Effective November 22, 2006, the Department of Health and Human Services’ Centers for Medicare & Medicaid Services (CMS) granted the Joint Commission deeming authority to accredit durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as required by the Medicare Modernization Act of 2003.

This new CMS designation means that DMEPOS suppliers accredited by the Joint Commission are “deemed” as meeting Medicare requirements, which include the recently published CMS Quality Standards. CMS found that the Joint Commission’s standards for DMEPOS are equal to, or more stringent than, the CMS Quality Standards.

“The Joint Commission is pleased to receive this recognition of its home care accreditation,” says Maryanne Popovich, R.N., M.P.H., executive director of the Joint Commission’s home care accreditation program. “The Joint Commission’s accreditation process sharpens the focus on continuous improvement of a supplier’s operational systems to provide safe, quality services and prevent errors. As the first accreditor of home medical equipment organizations, the Joint Commission’s longstanding experience in providing quality oversight is essential to DMEPOS providers in meeting the health care needs of America’s citizens and specifically, Medicare beneficiaries of durable medical equipment, orthotics, prosthetics, and other supplies.”

DMEPOS Requirements

A CD-ROM supplement containing all the standards and elements of performance that will be evaluated by the Joint Commission for DMEPOS companies seeking Medicare reimbursement under Part B is scheduled to be mailed to CEOs of home care organizations with home medical equipment accreditation during the week of January 15, 2007. These standards are also currently available online at http://www.jointcommission.org/AccreditationPrograms/HomeCare/hme_supplement.htm and will be included in 2007 Update 1 of the 2006–2007 Comprehensive Accreditation Manual for Home Care (CAMHC), available in March 2007.

This supplement will include CMS Quality Standards and Joint Commission requirements modified to conform to Medicare.
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.

**JOINT COMMISSION FIELD REVIEW**

Field review notifications are sent out electronically, as well as posted on the Joint Commission Web site. If you would like to be added to the electronic notification list, please contact the Division of Standards and Survey Methods at 630/792-5912.

- Proposed revisions to the emergency management standards for critical access hospitals, hospitals, and long term care organizations

- Proposed revisions to time frames for completion of history and physical examinations in Standard PC.2.120 for critical access hospitals and hospitals

- Proposed conflict management Standard LD.2.40 for the ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, and office-based surgery programs

- Proposed leadership requirement addressing disruptive behavior for the ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, and office-based surgery programs

- Proposed revisions to the medication management standards MM.4.10 and MM.8.10 for the critical access hospital and hospital programs

**CURRENTLY IN DEVELOPMENT**

- Possible 2008 National Patient Safety Goals

**JOINT COMMISSION INTERNATIONAL FIELD REVIEW**

Field review notifications are sent out electronically, as well as posted on the Joint Commission International (JCI) Web site. If you would like to be added to the electronic notification list, please sign up online by visiting the following direct link: http://www.jcrinc.com/international.asp?durki=7893.

- Revision of Joint Commission International hospital accreditation standards and survey process

**—STANDARDS—**

- Proposed requirement regarding the relationship between anesthesia providers and surgeons

- “Leadership” (LD) chapter review

- Review of Telemedicine standards

- Update of Opioid Treatment Program standards and elements of performance

- Review of current requirements addressing the equivalent credentialing and privileging process for physician assistants (PAs) and advanced practice registered nurses (APRNs)

- Proposed revisions to Standard MS.1.20
The Joint Commission has approved revisions to Accreditation Participation Requirements (APRs) 5 and 6 for the hospital program, related to the receipt of anonymous patient-level data, effective April 1, 2007. The revised APRs are noted in the box on page 4 in strikeout and underlined text. An explanation of these policy changes for access to selected patient-level data follows.

**Current Policy**

The Joint Commission currently receives from performance measurement systems aggregated monthly data points for all performance measures reported by a hospital. In addition, a 20% sample of patient-level data for four outcome measures is received to allow for risk adjustment of these measures. This sample contains administrative data and blinded patient and hospital identifiers assigned by the performance measurement system.

