UPDATE: The Joint Commission’s Hospital Deeming Authority Application

On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 became law, requiring all accrediting bodies, including The Joint Commission, to complete a formal application process to receive hospital deeming authority from the Centers for Medicare & Medicaid Services (CMS). This article provides an update on the progress of The Joint Commission’s application process for hospital deeming authority, as well as information on its impact on Joint Commission-accredited hospitals.

Previously, The Joint Commission derived its unique statutory hospital deeming authority directly from the 1965 Medicare statute. All other hospital accrediting bodies, as well as The Joint Commission’s non-hospital deemed programs, required application for deeming authority to CMS.

The Joint Commission’s current deeming authority for hospitals remains unaffected until July 15, 2010. Additionally, any hospital accreditation and corresponding Medicare deemed status granted prior to this date will remain in effect for the full term of that hospital’s accreditation. (For instance, a hospital receiving Joint Commission accreditation in May 2010 will continue to have deemed status for the duration of its three-year accreditation period, ending May 2013, subject to current Joint Commission policies and procedures.)

On August 1, 2008, The Joint Commission’s Board of Commissioners unanimously approved a resolution for The Joint Commission to apply to CMS to continue its hospital deeming authority. The Joint Commission fully expects to maintain deeming authority without interruption to its accredited hospitals, and will continue as the nation’s leading hospital accrediting body.

Continued on page 4
IN DEVELOPMENT AT JCI

- Revisions to international ambulatory care standards
- Revisions to international disease-specific care certification standards
- Revisions to international laboratory standards

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At its October 2008 meeting, The Joint Commission’s Accreditation Committee approved the remaining component for the 2009 accreditation decision methodology, effective January 1, 2009. This component includes elimination of the use of “thresholds” as determinants of Conditional Accreditation (CA) and Preliminary Denial of Accreditation (PDA). Details follow.

As part of its Standards Improvement Initiative, The Joint Commission is implementing its revised accreditation decision methodology for all surveys beginning in January 2009. The final component of the revised methodology for consideration was whether “thresholds” (that is, a set number of not-compliant Direct Impact standards) should be established for triggering an organization to be placed in CA or PDA.

**Thresholds to Serve as “Screens”**

Consequently, at its October 2008 meeting, the Accreditation Committee approved that program-specific thresholds should serve only as “screens” for identifying organizations whose survey findings should be subject to a more intensive review by Joint Commission Central Office staff (such as the Standards Interpretation Group [SIG] and Senior Management in the Division of Accreditation and Certification Operations), rather than serve as “automatic” determinants of CA and PDA decisions. This review would be in addition to the review conducted for organizations that meet a Situational Decision Rule for an adverse accreditation decision or for which an Immediate Threat to Life has been declared.

The screens for the Central Office review, based on the number of not-compliant Direct Impact standards, adjust for differences in size and complexity of surveyed organizations (“bands”). These bands are based on statistically significant differences in the number of Requirements for Improvement (RFIs) associated with various survey lengths (surveyor days). See Table 1 on page 4 for information on surveyor days associated with program-specific bands. The screens for Central Office review have been adjusted to a minimum of five not-compliant Direct Impact standards identified at their organization versus the average number identified within their peer group. The screens are presented in Table 2 on page 4.

**Focus of Central Office Review**

The internal review of survey findings will focus on identifying and resolving instances in which pre-established “situational” rules for CA or PDA were actually met but not recognized at the time of survey.

This revised process will also evaluate the magnitude and nature of the survey findings to determine if “systemic” problems exist across the organization (that is, similar issues identified across multiple departments or key systems), or if the findings would result in a “Condition” level deficiency in programs for which The Joint Commission has been granted deeming authority by the Centers for Medicare & Medicaid Services (CMS). Organizations will still be held accountable for addressing any RFIs found.

The Central Office review would result in one of the following three outcomes:

1. Identification of RFIs to be addressed via the submission of Evidence of Standards Compliance (ESC).
2. Recommendation for CA. The magnitude and nature of the survey findings warrant the more intensive follow-up that is associated with the CA process, including a focused follow-up survey. A recommendation for CA, as an exception to pre-established rules, would be made to the Accreditation Committee.
3. Recommendation for PDA. Immediate Threat to Life exists within the organization or a Situational Decision Rule was met as evidenced by the survey findings, but the threat or need to apply the decision rule was not identified by the survey team at the time of the survey.

**Next Steps**

The revised process and results from 2009 surveys will be closely monitored by The Joint Commission. Depending on the results, thresholds for determinants of CA and PDA decisions may be established for 2010.

