New York Recognizes Joint Commission Accreditation for Office-Based Surgery

Effective January 14, 2008, New York physician practices that perform office-based surgery must seek accreditation. This requirement is part of 2007 legislation designed to protect the thousands of patients who undergo surgery in a physician's office each year in New York State. One of the main components of the law is that office-based surgeries must be performed by physicians in a setting accredited by a nationally recognized accrediting organization, such as The Joint Commission.

New York office-based surgery practices, if not already accredited by The Joint Commission or two other approved accrediting agencies, must become accredited on or before July 14, 2009. This new law reflects a national trend of state health departments and boards of medicine strengthening their oversight of office-based surgery practices. The Joint Commission played a key role in development of the legislation by testifying and serving on panels that guided the process.

The need for strengthened oversight for office-based surgery has grown as the number of increasingly complex surgical and invasive procedures performed in doctors' offices has more than doubled in the last decade, with nearly 10 million surgical procedures performed annually in office-based settings nationwide since 2000. Before this new law, surgeries performed in doctors' offices were not regulated in New York.


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Standards Improvement Initiative: Revised “Management of the Environment of Care” (EC), “Management of Human Resources” (HR), and “Medication Management” (MM) chapters for the ambulatory care, critical access hospital, home care, hospital, and office-based surgery programs

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.

• Standards Improvement Initiative: “Surveillance, Prevention, and Control of Infection” (IC), “Management of Information” (IM), and “Improving Organization Performance” (PI) chapters for the behavioral health care, long term care, Medicare/Medicaid certification-based long term care, and laboratory programs

• Standards Improvement Initiative: “Nursing” (NR), “Transplantation Safety” (TS), and “Documentation of Care” (DC) chapters for the ambulatory care, critical access hospital, home care, hospital, and office-based surgery programs

• Proposed revisions to Standards MM.4.10 and MM.8.10 for the critical access hospital and hospital programs

• Proposed requirements for health care services certification in palliative care

CURRENTLY IN DEVELOPMENT

STANDARDS

• Development of a health care services certification program for services such as palliative care

• Comprehensive Standards Improvement Initiative encompassing the ambulatory care, critical access hospital, home care, hospital, and office-based surgery programs

• Comprehensive Standards Improvement Initiative encompassing the behavioral health care, long term care, Medicare/Medicaid certification-based long term care, and laboratory programs

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

• Proposed revisions to the Opioid Treatment Programs based on recent revisions to the Center for Substance Abuse Treatment’s accreditation guidelines for the behavioral health care program

• Potential standards related to Health Information Technology

• Development of new Distinct Part Units (DPU) requirements for the critical access hospital program

JOINT COMMISSION INTERNATIONAL
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.jointcommissioninternational.org/23201/

IN DEVELOPMENT AT JCI

• International primary care standards

• Revisions to ambulatory care standards

• Revisions to disease-specific care certification standards

• Revisions to laboratory standards
CORRECTION: Laboratory 2007 Update 2

This article corrects an error in the “National Patient Safety Goals” (NPSG) chapter of the September 2007 Update 2 for the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB), effective immediately for the laboratory program. The text of Implementation Expectation 1 for National Patient Safety Goal 1, Requirement 1A, is missing text on page NPSG–2. The correct version of Implementation Expectation 1 for Goal 1, Requirement 1A, is noted in the box below with underlined text. See the July 2007 issue of The Joint Commission Perspectives® for the full text of the 2008 National Patient Safety Goals.

**Correction to Implementation Expectation 1A of Goal 1, Requirement 1A**

**Applicable to Laboratory**

**Effective immediately**

National Patient Safety Goals

Implementation Expectation for Goal 1, Requirement 1A

C 1. Two patient identifiers are used when administering medications or blood products.

**New York Recognizes Joint Commission Accreditation for Office-Based Surgery (continued)**

Continued from page 1

Joint Commission. “To New York patients seeking surgical services outside the hospital setting, Joint Commission accreditation represents a commitment to maintaining compliance with national standards for providing safe, high-quality care.”

