The Joint Commission and National Quality Forum Announce the 2007 John M. Eisenberg Patient Safety and Quality Awards

The National Quality Forum (NQF) and The Joint Commission have announced the 2007 recipients of the annual John M. Eisenberg Patient Safety and Quality Awards. These awards are given annually to individuals and health care organizations that have made significant contributions to improving patient safety. The 2007 Eisenberg Patient Safety and Quality Awards were presented at the NQF’s Annual Policy Conference on Quality on September 27, 2007.

Honorees

Recipients of the 2007 John M. Eisenberg Patient Safety and Quality Awards were selected in all four award categories. The honorees are noted below and on pages 3–4 with a description of the award category appearing in italics.

Individual Achievement (2 Recipients)

Individuals who have demonstrated exceptional leadership and scholarship in patient safety and health care quality through a substantive body of work.

- Flaura Koplin Winston, M.D., Ph.D.—Center for Injury Research

Continued on page 3
IN SIGHT

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

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.

- Thrombolytic therapy revisions to the advanced disease-specific care certification program for primary stroke centers
- Health care services certification program: This new certification program, currently in development, is intended to improve health care quality by addressing smaller systems within health care delivery, based on the concepts of clinical microsystems and patient-centered care.

IN COMMITTEE OR BOARD REVIEW

- Standards Improvement Initiative: Revised “Infection Prevention and Control” (IC), “Management of Information” (IM), and “Improving Organization Performance” (PI) chapters for the ambulatory care, critical access hospital, hospital, home care, and office-based surgery programs
- Transplant Center Certification Program standards to recognize the unique care needs of solid organ (for example, kidney, liver, heart) transplant patients
- Revisions to fire-safety equipment maintenance Standard EC.5.40, Element of Performance 14, for the ambulatory care, behavioral health care, critical access hospital, home care, hospital, long term care, and office-based surgery programs

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
- Proposed revisions to medication management Standards MM.4.10 and MM.8.10 for the critical access hospital and hospital programs
- Potential 2009 National Patient Safety Goals
- 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

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.jcринc.com/7893/.

IN DEVELOPMENT AT JCI:

- International primary care standards
- Revisions to ambulatory care standards
- Revisions to disease-specific care certification standards
- Revisions to laboratory standards to begin in 2008
The Joint Commission and National Quality Forum Announce the 2007 John M. Eisenberg Patient Safety and Quality Awards (continued)

Continued from page 1

Dr. Winston is being recognized for her lifelong professional commitment to combining public health, biomechanical engineering, and psychologic methodologies to promote safety and prevent injury among children from motor vehicle crashes. Motor vehicle crashes are the leading cause of death and acquired disability among children. Dr. Winston established Partners for Child Passenger Safety (PCPS), a research-to-action program; the PCPS child-focused crash surveillance system today contains data from more than 500,000 crashes involving children. The research findings have informed safety design, as well as new legislation and regulations and anticipatory guidance by clinicians and public health educators. Child traffic deaths have been reduced by 15 percent since 1990, and PCPS is now recognized as the leading national resource for child safety experts. Dr. Winston has also provided expert input to national organizations such as the Institute of Medicine, the National Highway Traffic Safety Administration, the Maternal and Child Health Bureau, the National Institutes of Health, the Centers for Disease Control and Prevention, and the United States Product Safety Commission.

• Darrell A. Campbell, Jr., M.D.—University of Michigan Hospitals and Health Centers. Dr. Campbell is being recognized for advancing quality improvement initiatives at the national, regional, and local levels. He led the expansion of the National Surgical Quality Improvement Program (NSQIP) from the Veterans Administration to the private sector, and then used that experience to design and develop the Michigan Surgical Quality Collaborative (MSQC), a quality collaborative based on NSQIP. The MSQC is today a partnership involving 34 Michigan hospitals, the American College of Surgeons, and Blue Cross Blue Shield of Michigan. At the local level, Dr. Campbell has distinguished himself as chief of staff at the University of Michigan Health System, where he has implemented multiple patient safety and quality improvement–related initiatives. These include a hospitalwide rapid response team, regular patient safety rounds, establishment of a “full disclosure” policy for medical errors, annual patient safety training for all employees, and a patient safety certification program for house officers.

