proactive program for identifying and reducing unanticipated adverse events and safety risks to residents is defined and implemented.

Rationale for PI.3.20
Organizations should proactively seek to identify and reduce risks to the safety of residents. Such initiatives have the obvious advantage of preventing adverse events rather than simply reacting when they occur. This approach also avoids the barriers to understanding created by hindsight bias and the fear of disclosure, embarrassment, blame, and punishment that can happen after an event.

Elements of Performance for PI.3.20
The following proactive activities to reduce risks to residents are conducted:

1. Selecting a high-risk process to be analyzed (at least one high-risk process is chosen annually—the choice should be based in part on information published periodically by the Joint Commission about the most frequent sentinel events and risks)

(Continued on page 12)
Errata to Standards and Elements of Performance in 2004 Manuals (Continued)

2. Describing the chosen process (for example, through the use of a flowchart)
3. Identifying the ways in which the process could break down* or fail to perform its desired function
4. Identifying the possible effects that a breakdown or failure of the process could have on residents and the seriousness of the possible effects

* The ways in which processes could break down or fail to perform its desired function are many times referred to as "the failure modes".

5. Prioritizing the potential process breakdowns or failures
6. Determining why the prioritized breakdowns or failures could occur, which may include performing a hypothetical root cause analysis
7. Redesigning the process and/or underlying systems to minimize the risk of the effects on residents
8. Testing and implementing the redesigned process
9. Monitoring the effectiveness of the redesigned process

Joint Commission Examines Organ Donation (continued)

(Continued from page 2)

comments Mowll. “As with the previous roundtable, this meeting looked at the issue from multiple perspectives including that of hospitals, OPOs, and the Joint Commission itself.”

What the Future Holds

In early 2004 the Joint Commission is planning a symposium open to all to illuminate and provide possible solutions to the challenges surrounding organ donation. JCAHO will then host a national conference on organ donation scheduled for March 10–12, 2004, in Washington, DC. “From all this input, JCAHO will create a white paper that summarizes the challenges to increasing organ donation, outlines possible solutions, and recommends actions that will help organizations improve organ donation consent and conversion rates,” states Mowll.

As the gap between available organs and those in need of them progressively widens, the Joint Commission is supporting multiple efforts to examine the issues surrounding organ donation and is working to develop objectives and recommended actions that will ultimately help the nation’s hospitals more efficiently identify and transplant available organs.

Correction to Staffing Effectiveness Reference for Assisted Living

The June 2003 issue of Perspectives, page 11, included revisions and additions to staffing effectiveness standards for assisted living and long term care. Standard HR.2.1 from this material, #9 of the intent, included a cross-reference to performance improvement standards. The standard numbers given for assisted living were incorrectly stated as PI.1.10 and PE.2.20. The correct cross-references for assisted living are PI.1 and PI.2.
2004 Changes for Assisted Living, Critical Access Hospitals, Health Care Networks, Office-Based Surgery, and Preferred Provider Organizations

As a result of Shared Visions–New Pathways, changes have been made to the assisted living, critical access hospital, health care network, office-based surgery, and preferred provider organization (PPO) accreditation programs. The changes are summarized below.

National Patient Safety Goals

Assisted living organizations, critical access hospitals, health care networks, office-based surgery organizations, and PPOs will be expected to comply with JCAHO's 2004 National Patient Safety Goals, as applicable to the services and care they provide or provide for.

Because of the administrative structure of accredited networks and PPOs, a variation for implementing the goals has been approved. Networks are required to (1) inform their components and practitioner sites about the goals and (2) encourage component and practitioner site achievement of the applicable goals through either implementation of the requirements published under each goal or acceptable alternatives to the requirements. For any accredited component of an accredited network, implementation of the relevant goals and requirements will continue to be surveyed as part of that component's accreditation.

Please refer to the September 2003 issue of Perspectives for the complete list of the goals and their requirements for 2004.