**Revised Policy**

The revised approach, effective with April 1, 2007 hospital discharges, expands the existing transmittal requirements, and contractually requires listed core performance measurement system vendors to transmit all the data for each case used in calculating any performance measure value (that is, a 100% sample of data for all measures reported by individual hospitals), but only after removing all hospital and unique patient identifiers from the data file prior to transmission. Each case will be assigned a unique, randomly-generated tracking number by the measurement system vendor. Because these data cannot identify a hospital or a patient, they are anonymous patient-level data.

Although the Joint Commission will not receive any patient- or hospital-identifying data, some of the required anonymous patient-level data elements are considered protected health information (for example, admission date, discharge date, date of surgical procedure). The Joint Commission will receive only the minimum patient-level data elements necessary to verify measure calculations, continue to develop risk-adjustment models, and conduct data quality analyses.

**Increase in Performance Measurement System Accountability**

This revised approach directly addresses the concerns expressed predominantly by state hospital associations and their performance measurement systems. Further, this effort will not undermine the role currently played by some measurement systems and hospital associations in quality improvement. Measurement system vendors are still required to calculate and transmit a separate file containing monthly hospital measure rates aggregated at the health care organization level to the Joint Commission, and provide feedback, education, and quality improvement assistance to hospitals. Under this new policy, the performance measurement system will have increased accountability for the data they send to the Joint Commission in order to give all stakeholders using the measurement data greater confidence in the quality and accuracy of the data.

**Benefits of the Revised Policy**

The new policy will substantially enhance the Joint Commission’s ability to continuously monitor data quality. However, if data quality problems are identified in this approach, the Joint Commission will depend on the measurement system vendor for problem resolution. The measurement system will work with the hospital(s) in question to resolve the data quality issue(s), and report back to the Joint Commission (this will be contractually required). The eventual expectation is that the measurement system will correct, through retransmission, any aggregate data inaccuracies found as a result of errors uncovered during the analysis of the patient-level data, thereby ensuring the integrity of the aggregate data to be posted on Quality Check® and made available to the Centers for Medicare & Medicaid Service’s Hospital Compare Web site.

In addition, access to hospital-blinded, anonymous patient-level data will still provide the Joint Commission with sufficient data to evaluate the impact of potential modifications to existing performance measures and to perform measure maintenance functions. These data will also make it possible to mine the national database for as yet untapped opportunities for performance improvement.

(Continued on page 4)
Revisions to APRs 5 and 6

APPLICABLE TO HOSPITAL
Effective April 1, 2007

APR 5
The hospital selects and uses accepted core measure sets/measures and/or non-core performance measures from among those available through its at least one listed performance measurement system.

Rationale for APR 5
The hospital selects and uses core measures if appropriate to the patient populations served, or other accepted performance measures from at least one listed performance measurement system to meet current ORYX requirements. If core measures are not applicable to its services, the hospital identifies other accepted clinical measures available through its selected performance measurement system(s) based on current ORYX requirements.

The hospital continues to submit monthly patient-level data for each of its selected measures to the performance measurement system(s) at least quarterly and. Such submissions to the Joint Commission by the selected performance measurement system(s) identity are presented both as hospital-specific aggregate monthly data points and, for core measures, as anonymous patient-level data*.

A hospital applying for initial survey must notify the Joint Commission of its measure selection(s) no later than the time of survey. Each hospital must notify the Joint Commission of any subsequent additions or changes to its measure selections.

Elements of Performance for APR 5
1. The hospital has selected a sufficient number of core measure sets and/or non-core performance measures to meet current ORYX requirements.
2. The hospital notifies the Joint Commission of its core measure sets and/or non-core performance measures selections by the date requested.
3. The hospital notifies the Joint Commission of any changes in its core measure sets and/or non-core performance measures selections.
4. Each individual core measure set and/or non-core performance measure is used for at least four consecutive quarters.
5. For the most recent 12-month reporting period, the hospital must have achieved and sustained an acceptable level of performance, as defined by quarterly Joint Commission statistical analysis, for each core measure within a measure set before it can discontinue its use of such a measure set.

