Joint Commission Annual Report Names Top-Performing Hospitals

Accountability Measures Demonstrate Impact on Care

For the first time, The Joint Commission’s 2011 annual report on quality and safety lists those hospitals and critical access hospitals that are top performers in using evidence-based care processes closely linked to positive patient outcomes. The 405 organizations identified as attaining and sustaining excellence in accountability measure performance for the full previous year (2010) represent approximately 14% of Joint Commission–accredited hospitals and critical access hospitals that report core measure performance data, according to Improving America’s Hospitals: The Joint Commission’s Report on Quality and Safety 2011.

“The public expects transparency in the reporting of performance at the hospitals where they receive care, and The Joint Commission is shining a light on the top-performing hospitals that have achieved excellence on a number of vital measures of quality of care,” says Mark R. Chassin, MD, FACP, MPP, MPH, president, The Joint Commission. “Hospitals that commit themselves to accreditation-related quality improvement efforts, such as the use of evidence-based treatments, create better outcomes for patients and, ultimately, a healthier nation.”

The Joint Commission report singles out hospitals in 45 states based on performance data submitted in 2010 related to 22 accountability measures for heart attack, heart failure, pneumonia, surgical care, and children's asthma care. The list of top-performing hospitals and the measure set or sets for which the

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In Sight

This column informs you of developments and potential revisions that can affect your accreditation and certification 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.

Currently in Committee or Board Review

- Proposed new and revised standards for influenza vaccination of health care workers in all accreditation programs
- Revisions to telemedicine requirements to align with the Centers for Medicare & Medicaid Services’ (CMS) hospital Conditions of Participation (CoPs) for the critical access hospital and hospital programs

Currently in Field Review

- Proposed new standards for a comprehensive stroke center certification program in the disease-specific care program
- Proposed revision to the emergency management drill requirement for the home care program

Currently in Development

Standards and Goals

- Proposed new standards for children’s hospitals in the hospital program
- Proposed new standards for a comprehensive stroke center advanced certification program in the disease-specific care program
- Proposed revision to the emergency management drill requirement for the home care program
- Proposed new National Patient Safety Goal on alarm management for the ambulatory care, critical access hospital, hospital, long term care, and Medicare/Medicaid Certification–based long term care programs
- Proposed new National Patient Safety Goal on minimizing overuse of treatments, procedures, and tests in the critical access hospital and hospital programs
- Proposed revisions to the patient flow requirements for the hospital program
- Proposed new standards on promotion, prevention, and wellness for the behavioral health care program

Policies and Procedures

- Proposed revisions to the Sentinel Event Policy for all programs
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hospital was recognized are available online at http://www.jointcommission.org/accreditation/top_performers.aspx.

The annual report, which focuses on accountability measures, is an effort to clearly demonstrate performance measures’ impact on improving patient outcomes. Doing so will strengthen the partnerships hospitals have with physicians, nurses, pharmacists, and other clinicians who are engaged in the hard work of improving the processes of care.

What the Data Show
The sixth annual report shows continual improvement over a nine-year period on accountability measures—quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes. For example, the 2010 heart attack care result is 98.4%, up from 86.9% in 2002, meaning that in 2010 hospitals provided an evidence-based heart attack treatment 984 times for every 1,000 opportunities to do so.

The data, drawn from more than 3,000 Joint Commission-accredited hospitals, show the following key results:

1. Significant progress in consistently using evidence-based treatments. Hospital performance on accountability measures improved significantly over time. This improvement has greatly enhanced the quality of care provided in America’s hospitals and has resulted in better patient outcomes. For example, a composite result sums up the results of all individual accountability measures into a single percentage rating and can be calculated at the measure set level or over all reported accountability measures. In 2002, hospitals achieved 81.8% composite performance on 957,000 opportunities to perform care processes related to accountability measures. In 2010, hospitals achieved 96.6% composite performance on 12.3 million opportunities—a nine-year improvement of 14.8 percentage points.

2. Improved quality of care. Hospitals have significantly improved the quality of care provided to heart attack, pneumonia, surgical care, and children’s asthma care patients, according to composite accountability measures results. Composite accountability measures for heart attack and pneumonia care have been compiled since 2002, surgical care since 2005, and children’s asthma care since 2008.