New Accreditation Decision Process and Decision Rules for 2004

A new accreditation decision process and new decision rules for each program become effective January 1, 2004. A description of the new process and the decision rules for each program are accessible at http://www.jcaho.org by selecting Accredited Organizations, then the name of the accreditation program of interest (PPOs are accessible under Health Care Networks), and then the 2004 Decision Process and Decision Rules under the “What’s New” heading.

Requirements Eliminated for Health Care Networks

As a result of the elimination of the on-site survey of unaccredited components and practitioner sites, some intent statements are being eliminated from survey effective January 1, 2004. Please note that although the standard will be surveyed, only the specific intent statement that would have been evaluated by direct survey of the component or practitioner site has been eliminated. Components and practitioner sites must still meet these expectations; however, the on-site survey will focus on the network's oversight and validation of components’ and practitioner sites’ performance in meeting these expectations. The list of deleted requirements is accessible at http://www.jcaho.org by selecting Accredited Organizations, then selecting Health Care Networks, and then selecting Deleted Network Requirements for 2004 under the “What’s New” heading.

Reformatted Standards for 2005

Standards for each of these programs will be revised and reformatted in 2004 for implementation in 2005 to ensure and enhance the relevance of the standards to critical patient safety and health care quality issues, to reduce the duplication of standards requirements, and to improve their clarity. The standards will be displayed in a new format, which includes standards, rationales, and elements of performance (described below.) Draft versions of the reformatted standards will be presented to appropriate approval committees for feedback in early 2004.

Standard A statement that defines the performance expectations and/or structures or processes that must be in place in order for an organization to provide safe, high-quality care, treatment, and services. An organization is either “compliant” or “not compliant” with a standard. Accreditation decisions are based on simple counts of the standards scored “not compliant.”

Rationale A statement that provides background, justification, or additional information about a standard. A standard’s rationale is not scored. In some instances, the rationale for a standard is self-evident. Therefore, not every standard has a written rationale.

Elements of performance (EPs) The specific performance expectations and/or structures or processes that must be in place in order for an organization to provide safe, high-quality care, treatment, and services. The scoring of EP compliance determines an organization’s overall compliance with a standard. EPs are evaluated on the following scale:

- 0 Insufficient compliance
- 1 Partial compliance
- 2 Satisfactory compliance
- NA Not applicable

New editions of the assisted living, critical access hospital, health care network/integrated delivery system/managed care organization, office-based surgery, and PPO manuals will be available in fall 2004.
National Patient Safety Goal on Abbreviations Clarified, Implementation Revised

Changes in Survey and Scoring Effective Immediately

To help improve communication through standardizing terminology and address the barriers to absolute compliance in a short period of time, JCAHO has clarified its 2004 National Patient Safety Goal on the use of dangerous abbreviations, acronyms, and symbols and revised the requirements for being compliant with this goal requirement.

Goal 2b of the 2004 National Patient Safety Goals, which is carried over from the 2003 goals, requires organizations to improve the effectiveness of communication among caregivers by standardizing the abbreviations, acronyms, and symbols used throughout the organization, including having a list of abbreviations, acronyms, and symbols not to use.

Feedback from accredited organizations and surveyors supports the intent of the goal and the objective of 100% compliance but cites the difficulty of behavioral change among clinicians who have routinely used these abbreviations throughout their careers. Moreover, organizations cited the difficulty in applying this goal to print and electronic documentation. Finally, the scope of the lists of prohibited terms among health care organizations was inconsistent, varying from “lists” of only one term to much more extensive lists than needed.

Compliance

Effective immediately for all accreditation programs, JCAHO has revised the survey and scoring of compliance for this goal and, for implementation in 2004, clarified what is needed in the way of a list of abbreviations not to use. This approach is as follows:

- The objective of 100% compliance with a reasonably comprehensive list of prohibited dangerous abbreviations, acronyms, and symbols is retained.
- If a surveyor finds that an organization has not yet achieved 100% compliance with this requirement, as evidenced by a review of open medical records during survey, the organization will be considered in compliance if all of the following conditions are met:
  - Use of any item on the prohibited list is found in less than 10% of the instances in which the abbreviation, acronym, or symbol might have been used; and
  - Whenever any prohibited term has been used in an order, there is written evidence of confirmation of the clinician’s intent before the order is carried out; and
  - The organization has implemented a plan for continued improvement to achieve 100% compliance with this requirement by the end of 2004.