APR 6
The hospital ensures that aggregate data for the each of its selected core measure set and/or non-core performance measures are submitted to the Joint Commission at least quarterly four times per year as quarterly hospital-specific aggregate data and, for each of its selected core measures, as anonymous patient-level data.

Rationale for APR 6
For each of its selected core and/or non-core measures, hospital-specific quarterly aggregate data, reported as monthly data points, must be submitted four times per year by established deadlines from the performance measurement system to the Joint Commission for use in the accreditation process, as required by the Joint Commission. The Joint Commission has defined the type and format of performance measurement data to be submitted in a fashion consistent with nationally recognized standards.

The submission of hospital-specific data will be performed by the selected performance measurement system(s) and, for non-core measures, will include comparative data for hospitals in the same performance measurement system that have selected the same performance measures.

For each of the hospital’s selected core measures, anonymous patient-level data* must be submitted four times per year by established deadlines from the performance measurement system to the Joint Commission for use in assessing data quality, verification of measure calculations, and risk-adjustment model development, as required by the Joint Commission.

The Joint Commission has defined the type and format of performance measurement data to be submitted in a fashion consistent with nationally recognized standards.

Element of Performance for APR 6
1. The hospital ensures that hospital-specific aggregate data for its selected core measure set and/or non-core performance measures are submitted from its selected performance measurement system(s) to the Joint Commission four times per year in accordance with established time lines established by the Joint Commission.
2. The hospital ensures that quarterly anonymous patient-level data* for each of its selected core measures are submitted from its selected performance measurement system(s) to the Joint Commission four times per year in accordance with the established time lines.
3. The hospital agrees to resolve any data quality issues identified by the Joint Commission through the analysis of reported anonymous patient-level data* that are determined by the hospital’s performance measurement system to be the responsibility of the hospital.

* Anonymous patient-level data Patient-level data that are minimally necessary to maintenance of the integrity of the Joint Commission’s accreditation process through verification of measure rate calculations, the conduct of data quality analyses, and the formulation of risk adjustment models. These data are anonymous because the performance measurement system will remove all hospital- and patient-specific identifiers before transmission to the Joint Commission.
The decision to expand the scope of involvement by Life Safety Code Specialists follows two successful years of including the Life Safety Code Specialist in hospital surveys of 200 or more licensed beds. The survey method will not change for the Life Safety Code Specialist, other than inclusion in all acute care and critical access hospitals. The Environment of Care (EC) Interview will also be expanded to include the 1½ hour focused Emergency Management Interview. The increased participation of the Life Safety Code Specialist in critical access hospital and hospital surveys supports the Joint Commission’s continuing scrutiny of the EC requirements. Focused standards continue to include EC.5.20, EC.5.40, EC.5.50, EC.7.40, and EC.7.50.

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Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, Massachusetts.

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CMS Recognizes Joint Commission Accreditation (continued)

(Continued from page 1)

requirements from all nine functional chapters in the 2006–2007 CAMHC. The supplement will also contain the National Patient Safety Goals, Accreditation Participation Requirements, new glossary terms, and a list of required documentation for meeting the home medical equipment standards.

**Joint Commission Home Medical Equipment Evaluation**

The Joint Commission began evaluating home medical equipment suppliers in 1988 as part of its home care accreditation program. The Joint Commission evaluates and accredits nearly 3,500 organizations under its Home Care Program, which includes approximately 1,400 home medical equipment suppliers. Joint Commission accreditation provides an assessment of a supplier’s compliance with state-of-the-art standards that have been specifically adapted to the special services offered by these organizations, and that conform to CMS Quality Standards. The survey is performance focused and emphasizes the results home medical equipment suppliers should achieve, instead of the specific method used to achieve those results.

The primary home medical equipment services accredited under the Joint Commission’s home care accreditation program are as follows:

- Durable medical equipment—hospital beds, wheelchairs, lift chairs
- Oxygen delivery systems—CPAP, Bi-PAP, ventilators
- Diabetic supplies
- Ambulatory aids—canes, crutches, walkers
- Orthotics and prosthetics

In addition to DMEPOS, deemed status options are available to Joint Commission-accredited home health agencies, hospices, clinical laboratories, ambulatory surgical centers, hospitals, and critical access hospitals.