Continued on page 4
### Tables 1 and 2

#### Table 1. Surveyor Days Associated with Program-Specific “Bands”

<table>
<thead>
<tr>
<th>Surveyor Days–Band</th>
<th>AHC</th>
<th>BHC</th>
<th>CAH</th>
<th>HAP</th>
<th>LAB</th>
<th>LT2</th>
<th>LTC</th>
<th>OBS</th>
<th>OME</th>
<th>DSC</th>
<th>HCSS</th>
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<tbody>
<tr>
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<td>1–4</td>
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<td>≥ 3</td>
<td>5–6</td>
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#### Table 2. 2009 Program-Specific “Screens” for Central Office Review (Number of Not-Compliant Direct Impact Standards)

<table>
<thead>
<tr>
<th>RFIs–Band</th>
<th>AHC</th>
<th>BHC</th>
<th>CAH</th>
<th>HAP</th>
<th>LAB</th>
<th>LT2</th>
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<td>13</td>
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</tbody>
</table>

**Key:** AHC, ambulatory care; BHC, behavioral health care; CAH, critical access hospital; HAP, hospital; LAB, laboratory; LT2, Medicare/Medicaid certification-based long term care; LTC, long term care; OBS, office-based surgery; OME, home care; DSC, disease-specific care; HCSS, health care staffing services.

### Update: The Joint Commission’s Hospital Deeming Authority Application (continued)

Continued from page 1

Currently, The Joint Commission is working closely with CMS to understand its expectations, time frames, and process for accepting a hospital deeming authority application, and to ensure a seamless transition under the new law. The Joint Commission has learned that CMS will conduct a traditional deeming application review, during which issues will be identified and resolved. The review will include an assessment of a crosswalk between the Medicare hospital Conditions of Participation (CoPs) and The Joint Commission’s hospital standards, and will also include an evaluation of The Joint Commission’s survey process and surveyor training programs, among other things.

The Joint Commission is on target to submit its hospital deeming application by early next year and will receive a decision from CMS for continuation of its Medicare recognition by the end of the year.

Stay tuned to future issues of The Joint Commission Perspectives® for updated information on the status of The Joint Commission’s hospital deeming authority application and any forthcoming changes that may be implemented due to this process.
Joint Commission Resources Launches 2009 Manual E-ditions

As part of The Joint Commission’s Standards Improvement Initiative (SII), Joint Commission Resources is pleased to announce the launch of its new E-dition product. For the first time, electronic versions (E-ditions) of The Joint Commission’s comprehensive manuals are available for all Joint Commission accreditation programs.

Effective November 2008, in addition to the customary complimentary copy of the comprehensive print manual, Joint Commission–accredited organizations receive one free single user license to the E-dition for each of their accredited programs. Each single user license allows one simultaneous user per program to access the E-dition content. (In other words, one person can access a program in E-dition at a time, much like one person at a time uses a printed book.) There are several ways to access E-dition, including a link from an organization’s secure Joint Commission Connect™ extranet site. Joint Commission–accredited customers (primary accreditation contacts and Periodic Performance Review contacts) were notified of when and how to access their free E-dition via an e-mail from Joint Commission Resources during the second half of November 2008.

The new E-dition provides organizations with a Web-based, fully searchable version of The Joint Commission’s comprehensive accreditation manuals. E-dition is also an online companion to learning about the improvements made to Joint Commission requirements through SII.

Features of E-dition include the following:

● **Three-click access to most standards:** With only two clicks, the E-dition displays the standards within a chapter for a selected accreditation program. Once you have chosen a standard to access, the third click shows the full description of the standard, including the rationale, elements of performance (EPs), and scoring criteria.

● **History tracking:** Easy navigation to history tracking report information. While viewing an EP, a single click will show you a side-by-side display of how that EP changed from 2008 to 2009. This helpful tool will ease the transition to the reorganized and renumbered standards from SII.*

● **Full text searching:** Keyword search capability across one or more manuals. For instance, if a topic of interest is entered, the E-dition displays standards in order of relevance. Searches can span across Joint Commission standards, EPs, rationales, introductions, National Patient Safety Goals, and related accreditation process information.

● **Service profiles and filtering:** Based on the services your organization provides, not all EPs may apply to your setting. The new E-dition allows your staff to focus on the EPs relevant to your organization by setting a Service Profile to filter and display only the standards applicable to your particular health care service (for example, only requirements that apply to an ambulatory care diagnostic imaging center).*

Additional access to E-dition can be purchased by upgrading to a site license or by purchasing additional single-user licenses. A site license allows an unlimited number of users from a single site to access the E-dition content at the same time. Each accreditation program is available through a separate license.