- The 2010 heart attack care result is 98.4%, up from 86.9% in 2002.
- The 2010 pneumonia care result is 95.2%, up from 72.3% in 2002.
- The 2010 surgical care result is 96.4%, up from 82.1% in 2005.
- The 2010 children’s asthma care result is 92.3%, up from 79.8% in 2008.

3. Increased number of high achievers. The percentage of hospitals achieving composite accountability measures greater than 90% has also dramatically improved (see the table at left). In 2010, 91.7% of hospitals achieved 90% compliance, compared to 20.4% in 2002. This composite result includes accountability measures from all measure sets (all those listed in item 2 above).

4. Improvement is still needed. Although hospitals achieved 90% or better performance on most individual process of care measures, the report contends that more improvement is needed. For example, hospitals finished 2010 with relatively low performance on the following two measures introduced in 2005:

- 60.5% performance on providing fibrinolytic therapy within 30 minutes of arrival to heart attack patients
- 77.2% performance on providing antibiotics to immunocompetent intensive care unit pneumonia patients

Further Improvement Opportunities
“While the data across the annual report show impressive gains in hospital quality performance on many specific measures, further improvements can still be made,” says Dr. Chassin. “By

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Coffee with the Crew: Helping CEOs Better Understand Facility Needs

Many CEOs lead hospitals in facilities that were built with Hospital Survey and Construction Act (or Hill-Burton) funds under President Truman. The estimated average age of some health care power plants is 30- to 40-plus years, which is high considering the average equipment life cycle is between 20 to 30 years. So, if a CEO and other leaders haven’t replaced aging equipment because “we can still get one more year out of it” or “I haven’t heard of any problems,” it’s possible that the facility crew is doing a lot of temporary repairs or workarounds that became permanent for equipment that really should be replaced.

Not sure about the condition of your hospital’s current infrastructure? Then George Mills, MBA, FASHE, CEM, CHFM, CHSP, senior engineer for the Standards Interpretation Group of The Joint Commission, recommends as a CEO you should have “coffee with the crew” to learn the status of your facility infrastructure. Mills made this recommendation during a presentation at Joint Commission Resources’ Hospital Executive Briefings in September.

Over the past few months, The Joint Commission has introduced both leaders and facility managers to the idea of “Coffee with the Crew” as a way to promote a relaxed and non-confrontational interaction between organization leaders and facility management staff. Hospital leaders are encouraged to take the initiative by calling their facility management staff to set a time to have coffee with the facility team and informally talk about the status of the infrastructure. “We are encouraging organization leaders and facility staff to pursue this type of interaction regularly or at least to try it,” says Mills. “Both groups don’t really communicate enough with each other. This initiative is about building relationships. If you try it, I think it will be a learning experience that benefits both leadership and those that maintain the facility.”

In these relaxed gatherings, CEOs can tour the facilities’ infrastructure while discussing a variety of issues, including the following:

- The current condition of the power plant, fire protection system, and overall facility infrastructure
- Specific vulnerabilities that facility staff are concerned about
- Concerns about equipment reliability and efficiency
- Possible emergency management risks
- Facilities staff accomplishments (for example, internal projects that saved money instead of outsourcing)
- Cleanliness of mechanical areas and the boiler room
- Staff ideas for energy and other cost savings

The tour isn’t an opportunity for facility staff to lecture or present a laundry list of complaints; instead, it should be an informal opportunity for organization leaders to ask questions and learn more about the facility and infrastructure, says Mills. For example, if the CEO sees the rust at the bottom of the facility’s 30-year-old air handler, it can reinforce the need for a new system without facility staff having to draft a long report or lecture about its importance. “The CEO seeing how equipment is being repeatedly patched together can have a powerful impact,” Mills says. “Sometimes equipment gets fixed that should be replaced. Leaders need to know about these instances.”

Viewing the equipment can help CEOs better understand the organization’s short- and long-term facility needs, which is useful to know during the budget process. The tour and coffee gathering also allows the CEO to answer questions from the crew. “The crew could have questions about how the organization is doing financially or how infrastructure projects have been considered in the organization’s overall strategic plan,” says Mills. “A CEO taking the time to have coffee with the crew will show staff that senior leadership cares.”