For more information about Joint Commission home care accreditation, please visit http://www.jointcommission.org/AccreditationPrograms/HomeCare.
**APPROVED: New and Revised Molecular Testing Standards for Laboratory**

The Joint Commission has approved new and revised requirements addressing molecular testing for the laboratory program, effective July 1, 2007. The new and revised requirements, indicated in the boxes on pages 6–7 in underlined text, include the following:

- New standards QC.18.10 through QC.18.70 (see pages 6–7)
- An additional bullet point at Standard IM.6.190, Element of Performance (EP) 3 (see page 7)
- The addition of EP 9 to Standard LD.2.140 (see page 7) ▲

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**Official Publication of New Standards**

New Standards QC.18.10 – QC.18.70

**APPLICABLE TO LABORATORY**

**Effective July 1, 2007**

**Molecular Testing**

**Introduction**
Molecular testing is the analysis or the detection of nucleic acids by hybridization, with or without amplification. Molecular testing has become an area of rapid growth and change in the laboratory. This is due to the tremendous potential that molecular testing has for improving the prediction, prevention, detection, and treatment of disease. It promises to be extremely useful in diagnosis, therapy, epidemiologic investigations, and infection control. While molecular testing shows great promise, like any other medical test, it also has the potential to cause great harm if errors occur. Inaccurate results can lead to misdiagnosis or inappropriate treatment or counseling. Therefore, standards were developed to sufficiently support the safeguards required for molecular testing.

**Standard QC.18.10**
The laboratory follows written policies and procedures for molecular testing.

**Elements of Performance for QC.18.10**
The laboratory follows written policies and procedures that address the following (EPs 1–8):

- **1. Appropriateness of testing.**
  - Note: For genetic testing, additional information might be required to select appropriate tests and to ensure accurate test interpretation and reporting of results (see Standard IM.6.190, EP 3).

- **2. Prevention of nucleic acid contamination (including work areas, equipment, personal protective equipment, and reagents) during specimen preparation and testing.**

- **3. Documentation of all nucleic acid reagents, including probes and primers, used in a particular test.**

- **4. Quality and quantity of nucleic acid needed for a particular test.**

- **5. Investigation and corrective action taken for internal controls that fail to amplify.**

- **6. Competition between target and internal controls (for example, false negatives or presence of a target signal is strong with a negative internal control signal).**

- **7. Investigation of discrepant results between different methods.**

- **8. Re-use of patient specimens for quality control purposes.**

**Standard QC.18.20**
Validation studies include representatives from each specimen type expected to be tested in the assay and specimens representing the scope of reportable results.

**Note:** Other requirements for validating test methods are addressed in Standard QC.1.70.

**Elements of Performance for QC.18.20**

- **B 1. Validation studies include positive and negative representatives from each specimen type expected to be tested in the assay.**

- **B 2. Validation studies include specimens representing the scope of reportable results.**

- **A 3. Validation studies are documented.**

**Standard QC.18.30**
The laboratory establishes control limits, reference ranges, and reportable ranges.

**Elements of Performance for QC.18.30**

- **B 1. The laboratory establishes control limits, reference ranges, and reportable ranges to provide results with meaningful clinical applications.**

- **B 2. For quantitative tests, control limits are strict enough to promote precision and accuracy for reliable patient test results.**

**Standard QC.18.40**
The laboratory verifies each test run of patient samples in molecular pathology using quality controls.

**Elements of Performance for QC.18.40**

- **B 1. The laboratory defines the quality control procedure for each testing system or methodology, including the frequency of quality control testing.**

- **B 2. Procedures are consistent with current practice standards for this or similar methodologies, and are at least as rigorous as those required or recommended by the manufacturer.**

- **C 3. The laboratory documents quality control.**

**Standard QC.18.50**
Molecular testing reports include specific testing information.

**Elements of Performance for QC.18.50**
The laboratory reports include the following information (EPs 1–6):

- **C 1. Testing methodology used.**

- **C 2. Limitations of the method used.**

- **C 3. Any interpretation of findings.**

- **C 4. Any recommendations for additional testing.**

(Continued on page 7)
New Standards QC.18.10 – QC.18.70 (continued)

C 5. For assays developed by the laboratory, a statement that the assay was developed by the laboratory.