E-dition is available as a stand-alone product or with an upgrade that includes the self-assessment features of Accreditation Manager Plus (AMP). AMP is scheduled for release in December 2008.

For more information about E-dition and AMP, including pricing, please visit the Joint Commission Resources Web site at [http://www.jcrinc.com/e-dition](http://www.jcrinc.com/e-dition).

* Note: For Phase 2 programs (behavioral health care, laboratory, and long term care), these features will be available in the 2010 E-ditions.
At its October 2008 meeting, The Joint Commission’s Accreditation Committee approved a Joint Commission policy that laboratory accreditation decisions will no longer directly affect hospital accreditation decisions, effective January 1, 2009.

This new policy establishes comparability in the way that a laboratory with an adverse decision—whether that decision is rendered by The Joint Commission or one of its Cooperative Partners (College of American Pathologists [CAP] or COLA)—affects the hospital or other organization with which the laboratory is affiliated. Currently, a laboratory’s accreditation decision has a direct impact on the accreditation status of its affiliated organization.

Under the new policy, the laboratory and overall organization’s accreditation will continue to be linked due to the essential nature of laboratory services, but any adverse laboratory accreditation decision will not have an immediate impact on the overall organization’s accreditation decision.

Any adverse laboratory accreditation decision, whether due to survey by The Joint Commission, CAP, or COLA, will help prioritize the hospital’s or other organization’s next unannounced survey. Information from the laboratory’s survey will be included in the Priority Focus Process (PFP) along with other data to prioritize and customize the hospital’s or other organization’s next survey, which, as a result, could occur earlier in the organization’s 18–39 month survey window.

“The new approach meets the needs of Joint Commission customers and reinforces the importance of the laboratory in the delivery of patient care,” says Ann Scott Blouin, Ph.D., R.N., executive vice president, Accreditation and Certification Operations, The Joint Commission.

Additional changes to requirements for critical access hospitals with distinct part units were accepted by The Joint Commission’s Board of Commissioners in November 2008. These changes specifically relate to restraint and seclusion, and are effective January 1, 2009. These requirements are in alignment with the Centers for Medicare & Medicaid Services’ (CMS) hospital Conditions of Participation requirements for distinct part units.

These changes are located on The Joint Commission Web site at http://www.jointcommission.org and can be viewed in their entirety by selecting the “Accreditation Program” tab and then the “Critical Access Hospital” option. The direct link to these changes is as follows: http://www.jointcommission.org/AccreditationPrograms/CriticalAccessHospitals/.

All of these changes apply to rehabilitation and psychiatric distinct part units in critical access hospitals that use their Joint Commission accreditation for deemed status.
LETTER FROM DR. CHASSIN: The Use of Standing Orders in Hospitals

The following letter was sent to all Joint Commission–accredited hospitals on October 29, 2008.

October 29, 2008

Dear Hospital Colleague:

I am very pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) issued a memorandum on October 24 that clarifies the use of standing orders in hospitals. This clarification was sought by The Joint Commission and brings CMS’ interpretation of standing orders into alignment with The Joint Commission’s view on how to facilitate the timely treatment of certain patients, particularly those who need medications, not previously ordered, to be administered within brief timeframes. The Joint Commission identified the issue through concerns raised by the field and brought it to the attention of CMS. The Joint Commission has been working with CMS on this issue for some time, advocating on behalf of Joint Commission accredited hospitals. Subsequently, other organizations and hospitals voiced support for this CMS change.

The new memorandum clarifies an earlier CMS memo issued in February 2008, and removes a requirement to obtain patient-specific practitioner approval for standing orders that meet the CMS’ criteria prior to treatment. With this new memo, timely treatment can be provided to patients and the order can be signed by the physician at a later time. The Joint Commission believes this approach provides the safest, most expeditious way to provide timely care and treatment to patients. CMS’ previous interpretation of its Conditions of Participation on this issue raised serious questions about whether common safety practices in the care of newborns, patients with asthma and other acute conditions, and deteriorating patients would be permitted to continue.

The clarification in the Survey and Certification Group memo states: The use of standing orders must be documented as an order in the patient’s medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.

In the memo, CMS notes its intention to work with the professional community to develop an understanding of best practices and definitions for standing orders, pre-printed order sets, and effective methods to promote evidence-based medicine. The Joint Commission will continue to work with CMS and other stakeholders on these issues.

The CMS memorandum can be found at http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/. Please direct any questions to The Joint Commission’s Standards Interpretation Group at (630) 792-5900 or via the online submission form at http://www.jointcommission.org/Standards/OnlineQuestionForm/.