Summary of The Joint Commission’s Office-Based Surgery Accreditation Program

The Joint Commission began accrediting office-based surgery practices in 2001. The Joint Commission’s office-based surgery standards emphasize those issues that most directly affect patients such as patient care, patient safety, staffing, customer service, improving care, and responsible leadership. As a national evaluator of the safety and quality of care provided by health care organizations, The Joint Commission has more than 30 years of experience in promoting safe, high-quality care at more than 50 types of ambulatory care settings. The office-based surgery standards were established specifically for physicians offering surgical or invasive procedures in an appropriate physician-based setting. By year-end 2007, The Joint Commission accredited nearly 400 office-based surgery practices. Many different types of office-based surgery practices are eligible for accreditation and affected by this new law, including endoscopy suites, plastic surgery practices, and urology practices.

Ambulatory care organizations and office-based surgery practices can reap the benefits of Joint Commission accreditation, such as strengthening community confidence in the safety and quality of care, strengthening patient safety efforts, and enhancing business operations. Currently, 25 states recognize Joint Commission accreditation for ambulatory care settings—in whole or in part—in fulfillment of regulatory requirements. Fourteen states recognize Joint Commission accreditation for office-based surgery. For more information about the office-based surgery accreditation program, please call 630/792-5286, e-mail obs@jointcommission.org, or visit http://www.jointcommission.org/NYOBS.

**Reference**

UPDATE: Methods to Transmit Fire Alarm Signals

Manual Transmission Permitted Under Certain Circumstances

Joint Commission–approved methods of transmitting fire alarm signals, which can be used in all health care organizations with buildings classified as health care occupancies, are explained in the following paragraphs.*

With the advent of new and more sophisticated telecommunications systems, traditional methods for transmitting fire alarm signals to the local fire department have changed. Also, many communities find it difficult to fund and provide the staffing to support fire department–based alarm centers. The result is that communities, fire departments, and health care organizations are seeking viable, cost-effective alternatives to transmit fire alarm signals.

Four Traditional Methods

Traditionally, The Joint Commission has expected organizations with buildings classified as health care and ambulatory care occupancies to transmit fire alarm signals to the local fire department in accordance with the provisions of the National Fire Protection Association's NFPA 101-2000, Life Safety Code® (LSC),† Section 9.6.4, “Emergency Forces Notification” (referenced in 18.3.4.3.2 and 19.3.4.3.2). This paragraph of the LSC suggests the following four means by which the fire alarm signal may be transmitted to the fire department:

1. Auxiliary alarm system: Direct connect to servicing fire department (NFPA 72-1999, Chapter 16-6)
2. Central station connection: Managing of signals by contracted service (NFPA 72-1999, Chapter 5-2)
3. Proprietary system: Fire alarm systems that serve contiguous and noncontiguous properties under one ownership, with appropriately trained staff. (NFPA 72-1999, Chapter 5-3)
4. Remote station connection: Alarm monitoring center that sends signals to the public fire service communications center (NFPA 72-1999, Chapter 5-4)

The Joint Commission considers all four means to be effective and reliable. When possible, The Joint Commission expects health care organizations to continue using one of these four methods. However, The Joint Commission has approved an additional method of alarm transmission that meets standards requirements—a manual transmission system—described below.

Manual Transmission Method

One additional alarm transmission method, a manual transmission system, permits alarm signals to be manually transmitted to the local fire department. This method is allowed in NFPA 101-2000, 9.6.4, Exception:

For existing installations where none of the means of notification specified in 9.6.4(1) through (4) is available, a plan for notification of the municipal fire department, acceptable to the authority having jurisdiction, shall be permitted.

Before using this method, health care and ambulatory care occupancies must first comply with each of the following requirements:

1. Fire alarm signals must be received at a supervised location in the health care facility. Only a single, permanent, central location, such as a telecommunications center or a safety/security office, may be used. Multiple annunciator panels throughout the facility may also be used. However, the “official” alarm-receiving-and-transmitting location must be a single, permanent location.
2. The supervised location must never be left unattended. No staffing requirement is stipulated, but at least one person must be there at all times. If personnel will be performing multiple job functions, it may be necessary to increase staffing. Responding to fire alarms must take precedence over all other assigned job functions.
3. The supervised location must be protected in the same manner as a “hazardous area,” referenced in NFPA 101-2000, Sections 18.3.2.1 and 19.3.2.1. This affords a basic level of protection to both the operators and the equipment at the supervised location. At a minimum, the supervised location must be in a totally enclosed room (or equivalent). If the room is not equipped with sprinklers, all walls, doors, and other penetrations into the room must have a one-hour fire-resistance rating. If the room is equipped with sprinklers, the walls, doors, and other penetrations into the room may be unrated.