A 6. The disclaimer required by federal regulations for analytic specific reagents (ASR).

Note: Federal regulations require that the following disclaimer accompany the test result on the report: “This test was developed and its performance characteristics determined by laboratory name. It has not been cleared or approved by the U.S. Food and Drug Administration.”

C 7. Reports filed in the patient’s clinical record that require specific interpretation are authenticated by the qualified* individual making the interpretation.

Molecular Genetics

Note: These Standards and accompanying Elements of Performance are in addition to those presented in the Molecular Testing section of this manual (see standards QC.18.10-QC.18.50).

Standard QC.18.60

The laboratory follows written policies and procedures for molecular genetic testing.

* Qualified individual. Qualifications to provide technical consultation or supervision are described in CLIA ’88 under Subpart M–Personnel for Nonwaived Testing §493.1351 - §493.1495. A complete description of the requirement is located at http://www.cms.hhs.gov/clia or http://www.phppo.cdc.gov/clia.

Elements of Performance for QC.18.60

The laboratory follows written policies and procedures that address the following (EPs 1 and 2):

B 1. Recommending referral for genetic counseling.

B 2. Reporting of results when additional information necessary for interpreting test results is not received by the laboratory.

Note: For genetic testing, additional information might be required to select appropriate tests and to ensure accurate test interpretation and reporting of results (see Standard IM.6.190, EP 3).

Standard QC.18.70

Molecular genetics testing reports include specific testing information.

Elements of Performance for QC.18.70

The laboratory reports include the following information (EPs 1–5):

C 1. List of mutant genes or alleles tested.

C 2. Any recommendations for referral to a genetic counselor.

C 3. Detection rate of the test.


C 5. Clinical implications of mutation(s) detected.

New Standards QC.18.10 – QC.18.70 (continued)

APPLICABLE TO LABORATORY
Effective July 1, 2007

[Revision: Addition of bullet point in EP 3.]

B 3. Orders or requisitions for services clearly identify the following:

• Patient’s name
• Patient’s gender
• Patient’s age or date of birth
• Requesting individual, including, as applicable, a contact person to enable the reporting of imminently life threatening laboratory results including panic or alert values

• Test(s) required
• Special handling required
• Date and, when relevant, the time the specimen was collected
• Date and time the specimen and requisition arrived at the laboratory
• The specimen source, when appropriate
• Additional information required to select appropriate tests and to ensure accurate test interpretation and reporting of results (for example, race/ethnicity, family history, pedigree).

Approved: Molecular Testing Standards for Labs (continued)
REVISION: 2007 Laboratory Survey and Track Record Requirements

This article contains revisions to the full survey scoring compliance and track record achievements for the laboratory program, effective January 1, 2007. The revisions are noted in the box below with underlined text; an explanation of these revisions follows.

Beginning January 1, 2007, during the tracer portion of full laboratory surveys, surveyors will access data and records from up to 24 months prior to the date of survey when reviewing tracer patients. Doing so enhances the Joint Commission’s ability to provide a comprehensive and consistent laboratory survey process, particularly when reviewing standards requirements that occur periodically, such as annual competency assessments and policy review, semiannual correlations, calibration verification, and method verification of non-regulated analytes.

Surveyors will continue to use the existing tracer methodology. At the beginning of the survey, surveyors will select patients at random from the previous 24 months in each specialty and subspecialty. For the tracers, surveyors will select patients who have received laboratory services from within each of the following three timeframes:

1. less than 6 months
2. 6–11 months
3. 12–24 months

For example, the surveyor may review hematology testing for one or more patients selected randomly from each of the three incremental timeframes referenced above. The surveyor will then concurrently review the set of tracers for the specialty or subspecialty, maximizing the surveyor’s ability to review related data and records over time without extending the time needed on survey.