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Following evidence-based care processes, hospitals can improve quality of care and meet national mandates regarding performance. The Joint Commission will continue to seek new methods to inspire and assist hospitals in providing safe and effective care of the highest quality and value.”

One such effort is the integration of performance expectations for accountability measures into accreditation standards. Beginning January 1, 2012, Joint Commission–accredited hospitals will be required to meet new Performance Improvement (PI) Standard PI.02.01.03, Element of Performance 1, which establishes an 85% composite compliance target rate for performance on accountability measures. The new requirement is intended to help improve performance on selected core measures of patient care. This standard will not apply to critical access hospitals.

Download a copy of the Joint Commission’s 2011 annual report at the Joint Commission Web site at http://www.jointcommission.org./
Joint Commission Adds Accountability Measures for 2011

Four 2010 Non-accountability Measures Will Be Retired

The Joint Commission has completed an evaluation of its process measures (excluding those in the perinatal care test measure set) and has designated 22 new accountability measures in 2011. Those additional measures are listed in the box below. A complete list of the total 44 measures designated as accountability measures to date by The Joint Commission can be found at http://www.jointcommission.org/assets/1/6/ACCOUNTABILITY_MEASURES_August_2011_rev.pdf.

The Joint Commission will continue to re-examine all process (for example, proportion and ratio) measures categorized as accountability measures to ensure they continue to meet the accountability criteria. Also, accountability criteria are being developed for outcomes measures.

The perinatal care test measure set, anticipated to be re-examined in 2012, contains three process and two outcome measures. The measure set was derived from the National Quality Forum Perinatal Project and was adapted by The Joint Commission for use as ORYX® core measures. The Joint Commission began planned, formal reliability testing of the perinatal care test measures in September 2011. After testing is completed in early 2012, the test measures will be re-examined as accountability measures.

Measures to Be Retired

In June 2010, it was determined that all but six of the 28 Joint Commission core measures that were aligned with the Centers for Medicare & Medicaid Services (CMS) measures met The Joint Commission's criteria to be designated as accountability measures. Now, it has been determined that four of these six non-accountability measures that are common to CMS and The Joint Commission will be retired, effective with December 31, 2011, discharges.

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The Joint Commission provided input to CMS on the eight measures it proposed for retirement, including four non-accountability measures and four accountability measures. As reported by Jerod M. Loeb, PhD, executive vice president for Healthcare Quality Evaluation at The Joint Commission, at the Hospital Executive Briefings in September, CMS’s final rule on August 1 determined that four non-accountability measures would be retired and four measures would be suspended. The four non-accountability measures being retired include three smoking cessation advice/counseling measures—for heart attack, heart failure, and pneumonia care—and the measure for antibiotic within six hours of hospital arrival for pneumonia care.

CMS will suspend data collection beginning with January 1, 2012, discharges on three measures for heart attack care—aspirin at arrival, use of angiotensin converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARBs) for left ventricular systolic (LVS) dysfunction, and beta blocker prescribed at discharge—and appropriate hair removal in the surgical care improvement measure set. The Joint Commission will not suspend data collection on these four accountability measures. Rather, according to Loeb, continued data collection and reporting on these critical accountability measures will provide evidence that CMS could use in the future to confirm that organizations continue to perform these functions consistently.

After December 31, 2011, there will be two remaining non-accountability core measures:
1. Discharge instructions (heart failure care)
2. LVS function assessment (heart failure care)

The Joint Commission will continue to support those measures that are in common with CMS and will work with CMS to consider retiring the two remaining non-accountability measures.

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**Sentinel Events Statistics for First Half of 2011**

**Communication and Patient Assessment Remain Primary Factors**

The Joint Commission’s sentinel events statistics have been updated to include the first six months of 2011 and are now available on the Joint Commission Web site at [http://www.jointcommission.org/sentinel_event_statistics_quarterly/](http://www.jointcommission.org/sentinel_event_statistics_quarterly/).

Since implementation of the sentinel event database in January 1995, The Joint Commission has received 7,922 reports of sentinel events. A total of 4,909 patients were affected by these events, with 3,032, or 61.8%, resulting in patient death. The 10 most frequently reported sentinel events for the first six months of 2011 are shown in the box to the right.