* This information has been updated from its original publication in the March/April 1992 issue of Joint Commission Perspectives® (pages 7 and 10) and is referenced as such in the Statement of Conditions™, 3A.6A.3b and 3B.6A.3b.

† Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.
assemblies but must prevent the transmission of smoke into the room.

4. The supervised location must contain the appropriate equipment to receive fire alarm signals. The equipment may be either the master fire alarm control panel or an auxiliary annunciator panel. Annunciator panels must be at least as capable of identifying the location and type of alarm as the master fire alarm control panel. When a fire alarm signal is received at the supervised location, it must activate both a visual and audible signal at that location. The signal must be clearly distinguishable as the fire alarm signal and must be seen and heard above all other alarms or signals received at that location.

5. A log that records all status changes to the fire alarm system must be maintained in the supervised location. The log may be recorded either manually or with an automatic data recorder integrated with the fire alarm system.

6. Alarm signals received at the supervised location must be immediately transmitted to the fire department. At no time may a transmission of alarms be delayed while other personnel verify or investigate fire alarm signals. Fire alarm signals may be transmitted to the fire department via telephone, two-way radio, master (city) box, or any other means of communication acceptable to the local authority.

7. The supervised location must contain a master copy of the organizationwide fire plan and any other documents, equipment, or record necessary for the operators to implement, coordinate, or direct activities related to a fire emergency response.

The intent of the above requirements is to codify expected organization practices. When implemented, these practices can be an effective and reliable alternative method of transmitting fire alarm signals to the local fire department. This information is consistent with the Statement of Conditions™ reference in both existing and new health care life safety assessments, Part 3 A/B, 6A.3.b.

In addition to compliance with the LSC, The Joint Commission expects all accredited health organizations to be in full compliance with state and local fire codes. Organizations that may benefit from using the described alternative method should verify its acceptance by local fire officials.

For more information, call The Joint Commission’s Standards Interpretation Group at 630/792-5900.

**DACT Fire Alarm System Testing**

Generally, the testing frequencies listed in The Joint Commission’s “Management of the Environment of Care” (EC) standards are for older analog systems that do not have the intelligence to determine malfunction and thus require manual interventions (that is, quarterly testing). Intelligent systems (those programmed to test their own circuitry by sampling, such as a Digital Alarm Communicator Transmitter [DACT] system) can be tested annually. (See NFPA 72-1999, 7-3.2, remotely monitored, where the computer remotely monitors all signals on site.)

The Joint Commission expects the intelligent system to be calibrated, serviced, and inspected annually. Evidence of the intelligent system’s ability to self monitor (and alarm when trouble is identified) is helpful at survey. This could include a summary of points, including an actual trouble/alarmed report, and so on.

Valve and fire sprinkler flow switch tests are to be semi-annual, because of the mechanical nature of the devices involved.

Assuming the facility has a functional DACT, all the components are integrated into the system, and the DACT is sampling as designed, then testing frequencies should be as follows:

- Patient room supervisory detectors
  DACT: ANNUAL
- Supervisory duct smoke detectors
  DACT: ANNUAL
- Alarm and tamper testing
  DACT: ANNUAL
- Off premises Emergency Forces Notification transmission equipment
  DACT: QUARTERLY
- Fire sprinkler flow switches
  DACT: SEMI-ANNUAL
Preventing Accidents and Injuries in the MRI Suite

**Issue 38, February 14, 2008**

Magnetic resonance imaging (MRI) was applied to health care in the late 1970s to provide never-before-seen two- and three-dimensional views of body tissue and structure. Today, more than 10 million MRI, or MR, scans are performed in the United States each year. While the capabilities of the MRI scanner are well recognized, its inherent dangers may not be as well known. The following types of injury can and have occurred during the MRI scanning process:

1. “Missile effect” or “projectile” injury in which ferromagnetic objects (those having magnetic properties) such as ink pens, wheelchairs, and oxygen canisters are pulled into the MRI scanner at rapid velocity. (See the Sidebar on page 7 for examples of ferromagnetic objects.)
2. Injury related to dislodged ferromagnetic implants such as aneurysm clips, pins in joints, and drug infusion devices.
3. Burns from objects that may heat during the MRI process, such as wires (including lead wires for both implants and external devices) and surgical staples, or from the patient’s body touching the inside walls (the bore) of the MRI scanner during the scan.
4. Injury or complication related to equipment or device malfunction or failure caused by the magnetic field. For example, battery-powered devices (laryngoscopes, microinfusion pumps, monitors, and so forth) can suddenly fail to operate; some programmable infusion pumps may perform erratically; and pacemakers and implantable defibrillators may not behave as programmed.
5. Injury or complication due to failure to attend to patient support systems during the MRI. This is especially true for patient sedation or anesthesia in MRI arenas. For example, oxygen canisters or infusion pumps run out and staff must either leave the MRI area to retrieve a replacement or move the patient to an area where a replacement can be found.
6. Acoustic injury from the loud knocking noise that the MRI scanner makes.
7. Adverse events related to the administration of MRI contrast agents.
8. Adverse events related to cryogen handling, storage, or inadvertent release in superconducting MR imaging system sites.

Five MRI-related cases in The Joint Commission’s Sentinel Event Database resulted in four deaths and affected four adults and one child. One case was caused by a projectile, three were cardiac events, and one was a misread MRI scan that resulted in delayed treatment.

In 2005, Jason Launders, M.Sc., a medical physicist with the ECRI Institute, conducted an independent analysis of the Food and Drug Administration’s MAUDE (Manufacturer and User Facility Device Experience Database) reporting database over a 10-year time span, which revealed 389 reports of MRI-related events, including nine deaths—three related to pacemaker failure; two to insulin pump failure; and the remaining four events related to implant disturbance, a projectile, and asphyxiation from a cryogenic mishap during installation of an MR imaging system. More than 70% of the 389 reports were burns; 10% were projectile-related; another 10% were “other events, including implant disturbance;” 4% were acoustic injuries; 4% were fire-related; and 2% were internal heating-related.

The most common patient injuries in the MRI suite are burns, and the most common objects to undergo significant heating are wires and leads. Other objects associated with burns are pulse oximeter sensors and cables, cardiorespiratory monitor cables, safety pins, metal clamps, drug delivery patches (which may contain metallic foil), and tattoos (which may contain iron oxide pigment). Less common injuries involve pacemakers. The American College of Radiology recommends that implanted cardiac pacemakers and implantable cardioverter/defibrillators should be considered a relative contraindication for MRI. Any exception should be considered on a case-by-case basis and only if the site is staffed with individuals with the appropriate radiology and cardiology knowledge and expertise.

While only one missile-effect case has been reported to The Joint Commission, they are more common than is generally recognized. Many people—including health care workers—are unaware that the magnets in the MRI scanner are always “on” and that turning them “off” (quenching)
ing) is an expensive and potentially dangerous undertaking, involving the controlled release of cryogenic gases that can be deadly if released into a contained area. Due to the magnets, many of the objects pulled into the MRI scanner are cleaning equipment or tools taken into the MRI suite by housekeeping staff or maintenance workers.

Risk Reduction Strategies
Conventional metal detectors have been used to help identify metal objects in and on patients, but they are not 100% accurate and can give false-positives and false-negatives. Furthermore, metal detectors cannot alert personnel to all objects that are subject to heating, malfunction, or failure during an MRI scan. However, the recent availability of ferromagnetic detectors may help in screening patients for objects left on their person, according to Dr. Emanuel Kanal, chair of the American College of Radiology's (ACR) Magnetic Resonance Safety Committee. A recent study concludes that ferromagnetic detectors have 99% sensitivity.