Track record achievements for scoring compliance will be modified accordingly (see box below). Laboratory professionals should note this change in track record review and take steps to ensure that data and records for the past 24 months are readily available at the time of the full unannounced survey, including quality control, instrument maintenance, and competency records.

Official Publication of Revised Scoring Compliance and Track Record Achievements

Revised Full Survey Scoring Compliance and Track Record Achievements

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<thead>
<tr>
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</thead>
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<tr>
<td>2</td>
<td>24 months</td>
</tr>
<tr>
<td>1</td>
<td>6–23 months</td>
</tr>
<tr>
<td>0</td>
<td>Fewer than 6 months</td>
</tr>
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</table>

APPLICABLE TO LABORATORY
Effective January 1, 2007

Note: This revision supersedes the information printed in 2006 Update 2 to the 2005-2006 Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAM LAB) and the 2007 CAM LAB on pages HM-8, ACC-30, PI-5, LD-6, EC-6, and IC-6.
The Joint Commission has approved interim provisions for Standard MM.4.10, Element of Performance (EP) 1 for critical access hospitals and hospitals, effective January 1, 2007. A detailed explanation of the interim provisions and modifications follows.

The Joint Commission has recently received concerns from emergency department (ED) and radiology practitioners regarding Standard MM. 4.10, EP 1 in the “Medication Management” (MM) chapter. Organizations have found themselves consistently out of compliance with the requirements for a pharmacist to review prescriptions or medication orders before dispensing and administration in the ED, and in providing direct supervision to a patient by a licensed independent practitioner in radiology when IV contrast media is administered. Factors such as urgent patient situations, time, work flow constraints, and manpower have contributed to non-compliance with Standard MM. 4.10.

In response to these concerns, the Joint Commission is currently developing revisions to Standard MM. 4.10, EP 1 that were sent to the field for review in December 2006. However, it is anticipated that the revisions will not be effective until at least late 2007.

To address the field’s immediate concerns, an interim action has been implemented to the survey process for Standard MM.4.10, EP 1, as it applies to EDs. Additionally, the interpretation of Standard MM. 4.10, EP 1 has been modified for radiology services.

These modifications are presented in points 1 and 2 below, as follows:

1. Emergency Department Interim Action

While Standard MM. 4.10 is undergoing revision by the Joint Commission, the process for surveying EP 1 will be modified in the ED. The current exceptions to this requirement remain in effect (that is, permitting medications to be administered without prospective pharmacy review when the need for a medication is urgent, and/or when a licensed independent practitioner controls the ordering, preparation, and administration of the medication.) Licensed independent practitioner control is interpreted as the licensed independent practitioner being physically present with the patient while the medication is being administered.

Effective January 1, 2007, an organization’s ED will be viewed as compliant with Standard MM. 4.10, EP 1 under the following circumstances:

- If a pharmacist’s prospective review is not performed, a pharmacist conducts a retrospective review of medication orders within 48 hours.

This modification will prevent treatment delays while retaining a pharmacist’s involvement through a retrospective review.

This interim approach to the survey process for Standard MM. 4.10, EP 1, will be in effect throughout the Joint Commission’s standard revision process and will result in a pharmacist’s review of all medication orders in the ED through either a prospective or retrospective review.

2. Radiology: Hospital and Hospital-Associated Ambulatory Services

Standard MM. 4.10, EP 1 requires a pharmacist to review all prescriptions or medication orders before dispensing, with the following two exceptions: (1) When the medication is urgently needed, or (2) when a licensed independent practitioner controls the ordering, preparation, and administration of the medication. The Joint Commission has consistently stated that the second exception requires the licensed independent practitioner to remain with the patient during administration of the medication. The Joint Commission has modified this interpretation of Standard MM. 4.10, EP 1 for radiology services only, as described below:

- Effective January 1, 2007, a hospital’s radiology services (including hospital-associated ambulatory radiology) will be allowed to define, through protocol or policy, the role of the licensed independent practitioner in the direct supervision of a patient during and after IV contrast media is administered. The protocol/policy is to be approved by the medical staff and the role of the licensed independent practitioner is to be defined so that there can be timely intervention by the licensed independent practitioner in the event of a patient emergency. The Joint Commission recommends that organizations refer to the American College of Radiology Practice Guidelines for the Use of Intravascular Contrast Media, 2001, during development of the protocol/policy.