Research

Individuals or projects that involve the scholarly or scientific investigation of patient safety or quality measurement, reporting or improvement.

• Eric J. Thomas M.D., M.P.H.—The University of Texas Health Science Center at Houston. Dr. Thomas’ broad-based patient safety and quality research activities have focused on the epidemiology of errors and adverse events, teamwork, incident reporting, measuring and improving cultures of safety, claims file analysis, pediatric patient safety, geriatric patient safety, and organizational learning. His work has been featured in leading quality and safety journals and other peer-reviewed publications, and his expert opinion and research findings have been relied upon by the Institute of Medicine, the World Health Organization, and the Institute for Healthcare Excellence, among others.

Innovation in Patient Safety and Quality at the National Level

Original projects or initiatives resulting in successful system changes or interventions that make the environment of care safer or improve advocacy on behalf of patients. Such projects have national or regional impact and may involve technology, protocols, educational approaches, organization culture change, or systems theory applications, among others.

• Beth Israel Deaconess Medical Center, Harvard Medical School—Boston, Mass. This organization is being recognized for adapting and applying the military and commercial aviation Crew Resource Management (CRM) principles to the field of obstetrics. After the CRM curriculum was modified for clinical application, 220 staff received training to incorporate the CRM principles and concepts into their daily work processes. The result was a dramatic reduction in major adverse obstetric events, which reduced malpractice liability exposure and improved overall patient safety and the quality of obstetric care. Specifically, a 25.4 percent reduction in the Adverse Outcomes Index (a measure developed for the project) was realized, and the severity of adverse events was reduced by 13.4 percent. The success of this work has been broadly recognized and has driven or influenced similar initiatives, including those of the Harvard Risk Management
Innovation in Patient Safety and Quality at the Local Level

Projects or initiatives involving successful system changes or interventions that make the environment of care safer, or that advocate on the patient’s behalf, and are new to the organization. These efforts may involve technology, protocols/procedures, education, organization culture, legislation, the media, or systems theory, among others.

- Evanston Northwestern Healthcare—Evanston, Ill.
  This organization is being recognized for developing and deploying the first universal admission surveillance program for methicillin-resistant Staphylococcus aureus (MRSA). The first year of this patient safety initiative resulted in a 62 percent reduction of MRSA and avoidance of more than 50 episodes of MRSA infection. The approach was judged to be easily and cost-effectively reproducible in any organization, and, as such, has the potential to significantly affect the nationally increasing mortality rates and rising costs associated with MRSA infections.

The December 2007 issue of *The Joint Commission Journal on Quality and Patient Safety™* will feature the achievements of each of the award recipients in greater detail. This special issue will be available for free viewing at http://www.jcrinc.com/journal by mid-November 2007.

“We applaud each of these outstanding recipients for their efforts which have truly advanced patient safety in the United States,” says Dennis S. O’Leary, M.D., president, The Joint Commission. “Their demonstrated commitment to patient safety and innovative efforts are inspirations to the American health care community.”

“The Eisenberg Awards are very important to all of us who are working to enhance health care quality and, more importantly, reduce the suffering that unfortunately happens in the health care environment,” says Janet M. Corrigan, Ph.D., president and C.E.O., NQF. Each one of these awardees is examples of people and organizations that are making a difference and leading the health care industry into a better, safer tomorrow for patients and health care consumers.”

The patient safety awards program, launched in 2002 by NQF and The Joint Commission, honors John M. Eisenberg, M.D., M.B.A., former administrator of the Agency for Healthcare Research and Quality (AHRQ). Dr. Eisenberg was one of the founding leaders of the NQF and sat on its board of directors. In his roles both as AHRQ administrator and chair of the federal government's Quality Inter-Agency Coordination Task Force, he was a passionate advocate for patient safety and health care quality and personally led AHRQ's grant program to support patient safety research.