A report on projectile cylinder accidents in the American Journal of Radiology recommends strategies to prevent missile-effect accidents, including implementing protocols that allow maintenance and housekeeping personnel to enter the MRI suite only after proper safety education and when no patient is in the suite. A number of preventive measures for hazards in the MRI environment are recommended by Dr. Kanal and supported by the ECRI Institute, including the following:

- Appoint a safety officer who is responsible for implementing and enforcing safety procedures in the MRI suite.
- Implement systems to support safe MRI practice such as written protocols and checklists, and periodically review and assess compliance with your organization’s MRI policies, procedures, and protocols.
- In general, do not bring any device or equipment into the MRI environment unless it is proven to be “MR safe” or “MR conditional.” “MR safe” items pose no known hazard in all MRI environments, and “MR conditional” items have been demonstrated to pose no known hazards in a specified MRI environment with specified conditions of use. “The safety of “MR conditional” items must be verified with the specific scanner and MR environment in which they will be used.

Joint Commission Recommendations
The Joint Commission offers the following 10 recommendations and strategies to health care organizations for reducing MRI accidents and injuries:

1. Restrict access to all MRI sites by implementing the four zone concept as defined in the ACR Guidance Document for Safe MR Practices: 2007. The four zone concept provides for progressive restrictions in access to the MRI scanner, as follows:
   - Zone I: General public
   - Zone II: Unscreened MRI patients
   - Zone III: Screened MRI patients and personnel
   - Zone IV: Screened MRI patients under constant direct supervision of trained MR personnel

2. Use trained personnel to screen all non-emergent patients twice, providing two separate opportunities for them to answer questions about any metal objects they may have on them, any implanted devices, drug delivery patches, tattoos, and any electrically, magnetically, or mechanically activated devices they may have. If the patient is unconscious or unable to answer questions, question the patient's family member or surrogate decision maker. If this person is unsure, use other means to determine if the patient has implants or other devices that could be negatively affected by the MRI scan (for example, look for scars or deformities, scrutinize the patient's history, use plain-film radiography, use ferromagnetic detectors to assist in the screening process).

3. Ensure that the MRI technologist has the patient's complete and accurate medical history to ensure that the patient can be safely scanned. All implants

Continued on page 8
Sentinel Event Alert: Preventing Accidents and Injuries in the MRI Suite (continued)

Continued from page 7

should be checked against product labeling or manufacturer literature specific to that implant, or peer-reviewed published data regarding the device or implant in question. Technologists should be provided with ready access to this information.

4. Have a specially trained staff person who is knowledgeable about the MRI environment accompany any patients, visitors, and other staff who are not familiar with the MRI environment inside the MRI suite at all times.2,8

5. Annually, provide all medical and ancillary staff who may be expected to accompany patients to the MRI suite with safety education about the MRI environment and provide all staff and patients and their families with appropriate materials (for example, guidelines, brochure, poster) that explain the potential for accidents and adverse events in the MRI environment.

6. Take precautions to prevent patient burns during scanning, including the following:
   - Ensure that no items (such as leads) are formed into a loop, since magnetic induction can occur and cause burns.4
   - If the patient’s body touches the bore of the MRI scanner, use non-conductive foam padding to insulate the patient’s skin and tissues.2
   - Place a cold compress or ice pack on electrocardiogram leads, surgical staples, and tattoos that will be exposed to radiofrequency irradiation during the MR imaging process.2

7. Only use equipment (for example, fire extinguishers, oxygen tanks, physiologic monitors, aneurysm clips) that has been tested and approved for use during MRI scans.2

8. Proactively plan for managing critically ill patients who require physiologic monitoring and continuous infusion of life sustaining drugs while in the MRI suite.

9. Provide all MRI patients with hearing protection (such as ear plugs).

10. Never attempt to run a cardio-pulmonary arrest code or resuscitation within the MR magnet room itself.

References


**UPDATE: Standards Improvement Initiative**

The Joint Commission has initiated Phase Two of its Standards Improvement Initiative (SII), which encompasses a review of the standards for the behavioral health care, laboratory, and long term care accreditation programs. The new chapters and manuals for Phase One are taking form and require some formatting and organizational changes, including renumbering the standards and Elements of Performance (EPs) for logic and consistency. The new numbering system will accommodate future additions to the chapters and manuals, and will facilitate sorting of the standards and EPs in electronic documents. The new manuals will include comparison tables between the existing standards and the new standards, including the numbering changes.