For questions about these modifications, please contact Kelly Podgorny, R.N., M.S., C.P.H.Q., project director in the Division of Standards and Survey Methods, at kpodgorny@jointcommission.org or the Joint Commission’s Standards Interpretation Group through its online question form at http://www.jointcommission.org/Standards/OnlineQuestionForm and by phone at 630/792-5900.
**APPROVED: Additional Exemptions from Completely Unannounced Surveys for Ambulatory Care and Disease-Specific Care Programs**

The Joint Commission has approved additional exemptions from completely unannounced surveys in the ambulatory care and disease-specific care programs, as outlined in the table below. These exemptions are in addition to those published in the January 2006 issue of Joint Commission Perspectives.

Since the Joint Commission’s introduction of unannounced surveys in 2006, experience has shown that unannounced surveys may disrupt daily operations or not be feasible in certain situations. The table below provides the additional exemptions.

<table>
<thead>
<tr>
<th>Program</th>
<th>Subject</th>
<th>Exemption</th>
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<tbody>
<tr>
<td>Ambulatory Care</td>
<td>Organizations that provide specified diagnostic and therapeutic services* and have fewer than 3,000 annual visits or four or fewer licensed independent practitioners</td>
<td>5-day notice</td>
</tr>
<tr>
<td></td>
<td>Organizations that provide mobile diagnostic services</td>
<td>5-day notice</td>
</tr>
<tr>
<td>Disease-Specific Care</td>
<td>All reviews</td>
<td>5-day notice</td>
</tr>
</tbody>
</table>

*Note: Diagnostic/Therapeutic Services/Other: This includes Allergy, Alternative/Complementary Care, Audiology, Chiropractic Medicine, Diagnostic Imaging, Dialysis, Hematology, Infusion Therapy, Lithotripsy, Orthotics/Prosthetics, Pain Management, Pulmonary Medicine, Physical Medicine, Radiation Oncology, Sleep Diagnostic, and Telehealth.

†Note: This does not include Health Care Staffing Certification, Organ Transplant Certification, Ventricular Assist Device (VAD), and Lung Volume Reduction Surgery (LVRS) reviews

**World Health Organization’s Collaborating Centre on Patient Safety Seeks Comment on Proposed International Patient Safety Solutions**

Health care professionals and patient advocates from around the world are invited to comment on nine proposed solutions for improving patient safety that have been developed under the guidance of the World Health Organization’s Collaborating Centre on Patient Safety. The proposed Patient Safety Solutions address the following issues:

1. Look-alike, sound-alike medications
2. Correct patient identification
3. Hand-over communications
4. Wrong site, wrong patient surgery
5. Use of concentrated electrolyte solutions
6. Medication reconciliation
7. Catheter and tubing misconnections
8. Needle reuse and injection safety
9. Hand hygiene

The electronic Patient Safety Solution survey will be available online at http://www.jcipatientsafety.org/survey. The deadline for the survey is February 16, 2007.

**Background on Patient Safety Solutions**

The World Health Organization (WHO) designated the Joint Commission and Joint Commission International as its Collaborating Centre on Patient Safety in 2005. The Joint Commission International Center for Patient Safety is establishing a collaborative network of leaders in developing, transitional, and developed countries to help identify health care safety needs and match these with known best practices and solutions.

The proposed Patient Safety Solutions have been reviewed by an international panel of patient safety experts as well as regional advisory councils in Europe, the Middle East, and the Asia-Pacific region; their comments have been integrated into the proposed solutions. The purpose of the solutions is to guide the re-design of patient care processes to prevent inevitable human errors from reaching patients.