By identifying causes, trends, settings, and outcomes of sentinel events, critical information can be learned which may help prevent sentinel events. Preliminary assessment of the updated data shows that among frequently identified root causes, spanning several types of events, are the following:
1. Communication (including verbal, written, and electronic; among health care teams and with patients and families)
2. Patient assessment (such as patient observation protocols, scope of an assessment tool, timing of the assessment)

“We recognize that there are multiple factors which contribute to any patient safety incident. And, there are multiple processes and systems that, when improved, play a role in preventing or mitigating occurrences,” says Anita Giuntoli, director of the Office of Quality Monitoring at The Joint Commission. “Organizations are increasingly aware that the complexities in health care delivery inherently bring risk. Thus, a multi-faceted, systems approach can help toward learning, and improving.”

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**Top Reported Sentinel Events, January–June 2011**

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Cases Reported, January–June 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal death/injury</td>
<td>18</td>
</tr>
<tr>
<td>Medication error*</td>
<td>19</td>
</tr>
<tr>
<td>Criminal event</td>
<td>23</td>
</tr>
<tr>
<td>Other unanticipated event*</td>
<td>31</td>
</tr>
<tr>
<td>Falls*</td>
<td>42</td>
</tr>
<tr>
<td>Suicide</td>
<td>49</td>
</tr>
<tr>
<td>Delay in treatment*</td>
<td>59</td>
</tr>
<tr>
<td>Wrong-patient, wrong-site, wrong-procedure</td>
<td>67</td>
</tr>
<tr>
<td>Operative/post-operative complication</td>
<td>67</td>
</tr>
<tr>
<td>Unintended retention of a foreign body</td>
<td>76</td>
</tr>
</tbody>
</table>

*Resulting in death or major permanent loss of function
On-site Survey Experience Can Be Educational for Nursing Students

Some Joint Commission–accredited organizations do not allow nursing students in the facility after a Joint Commission surveyor arrives for an on-site survey. The organization usually contacts the college or university staff to request that nursing students not be on location so they do not “get in the way” of the survey. However, an on-site survey can be, in fact, a positive, educational experience for nursing students if an organization properly plans, says Dr. Geraldine Bednash, RN, FAAN, member of The Joint Commission 2011 Nursing Advisory Council, and CEO and Executive Director, American Association of Colleges of Nursing, Washington, DC.

“I’ve heard from many deans and faculty who repeatedly mention that a health care organization asks them not to have (nursing) students present when an on-site survey is about to occur or is still going on,” says Bednash. “That is a tremendous loss for the students. The issue is to try to prepare a workforce who understands the importance of Joint Commission accreditation and how it fits in with delivering quality patient care.”

By learning about the accreditation and survey process, nursing students can better understand a nurse’s critical role in providing safe, high-quality care and helping the overall health care organization set the stage for best practices. Students can see clinical care from a process flow perspective across sites and services and how all the organization’s parts affect the bedside delivery of care, says Julianne Morath, RN, MS, the 2011 Joint Commission Nursing Advisory Council Chair, nurse-at-large representative on The Joint Commission’s Board of Commissioners, and Chief Quality and Patient Safety Officer, Center for Clinical Improvement, Vanderbilt University Medical Center, Nashville.

Preparation for the Future Workforce

Bednash and Morath encourage accreditation liaisons and chief nursing officers to talk with their organization leaders about how nursing students could positively benefit from witnessing the ongoing continuous compliance activities and even the organization’s environment during an on-site survey. The following are some examples of how organizations can involve nursing students in the accreditation process:

- A nursing student can shadow a full-time staff member in charge of gathering data about infection control surveillance or performance improvement. This can help a student understand clearly how an organization's data collection policy is put into action through daily or weekly tasks.
- A nursing student can attend a committee meeting to observe staff from multiple departments discussing how the organization makes decisions on how best to provide safe, high-quality care and, in turn, stay prepared for an on-site survey.
- The organization’s accreditation liaison can show nursing students examples of Joint Commission standards such as those in the “Medication Management” and “Infection Prevention and Control” chapters. The liaison can also explain what the accreditation award means for the organization and its importance to safe, high-quality care.
- If an organization conducts its own mock tracers, a nursing student can see how a staff member uses a patient’s open or closed medical record to follow the patient’s path of care through the organization. Observing an interview between the mock surveyor and staff member can help the student see the correlation between Joint Commission requirements and a nurse’s everyday responsibilities to provide quality patient care.
- If a nursing student is on site when a surveyor arrives, he or she can watch how other staff members continue to do their jobs while a surveyor observes care and patient interactions. It is enlightening to see how staff can converse comfortably with a surveyor without being overly anxious.