SII is part of a continuous effort to eliminate non-essential standards and to ensure that the remaining standards are understandable and relevant to the care setting to which they apply. The initiative is limited to changes of current standards; it is not designed to introduce new requirements. For more information, visit [http://www.jointcommission.org/Standards/SII](http://www.jointcommission.org/Standards/SII). E-mail questions and suggestions to standardsimprovement@jointcommission.org.

**Standards Improvement Initiative Time Line**

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<th>October 2006:</th>
<th>March 2008:</th>
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<tr>
<td>The Standards Improvement Initiative (SII) launched. The Joint Commission began seeking feedback through online surveys and public comment on standards for the Phase One programs—<strong>ambulatory care, critical access hospital, home care, hospital, and office-based surgery</strong>.</td>
<td>Accredited organizations will receive a March 2008 Update 1 to their comprehensive accreditation manuals, which will include an “SII Overview” booklet. Phase One organizations will also receive sample “Infection Prevention and Control,” “Management of Information,” and “Improving Organization Performance” chapters, containing SII revisions for Phase One programs only.</td>
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<td>June 2007:</td>
<td>Mid-2008:</td>
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<td>“Virtual” pilot testing was conducted with selected Joint Commission surveyors and Central Office staff.</td>
<td>Target date for completing improvements to the ambulatory care, critical access hospital, home care, hospital, and office-based surgery manuals. Final revised standards will be provided to accredited organizations in the affected programs in fall 2008.</td>
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<tr>
<td>August and October 2007:</td>
<td>January 2009:</td>
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<td>The revamped “Infection Prevention and Control” (IC), “Improving Organization Performance” (PI), and “Management of Information” (IM) chapters were approved by the Joint Commission’s Standards and Survey Procedures Committee.</td>
<td>Phase One SII improvements are targeted to go into effect for the ambulatory care, critical access hospital, home care, hospital, and office-based surgery programs.</td>
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<td>Early 2008:</td>
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<td>The Joint Commission begins conducting mock surveys using the improved standards and manuals.</td>
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New Patient Flow System Tracer for Critical Access Hospitals and Hospitals

Starting January 2008, surveys of critical access hospitals and hospitals have included a new system tracer to identify problems with patient flow. The rationale for this new tracer centers on patient safety. Treatment delays, medical errors, and unsafe practices thrive during times of patient congestion and can lead to sentinel events. Joint Commission–accredited hospitals are required to identify and correct patient flow issues organizationwide.

The only standard that specifically includes the words “patient flow” is Standard LD.3.15. However, patient flow problems stress the hospital’s entire system. This stressed environment can lead to staff cutting corners while delivering care, which may cause non-compliance with many Joint Commission standards, core measures, and National Patient Safety Goals. While Standard LD.3.15 does not apply to critical access hospitals, Joint Commission surveyors may still conduct an individual patient flow system tracer for a patient who has experienced a patient flow problem in any hospital, including critical access hospitals. In critical access hospitals, compliance with Standard LD.3.15 will not be part of the evaluation. However, compliance with other standards and requirements can be jeopardized by log jams in the system, and surveyors will evaluate the critical access hospital’s entire system to identify any areas of non-compliance with applicable standards. Non-compliance may be caused by ineffective systems often seen with patient flow problems. Therefore, a cue for surveyors and for your organization is anywhere in the care delivery system when patient care is restricted. These restrictions become the trigger point for further evaluation into what is happening and why it is happening.

What Are Surveyors Looking For Related to Standard LD.3.15?

Patient flow Standard LD.3.15,* details leadership responsibility for evaluating patient flow, accepting responsibility, and making necessary changes to improve throughput. Leaders must develop and implement plans to evaluate patient flow in the entire organization. They must identify problems in the organization and take action to prevent barriers to patient flow. If patient flow problems are identified during the survey, the surveyor will interview hospital leaders about actions they have taken to mitigate consequences of patient congestion, how they have shared accountability with medical staff, evidence of their shared accountability, the indicators throughout the hospital, how indicator results are reported to leadership, and how this information has been used to improve patient flow.