Sincerely yours,

Mark R. Chassin, M.D., M.P.P., M.P.H.
President

www.jointcommission.org
LETTER FROM DR. CHASSIN: Deeming Authority for Critical Access Hospitals

The following letter was sent to all Joint Commission–accredited critical access hospitals on October 24, 2008.

October 24, 2008

Dear Critical Access Hospital Colleague:

We are pleased to inform you that the Department of Health and Human Services’ Centers for Medicare & Medicaid Services (CMS) has again granted The Joint Commission deeming authority for Critical Access Hospitals.

The Joint Commission recognizes that Critical Access Hospitals are an important safety net, providing Medicare beneficiaries living in rural areas with the care that they need. We are proud to provide quality oversight for Critical Access Hospitals by collaborating with CMS.

CMS found that The Joint Commission’s quality and safety standards for critical access hospitals meet or exceed those established by the Medicare and Medicaid program. CMS’ notice of approval for Joint Commission deeming authority for Critical Access Hospitals is effective November 21, 2008 through November 21, 2011. CMS will evaluate, within 180 days, the changes The Joint Commission agreed to make on behalf of CMS. This probationary period allows time for CMS and The Joint Commission to work together to ensure that accreditation standards and Medicare Conditions of Participation related to distinct part units for rehabilitation and psychiatric services are compatible.

We appreciate your continuing commitment to accreditation and I welcome any suggestions about how The Joint Commission can strengthen its accreditation process. My e-mail address is mchassin@jointcommission.org.

Sincerely yours,

Mark R. Chassin, M.D., M.P.P., M.P.H.
President

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One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630-792-5000 Voice


Data collection and reporting of these measures are required for certification of primary stroke centers under the disease-specific care program. This latest version of the Guide contains modifications to the stroke measure set from feedback received from primary stroke centers and other stakeholders over the past year.

Key modifications include the following:
- Expansion of the data element definition for Admitted for Elective Carotid Endarterectomy. The revised definition, Elective Carotid Intervention, details exclusions for percutaneous insertion of carotid artery stents and other elective procedures involving the carotid artery.
- “Stroke-5: Antithrombotic Therapy by End of Hospital Day Two” was modified, and a new decision point was added to the measure calculation to exclude patients who received recent intravenous or intra-arterial thrombolytic therapy.
- Significant revisions were made to “Stroke-6: Discharged on Cholesterol Reducing Medications,” as follows:
  - This measure is now titled “Stroke-6: Discharged on Statin Medication,” and detailed specifications can be found in the Guide Version 2.a.
  - To ensure adequate time for certified primary stroke centers to incorporate these changes into their data collection and reporting processes, these modifications to Stroke-6 are not effective until fourth quarter 2009. Data collection per the current Stroke-6 measure specifications should be continued without interruption until that time.

A complete list of measure modifications is available in Release Notes, Version 1.1, which can be accessed by clicking on “Release Notes 1.1” at the bottom of the following page: http://www.jointcommission.org/CertificationPrograms/PrimaryStrokeCenters/stroke_pm_edition_2_ver_2a.htm.

All measure revisions in the Guide Version 2.a will become effective with discharges occurring on or after January 1, 2009, with the exception of the aforementioned modifications to Stroke-6. Stroke-6 revisions will become effective for discharges occurring in the fourth quarter 2009.

For more information about the stroke measures, visit The Primary Stroke Center Certification section of The Joint Commission’s Web site or e-mail your questions to DSC_Stroke@jointcommission.org. See page 9 of the October 2008 issue of The Joint Commission Perspectives® for information on National Quality Forum endorsement of eight of the stroke measures.
At its October 2008 meeting, The Joint Commission’s Accreditation Committee approved elimination of the one-year follow-up survey for organizations new* to the accreditation/certification process that provide high risk/critical services.

With the introduction of unannounced surveys being conducted within 18–39 months after the organization’s previous full survey, continuing the one-year follow-up survey could result in multiple surveys within a short period of time. Elimination of the one-year follow-up survey alleviates this concern.

All organizations new to the accreditation/certification process that provide high risk/critical services that were surveyed beginning in July 2007 will be subject to this policy change.

For a list of high risk/critical services by program, see the January 2008 issue of The Joint Commission Perspectives®, pages 4–5.

* Defined as an organization that has either never been surveyed/reviewed by The Joint Commission or has not been accredited/certified by The Joint Commission for at least four months.

The Joint Commission’s Accreditation Committee has approved not factoring Requirements for Improvement (RFIs) that were previously scored as supplemental findings into the current threshold for critical access hospital surveys conducted between October 1, 2008, and December 31, 2008.