Nomination forms for the Eisenberg Awards are available from http://www.jointcommission.org and http://www.qualityforum.org. Those submitting nominations will be asked to provide information about the nominee’s patient safety-related achievements, why these achievements are important, and the impact of these achievements on improving patient safety. Self-nominations are welcome. All submissions will be evaluated by an awards panel composed of patient safety and health care quality experts identified by the Joint Commission and NQF.

Questions about the award can be e-mailed to EisenbergAward@jointcommission.org.
The Joint Commission has been awarded a contract by the World Health Organization (WHO) to oversee global field testing of the long-planned International Classification for Patient Safety (ICPS). The project has been sponsored by the WHO World Alliance for Patient Safety and is overseen by a panel of international experts.

The Joint Commission was first approached by WHO in 2005 to coordinate the development of the ICPS in collaboration with a panel of experts. The goal of the project has been to create a classification system that optimizes the comparability of patient safety data and information across international borders. The ICPS is based upon the Joint Commission’s Patient Safety Event Taxonomy and draws as well from the National Patient Safety Agency’s National Reporting and Learning System in the United Kingdom; the Australian Patient Safety Foundation’s Advanced Information Management System; and the Eindhoven/PRISMA-Medical Classification Model from Eindhoven University of Technology and Leiden University Medical Center in the Netherlands. The Patient Safety Event Taxonomy has been endorsed by the National Quality Forum as the U.S. standard.

The ICPS seeks to define, harmonize, and group patient safety concepts into an internationally agreed upon classification in a way that is conducive to learning and to improving patient safety across health systems. The system has been designed to translate patient safety data and information into a common terminology; facilitate the systematic collection of patient safety data and information; enable data to be aggregated and compared; and provide a basis for international analysis. The field testing effort will determine the extent to which the ICPS reflects the realities and scope of patient safety worldwide, is feasible to implement across disparate health care settings, and produces valid and reliable results which can be used to enhance patient safety globally. The ICPS methodology is consistent with the WHO–Family of International Classifications guidelines and previous field testing undertaken by the WHO for the International Classification of Diseases (ICD).

“The Joint Commission is pleased to have been chosen by WHO to conduct field testing for the ICPS,” says Jerod M. Loeb, Ph.D., executive vice president, Division of Quality Measurement and Research, the Joint Commission. “This will lead to patient safety strategies that reduce the risk of patient harm.”

“By translating data and information into a common terminology, the ICPS will have broad applications across nations, cultures, and languages that results in improved patient outcomes,” says Martin Fletcher on behalf of the WHO World Alliance for Patient Safety. The official version of the ICPS is expected to be available for global implementation in late 2008. For more information about the ICPS, please contact Heather Sherman, Ph.D., Division of Quality Measurement and Research, the Joint Commission, at hsherman@jointcommission.org.

http://www.jointcommission.org
The Joint Commission has announced its intention to transition to annual subscription billing for disease-specific care certification and health care staffing services certification for implementation in January 2008. If approved, annual subscription billing will replace the current fee-for-service approach for certification services and will allow organizations to spread certification costs over the entire certification cycle. For all certification programs, subscription billing will involve annual billing at a base rate and an add-on fee to cover all review-related direct costs in the year in which on-site reviews are conducted.

All accreditation programs at the Joint Commission converted to the subscription billing model in 2006. Moving the disease-specific care and health care staffing services certification programs to this model aligns them with all other programs at the Joint Commission. Because certification programs are reviewed every two years, certified organizations will see less of an impact with the subscription billing model than accredited organizations did during their transition to subscription billing.

All currently certified organizations should have received a letter in October 2007 explaining the subscription billing model. Within the letter, they will also find estimated fees for the full certification cycle. The typical disease-specific care organization can expect the annual fee to be approximately 15-20% of the total costs for certification, while the onsite fee will cost approximately 60-70% of the total cost of certification. The typical health care staffing agency can expect the annual fee to be approximately 15-30% of the total costs for certification, while the onsite fee will cost approximately 40-70% of the total cost of certification. Organizations seeking more exact pricing estimates or additional information may contact the Joint Commission's Pricing Unit at 630/792-5115, or PricingUnit@jointcommission.org.