- Surveying and scoring of this goal in the remainder of 2003 and 2004 will be limited to only handwritten documentation to address concerns of the cost and time factors associated with changing large stocks of preprinted forms and reprogramming software.

JCAHO List of Prohibited Terms

To address confusion in the field about what is an acceptable list of terms not to use, JCAHO has identified that an organization’s list should include, at a minimum, a nine-item set of JCAHO–specified dangerous abbreviations, acronyms, and symbols. This list is provided in the box on page 15 along with a summary of the potential problems associated with their use and suggestions for preferred terms to use. Organizations in all accreditation programs must implement this list beginning January 1, 2004.

In addition, organizations in all programs are expected to select at least three additional prohibited abbreviations, acronyms, or symbols not to be used in their organization by April 1, 2004.

Questions about National Patient Safety Goal 2b should be directed to Rick Croteau, M.D., JCAHO’s executive director of strategic initiatives at rcrroteau@jcaho.org. ▲

(Continued on page 15)
National Patient Safety Goal Clarified, Revised (continued)

(Continued from page 14)

OFFICIAL PUBLICATION OF NATIONAL PATIENT SAFETY GOAL INFORMATION

JCAHO List of Dangerous Abbreviations, Acronyms, or Symbols Not to Be Used (effective January 1, 2004)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. U (for unit)</td>
<td>Mistaken as zero, four or cc</td>
<td>Write &quot;unit&quot;</td>
</tr>
<tr>
<td>2. IU (for International unit)</td>
<td>Mistaken as IV (intravenous) or 10 (ten)</td>
<td>Write &quot;International unit&quot;</td>
</tr>
<tr>
<td>3. Q.D.</td>
<td>Mistaken for each other</td>
<td>Write &quot;daily&quot; and &quot;every other day&quot;</td>
</tr>
<tr>
<td>4. Q.O.D. (Latin abbreviations</td>
<td>The period after the Q can be mistaken for an &quot;I&quot; and the &quot;O&quot; can be mistaken for a &quot;I&quot;</td>
<td>Write &quot;daily&quot; and &quot;every other day&quot;</td>
</tr>
<tr>
<td>for once daily and every other day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Trailing Zero (X.0 mg)</td>
<td>Decimal point is missed</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)</td>
</tr>
<tr>
<td>6. Lack of Leading Zero (.X mg)</td>
<td>Confused for one another</td>
<td>Write &quot;morphine sulfate&quot; or &quot;magnesium sulfate&quot;</td>
</tr>
<tr>
<td>7. MS</td>
<td>Confused for one another</td>
<td>Write &quot;morphine sulfate&quot; or &quot;magnesium sulfate&quot;</td>
</tr>
<tr>
<td>8. MSO₄</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td></td>
</tr>
<tr>
<td>9. MgSO₄</td>
<td></td>
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</tr>
</tbody>
</table>

JCAHO Requirements Page Tracks Manual Changes

If you’re looking for another way to track changes that have been made to your accreditation manual since it last published, visit the JCAHO Requirements page of the Perspectives homepage. Every change or addition to standards, Accreditation Participation Requirements, and policies that appears in Perspectives is also posted to this section of the homepage.

Material is organized by accreditation program and manual, with a different section for each program. Within each program, changes are broken out by chapters within the accreditation manual. A brief summary of the change is given, with a reference back to the Perspectives article in which it appeared. Subscribers to the online version of Perspectives can click on the section and go directly to the complete revised or additional information.

Material is posted on JCAHO Requirements until the change is published in the next iteration of the accreditation manual. To visit this page, go to http://www.jcrinc.com/subscribers/printview.asp?durki=2815. ▲
The Joint Commission and Joint Commission Resources wish you a very happy holiday season.