Due to the change effective October 1, 2008, eliminating supplemental findings as part of The Joint Commission’s Centers for Medicare & Medicaid (CMS) deemed status application for the critical access hospital program, all survey findings now become an RFI. As a result, The Joint Commission has determined that findings that would have been a supplemental finding prior to October 1 will not be counted towards the threshold for a Preliminary Denial of Accreditation (PDA) or a Conditional Accreditation (CA) decision for critical access hospital surveys between October 1 and December 31, 2008.

This article serves as a reminder to health care staffing firms to please refer to the November 2008 issue of The Joint Commission Perspectives® (pages 4–7) for the complete 2009 Certification Participation Requirements (CPRs) for health care staffing services certification, effective January 1, 2009.

The CPRs published in the 2009 Health Care Staffing Services (HCSS) Certification Manual and October 2008 Update (pages CPR-1–CPR-8) are incorrect. The CPRs in the 2009 Manual and Update were printed prior to approval of the revised 2009 CPRs by The Joint Commission’s Accreditation Committee.

Pain is one the main reasons that Americans seek medical treatment, and untreated pain can have serious effects such as slowed recovery times, poor quality of life, and higher health care costs.

“Effective pain management is a crucial component of good health care, and treating pain is the responsibility of all caregivers,” says Mark R. Chassin, M.D., M.P.P., M.P.H., president, The Joint Commission. “The Joint Commission encourages patients to ask the right questions so that they can find relief.”

The Joint Commission has made pain assessment and management a priority in its national standards and accreditation process since 2000. This new education campaign is part of The Joint Commission's award-winning national Speak Up program that helps patients become more informed and involved in their health care.

“What You Should Know about Pain Management” (brochure pictured at left) identifies answers that will help patients find out more about pain treatments that can be used for pain caused by injury, illness, or surgery. Topics addressed include the following:

- Talking about and describing pain
- Understanding pain treatments
- Managing pain
- Questions to ask caregivers

The brochure encourages patients to ask their caregivers specific questions about pain medication—including doses and times that medication should be taken, side effects, how long the medication will take to work, and what to do if the medication does not work.

Speak Up brochures are available on understanding caregivers, understanding medical tests, recovering after leaving the hospital, preventing medication mistakes, preventing infections, preparing to become a living organ donor, avoiding wrong-site surgery, and preventing other errors in care. The brochures are also available in Spanish.

To order Speak Up materials, call 1-877-223-6866, or visit the Joint Commission Resources Web Store at http://www.jcrinc.com.

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**UPDATE: 2009 Universal Protocol FAQs Now Available Online**

The Joint Commission's Web site has been updated to include answers to Frequently Asked Questions (FAQs) and clarifying information on the revised Universal Protocol, effective January 1, 2009.

To access a PDF of the new FAQ document, please visit http://www.jointcommission.org/PatientSafety/UniversalProtocol/ and click on the link titled “2009 FAQs about the Universal Protocol.”

The Web site also contains links to the full text of the current Universal Protocol requirements for 2008, as well as program-specific versions for 2009 for the ambulatory care, critical access hospital, disease-specific care, hospital, and office-based surgery programs.

The requirements associated with the existing Universal Protocol, initiated to help prevent errors in surgical and non-invasive surgical procedures, were improved for 2009. Changes—which address verifying procedure, marking the procedure site, and conducting a “time out” immediately before starting procedures—were based on feedback received at the Wrong Site Surgery Summit in 2007. The Universal Protocol was also improved as part of The Joint Commission's Standards Improvement Initiative.
Environment of Care® Essentials for Health Care, Ninth Edition

The most up-to-date Environment of Care, Emergency Management, and Life Safety standards and survey information for the accreditation process—all in one convenient, spiral-bound volume. That's the heart of this must-have book: Environment of Care® Essentials for Health Care, Ninth Edition. This popular product now features the new Environment of Care (EC), Emergency Management (EM), and Life Safety (LS) chapters, developed through the Joint Commission's Standards Improvement Initiative (SII). It includes an Environment of Care Checklist CD-ROM—and an electronic version of the popular EC, EM, and LS Standards Matrix.

Environment of Care Essentials for Health Care, Ninth Edition also features the following:

- Details on how to understand the new chapters across all accreditation programs, including the new numbering, organization, scoring, and use within an on-site survey
- The EC, EM, and LS history tracking charts showing the 2008 standards tracked to the corresponding 2009 standards, and vice versa

It's an invaluable tool for managers in charge of multiple facilities!

Order Code: ECE09
Price: $139.00

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