Beginning in 2008, the annual fees will be due each January. These fees are non-refundable. Organizations being reviewed in 2007 will have 60 additional days to pay their 2007 certification fees and their 2008 annual fees.

During the fourth quarter of 2007, the Joint Commission intends to enter into new certification contracts with all certified organizations. The contract will generally describe the services that the Joint Commission provides to health care organizations and will primarily consist of the Terms of Agreement that were previously contained in the Application for Certification.

Please visit the Joint Commission's Web site (http://www.jointcommission.org) for Frequently Asked Questions on subscription billing. As mentioned above, for additional information and specific questions about annual subscription billing, please contact the Joint Commission's Pricing Unit at 630/792-5115 or PricingUnit@jointcommission.org.

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*Note: The Joint Commission’s Ventricular Assist Device Certification and Lung Volume Reduction Surgery Certification programs are exempt from this transition.

† See page 5 of the April 2005 issue of Joint Commission Perspectives for further information.

‡ A typical disease-specific care customer is single site, with one disease management program.

# A typical health care staffing services agency has fewer than 150 full time employees, less than 10 disciplines, and operates in fewer than 25 sites.
**UPDATE: Clarification Process and Periodic Performance Review Process**

**Clarification Process**

After a survey event, organizations have the opportunity to submit clarifying Evidence of Standards Compliance (ESC) if they believe that their organization was in compliance with a particular standard at the time of survey.

When submitting clarifying ESCs after a survey event, it is important to follow the directions in the submission tool. For “A” and “B” elements of performance (EPs), be sure to address each prompt, detailing why you believe that your organization was in compliance at the time of survey. Remember to address the EP as well as the actual surveyor observation.

For “C” EPs, an audit must be submitted that addresses the thirty days prior to the start of the survey. The sample sizes are defined in “The Accreditation Process” (ACC) chapter of the accreditation manuals and must be adhered to. Challenging specific surveyor observations will not result in the removal of a Requirement for Improvement (RFI). It is important to include all of the information regarding how the sample size was determined, how the sample was randomized, who conducted the audit, and the date range for the audit.

Before the implementation of The Joint Commission's Shared Visions–New Pathways® accreditation process, if an organization was able to correct an identified issue while surveyors were still conducting the survey, many times the issue would not be cited in the survey report. That is no longer the case. Changes that the organization implements while the surveyors are present are considered corrective in nature; therefore, the issue remains in the survey report. These changes can be submitted as part of the corrective ESC post survey.

**Periodic Performance Review Process**

The following information applies to organizations surveyed after January 1, 2008.

If an organization, through their participation in the Joint Commission's Periodic Performance Review (PPR) process, has self-identified compliance issues that are then identified by surveyors on-site, the Joint Commission's Standards Interpretation Group (SIG) will review the accreditation report along with the health care organization's PPR. If an issue identified by the surveyor is identical to an issue in the PPR, the Plans of Action (POA) and Measures of Success (MOS) are appropriate, and the POA implementation date has not yet passed (or in the case of a PPR that has not yet received SIG approval and everything is acceptable), the RFI will remain in the report but will not count toward the accreditation decision threshold.

For example, if a small hospital has 15 RFIs (the threshold is 14 for Preliminary Denial of Accreditation), and the organization, through the PPR, has self-identified three of the issues identified in the accreditation report and they met the criteria noted above, the RFIs would remain in the report. However, only 12 of the RFIs would count toward the decision, making the organization eligible for Conditional Accreditation. This change acknowledges the organization's assessment while ensuring that all identified compliance issues are corrected within the time frames required for corrective ESC.

Only those organizations submitting full PPR and PPR Option 2 are eligible for this consideration, as they are the only submission types that include the submission of actual compliance issues along with POA and MOS.