When evaluating patient flow, Joint Commission surveyors will look for compliance with all standards and requirements. Standard LD.3.15 addresses patient flow from a performance improvement perspective. Surveyors will ensure that a hospital is not just looking at one area (for example, emergency department, laboratory, radiology), but at its processes in its entire system. Literature shows that patient flow problems emerge in various departments and units in different hospitals; therefore, the hospital needs to evaluate all of its areas to identify where it needs to focus. In addition to Standard LD.3.15, there are many other standards and EPs that can be cited when the flow of patient care is disrupted.

Understanding the Impact of Patient Flow

To understand patient flow, hospitals and critical access hospitals can use tracers. For instance, select a patient who experienced a delay somewhere in the system and trace what happened with that patient. How did he or she enter the organization? Were there any delays in care? If so, why? What time was it? What day of the week was it? Were other patients also delayed? Where did the patient go after admission? How quickly was he or she assessed? Was treatment delayed? If so, why? Travel the path that the patient took from entry through discharge to better understand patient flow in your organization.

For More Information

For questions or additional information on the patient flow system tracer, please contact Deborah Ondeck, Project Director, Division of Standards and Survey Methods, The Joint Commission, at dondeck@jointcommission.org or 630/792-5980.

* Standard LD.3.15 is applicable to hospitals.
As of December 31, 2007, The Joint Commission’s sentinel event statistics have been updated and are available on the Joint Commission Web site.

Since implementation of the sentinel event database in January 1995, The Joint Commission has received 4,817 reports of sentinel events. A total of 4,945 patients were affected by these events, with 3,478, or 70%, resulting in patient death. The 10 most frequently reported sentinel events are as follows:

1. Wrong-site surgery (625 cases reported)
2. Suicide (596 cases reported)
3. Operative/post-operative complication (568 cases reported)
4. Medication error (446 cases reported)
5. Delay in treatment (360 cases reported)
6. Patient fall 281 (cases reported)
7. Assault, rape, or homicide (177 cases reported)
8. Patient death or injury in restraints (176 cases reported)
9. Perinatal death/loss of function (143 cases reported)
10. Unintended retention of foreign body* (141 cases reported)

To view the full updated sentinel event statistics and additional information, visit http://www.jointcommission.org/SentinelEvents/Statistics/. This site includes additional statistics such as “Sentinel Event Trends Reported by Year,” “Total ‘Reviewed’ Events by State,” “‘Reviewed’ Events per Million Population,” “Self-Reported Events by State,” “Sources of Sentinel Event Information,” and “Settings of Sentinel Events.”

* Unintended retention of a foreign object was added to the definition of reviewable events in June 2005. These data represent events reviewed since that date, not 1995–2007.
Call for Applicants
John M. Eisenberg Patient Safety and Quality Awards


The John M. Eisenberg Patient Safety and Quality Awards recognize the achievements of individuals who have made significant and lasting contributions to improving patient safety and health care quality and individuals and organizations who, through a specific initiative or project, have made an important contribution to patient safety and health care quality. The awards program provides an opportunity for individuals and/or organizations to receive national recognition for their ongoing contributions to patient safety and quality of care.

This memorial awards program was created jointly by NQF and The Joint Commission and named for John M. Eisenberg, director of the Agency for Healthcare Research and Quality and a member of the founding Board of Directors of NQF. It honors the enduring contributions of this impassioned advocate of health care quality improvement, who passed away in March 2002.

Awards are available annually in the following categories:

- Individual Achievement
- Innovation in Patient Safety and Quality—National
- Innovation in Patient Safety and Quality—Local
- Research

The awards will be presented in conjunction with NQF’s Annual National Policy Conference on Quality in Washington, D.C., on October 15–16, 2008. Additional information about the award and the award application form are available on The Joint Commission Web site (http://www.jointcommission.org) and the NQF Web site (http://www.qualityforum.org).