To learn more about the Patient Safety Solutions, participate in the survey, or provide suggestions for future solutions development, please visit http://www.jcipatientsafety.org.
**Revision:** Standard NR.1.10, Element of Performance 6, for Critical Access Hospitals and Hospitals

This article contains revisions to Standard NR.1.10, Element of Performance (EP) 6, for critical access hospitals and hospitals, effective immediately.

Pages 10-11 of the November 2006 issue of Joint Commission Perspectives® contain editorial revisions to the “Nursing” (NR) chapter for critical access hospitals and hospitals. Those editorial revisions clarify expectations of nursing leadership’s role at the executive level of the organization. That clarification included a revised expectation in EP 6 of Standard NR.1.10, stating the following: “An identified nurse leader, at the executive level, assumes an active leadership role in the [hospital]’s decision-making structures and process.”

However, per customer feedback, it has come to the Joint Commission’s attention that the above revision to EP 6 has strayed from the expectation that the nurse executive would actively participate with the governing body, the organized medical staff, management, and clinical leaders to keep the organization’s leadership apprised of issues and concerns confronting nursing and the patient care arena as well as to propose solutions and initiatives.

The Joint Commission did not intend to omit expectations about nursing leadership’s vital role in the organization’s decision-making structures and processes. To rectify this omission, additional editorial revisions have been made to EP 6, as shown in the box below in strikethrough and underlined text.

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**Revision:** Standard QC.4.23, Element of Performance 5, for Laboratory

The Joint Commission has approved revisions to Element of Performance (EP) 5 for Standard QC.4.23 for the laboratory program, effective July 1, 2007. The revised EP text is noted in the box below with underlining indicating new text and strikethrough indicating deleted text. These revisions have been made to bring this standard into compliance with the current Clinical Laboratory Improvement Amendment of 1988 (CLIA ‘88) regulations.

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**Official Publication of EP Revision**

Revision to Standard NR.1.10, EP 6

**Applicable to Critical Access Hospitals and Hospitals**

[Revision: Editorial revision to EP 6 of Standard NR.1.10]

Effective immediately

A 6. An identified nurse leader, at the executive level, assumes an active leadership role with the organization’s governing body, management, organized medical staff, and clinical leaders in the organization’s decision-making structures and processes.

**Official Publication of Revised Standard**

Revision to Standard QC.4.23, EP 5

**Applicable to Laboratory**

Effective July 1, 2007

A 5. The maximum total number of slides an individual may screen is one of the following:

- For gynecological specimens:
  - 100 “full” slides (manual screening) (traditional preparatory techniques)
- For non-gynecological specimens:
  - 100 “full” slides (manual screening)
  - 200 “half” slides (manual screening; ½ of the slide or less)

A combination of full and half slides (based on prorated time, not to exceed the preceding limits)

For both gynecological and non-gynecological specimens:

- As specified by the manufacturer for automated or semi-automated screening devices.

Note: The workload limit for individuals reading slides requiring 100% manual review may not exceed 100 slides, as a result of automated or semi-automated analysis or in the routine workload.
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Michael Woods walks health care providers through the Five “R”s of Apology:

1. Recognition: Know when an apology is in order.
   • Read the feelings of your patient and family—is there fear, disappointment, or anger regarding an outcome?
   • Be aware of your own feelings.
   • Analyze exactly what happened to cause these feelings.

2. Regret: Respond empathetically.
   • Tell your patient you’re sorry for what he’s going through.
   • Acknowledge the patient’s disappointment, fear, and anger.
   • Remember that saying I’m sorry doesn’t imply guilt or fault on your part.

3. Responsibility: Own up to what’s happened.
   • Be accountable for the problem, even if it was unforeseeable.
   • Disclose all details that lead to the outcome or complication and explain why it happened.

4. Remedy: Make it right.
   • Explain to your patient what’s being done to correct the problem.
   • Evaluate how it will affect your patient’s health and then begin appropriate therapy.
   • Consider who will bear the cost of the error or complication—are there any costs you can absorb?

5. Remain Engaged: Be there for your patient.
   • Reassure your patient that you will not abandon him.
   • Focus on and provide for your patient’s continuing care needs after the outcome or complication.

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