PPR Option 1 and PPR Option 3 do not submit identified compliance issues or POA and MOS and therefore are not eligible for this consideration.

http://www.jointcommission.org  
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CORRECTION: Rationale for Standard EC.4.16, for Critical Access Hospitals and Hospitals

This article contains revisions to the rationale for Standard EC.4.16 for critical access hospitals and hospitals. The revised Standard EC.4.16, effective January 1, 2008, was originally published in the June 2007 issue of The Joint Commission Perspectives® (page 8).

The revised rationale is noted in the box below in strike-out and underlined text. These revisions direct organizations to the “Management of Human Resources” (HR) chapter for the process for accepting volunteer practitioners.

CORRECTION: Rationale for Standard EC.4.16, for Critical Access Hospitals and Hospitals

To provide safe and effective patient care during an emergency, staff roles are well defined; staff are oriented and trained in their assigned responsibilities; and staff maintains their competencies over time. Staff roles in emergencies are determined largely by the priority emergencies defined in the Hazard Vulnerability Analysis, and the reporting relationships in the command and control operations of the organization. As such, staff must stand ready to adjust to changes in patient volume or acuity, work procedures or conditions, and response partners within and outside the organization. (Note: Standards MS.4.110 and HR.1.25 in the “Medical Staff” [MS] chapter define the processes for accepting granting privileges to licensed independent practitioners and others as volunteers during emergencies, and standards in the “Management of Human Resources” [HR] chapter define the processes for accepting assigning disaster responsibilities to volunteer practitioners during emergencies.) Staff roles and responsibilities may be documented in the EOP using a variety of formats: job action sheets, checklists, flow charts, etc.

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For technical support of the online version of Perspectives, please email perspectives@jcrinc.com. For all other customer service–related issues, please contact Joint Commission Resources customer service at 800/746-6578.
This article corrects the elements of performance (EPs) referenced in Note 2 of Standard EC.4.20, EP 4 for the critical access hospital, hospital, and long term care programs. The revised Standard EC.4.20, effective January 1, 2008, was originally published in the June 2007 issue of The Joint Commission Perspectives® (pages 9–10). The corrected text for Note 2 is noted in the box below in strikeout and underlined text. The addition of EP 4 in Note 2 is a result of both the renumbering of the EPs for Standard EC.4.20 and the new requirement in EP 3.

**Correction: Standard EC.4.20, Element of Performance 4**

APPLICABLE TO CRITICAL ACCESS HOSPITAL (CAH), HOSPITAL (HAP), AND LONG TERM CARE (LTC) Effective January 1, 2008

Management of the Environment of Care (EC)

Elements of Performance for Standard EC.4.20

A 4. (CAH, HAP, LTC) [Organizations] that have a defined role in the communitywide emergency management program participate in at least one communitywide exercise a year.

Note 1: “Communitywide” may range from a contiguous geographic area served by the same health care providers, to a large borough, town, city, or region.

Note 2: Exercises for EC.4.20, Elements of Performance 2, and 3, and 4 may be conducted separately or simultaneously.

Note 3: Table top sessions are acceptable in meeting the community portion of this exercise.

**Update: Disease-Specific Care Certification Manual**

The Disease-Specific Care Certification manual has been updated and is effective January 1, 2008. The updates made to this manual were based on feedback from the Disease-Specific Care Advisory Council, Joint Commission reviewers, and from issues identified from the field.

The manual updates include the following enhancements:

- Integration of the Advanced Disease-Specific Care Certification requirements with consensus-based national core requirements. This integration eliminates the mapping of requirements to standards and elements of performance (EPs).
- Revised language to clarify standards and EPs.
- Re-ordered standards and EPs, to follow a more logical flow.

A self-assessment scoring grid provided in the margins so certified programs can continuously identify program performance.

No new requirements were added to the standards and EPs. The purpose of the updates was to enhance clarity and logic within the standards and EPs and to promote ease of use by organizations and reviewers.

Certified organizations will receive one complimentary copy of the revised manual, addressed to their C.E.O. The revised manual is currently available for purchase on Joint Commission Resources’ On-line Store at http://www.jcrinc.com, or by contacting customer service at 877/223-6866. For more information on disease-specific care certification, visit The Joint Commission’s Web site at http://www.jointcommission.org/CertificationPrograms/Disease-SpecificCare/, or call 630/792-5291.

[http://www.jointcommission.org](http://www.jointcommission.org)
CORRECTION: National Patient Safety Goal 3, Requirement 3E Applicability

This article corrects applicability for National Patient Safety Goal 3, Requirement 3E. In the July 2007 issue of The Joint Commission Perspectives® (pages 13–14) announcing the 2008 Nationals Patient Safety Goals and Requirements, effective January 1, 2008, Requirement 3E of Goal 3 was inadvertently listed as applicable for the office-based surgery program. This is incorrect.

National Patient Safety Goal 3, Requirement 3E, regarding anticoagulation therapy, is not applicable to the office-based surgery program. This correction in applicability is noted in the box below, with the deletion of the office-based surgery program (“OBS”) noted in strikeout text.

The Implementation Expectations (IEs) that will apply beginning January 1, 2009, are provided below (IEs 1–11).

Implementation Expectations for 3E
A 1. (AHC, HAP, CAH, LTC, OBS, OME) The organization implements a defined anticoagulant management program to individualize the care provided to each patient receiving anticoagulant therapy.

A 2. (AHC, HAP, CAH, LTC, OBS, OME) To reduce compounding and labeling errors, the organization uses ONLY oral unit dose products and pre-mixed infusions when these products are available.

C 3. (AHC, HAP, CAH, LTC, OBS, OME) When pharmacy services are provided by the organization, warfarin is dispensed for each patient in accordance with established monitoring procedures.

C 4. (AHC, HAP, CAH, LTC, OBS, OME) The organization uses approved protocols for the initiation and maintenance of anticoagulation therapy appropriate to the medication used, to the condition being treated, and to the potential for drug interactions.
The Joint Commission Launches New Ventricular Assist Device Certification Program

The Joint Commission has officially implemented its certification program for hospitals that perform ventricular assist device (VAD) surgery as destination therapy.

The Joint Commission will immediately begin conducting thorough on-site reviews of organizations that apply for VAD certification. To date, hundreds of hospitals have expressed interest in this certification program.

Hospitals performing VAD as a destination therapy will receive a certificate of distinction under the Joint Commission’s Disease-Specific Care (DSC) Program for Ventricular Assist Device. These organizations are required to meet DSC standards that address program management, delivering or facilitating care, performance measurement, supporting self management, clinical information systems, and VAD-specific requirements.

The Centers for Medicare & Medicaid Services (CMS) will reimburse for VAD surgery as a destination therapy when it is performed at Joint Commission–certified organizations. Programs that are currently Medicare-approved have until March 27, 2009, to become certified by the Joint Commission. Facilities currently not Medicare-approved will be added to the CMS approval list following certification.

A VAD is used to aid the pumping action of a weakened heart ventricle, a major pumping chamber of the heart. While VADs were originally used on a short-term basis to support failing hearts until donor hearts became available, these devices are now also used as a destination or long-term therapy in severe heart failure patients who are not candidates for heart transplantation.

“The VAD Certification Program will help standardize the care provided for heart patients who are very sick and face limited treatment choices,” says Jean Range, M.S., R.N., C.P.H.Q., executive director, Disease-Specific Care Certification, the Joint Commission. “By focusing on quality and safety, Joint Commission certification will help patients and their families recognize which health care facilities are best equipped to perform this high-risk surgical procedure.”

The VAD standards were developed in consultation with an external task force of experts with relevant experience, and reviewed through a public comment period. For more information about the VAD Certification Program, please contact DSCinfo@jointcommission.org.
New!

Medication Use: A Systems Approach to Reducing Errors
Second Edition

Written by nationally recognized experts, this new edition helps organizations evaluate and improve their medication use systems by providing guidance on using a systems approach to medication use. This systems approach includes defining and preventing medication errors; measuring and monitoring the medication use system; and incorporating physicians, nurses, pharmacists, caregivers, and patients into the medication use system.

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