“The key is for the organization and nursing school faculty to work together to determine how to involve the nursing students in some or all stages of accreditation preparation and compliance so students can be engaged and ask questions,” says Morath. “Students shouldn’t be sitting on the edge of the process. Involve them and let them know what is occurring and why. Having the opportunity to work side by side with nursing leadership and staff while observing the preparation for and interactions during survey can demystify the accreditation experience.”

http://www.jointcommission.org
New Joint Commission Sentinel Event Alert Issue 47 warns health care organizations to seek new ways to reduce exposure to repeated doses of harmful radiation from diagnostic procedures. The Alert also urges greater attention to the risk of long-term damage and cumulative harm if a patient is given repeated doses of diagnostic radiation.

“Diagnostic imaging is a necessary medical tool, but it must be used with great care,” says Mark R. Chassin, MD, FACP, MPP, MPH, president, The Joint Commission. “Although there is still debate about how much is too much radiation, and the time frame within which radiation can be safely administered, the recommendations in this Alert give health care organizations practical strategies to make sure that patients get the right diagnostic imaging tests with the lowest dose of radiation needed to make a diagnosis. In addition, The Joint Commission’s standards support the use of safe and effective diagnostic radiation and promote a safety culture, which is necessary for the safe use of diagnostic radiation.”

Sentinel Event Alert Issue 47, published here in its entirety is part of a series of Alerts issued by The Joint Commission. It can be found on the Joint Commission Web site, along with previously released Alerts, at http://www.jointcommission.org/sentinel_event.aspx.

Sentinel Event Alert 47: Radiation Risks of Diagnostic Imaging

Diagnostic radiation is an effective tool that can save lives. The higher the dose of radiation delivered at any one time, however, the greater the risk for long-term damage. If a patient receives repeated doses, harm can also occur as the cumulative effect of those multiple doses over time.1–3 Conversely, using insufficient radiation may increase the risk of misdiagnosis, delayed treatment, or, if the initial test is inadequate, repeat testing with the attendant exposure to even more radiation.4 The risks associated with the use of ionizing radiation in diagnostic imaging include cancer, burns, and other injuries.1,5–7 X-rays are officially classified as a carcinogen by the World Health Organization’s International Agency for Research on Cancer, the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention, and the National Institute of Environmental Health Sciences.1

Over the past two decades, the U.S. population’s total exposure to ionizing radiation has nearly doubled.8 Diagnostic imaging can occur in hospitals, imaging centers, physician and dental offices, and any physician can order tests involving exposure to radiation at any frequency, with no knowledge of when the patient was last irradiated or how much radiation the patient received. From the 72 million computerized tomography (CT) scans performed in the U.S. during 2007, one study estimated that 29,000 future cancers and 14,500 future deaths could develop due to radiation (cancer incidence = 0.04%).9 Another study estimates the incidence of cancer related to CT radiation at 0.02 to 0.04 percent.10 While these studies’ conclusions rely upon some currently unverified scientific assumptions—namely, a linear relationship between radiation dose and risk even at very low exposures—they do highlight the need to maintain radiation doses as low as reasonably achievable when obtaining needed diagnostic information.

While experts disagree on the extent of the risks of cancer from diagnostic imaging, there is agreement that care should be taken to weigh the medical necessity of a given level of radiation exposure against the risks, and that steps should be taken to eliminate avoidable exposure to radiation.7 Patients most prone to harm from diagnostic radiation are children and young adults;11 pregnant women;12 individuals with medical conditions sensitive to radiation, such as diabetes mellitus and hyperthyroidism;6 and individuals receiving multiple doses over time.2 The diagnostic procedures most commonly associated with avoidable radiation doses are CT, nuclear medicine, and fluoroscopy.13 This Sentinel Event Alert focuses on diagnostic radiation and does not cover therapeutic radiation or fluoroscopy. While fluoroscopy is used diagnostically, there are special issues associated with its use that make it inappropriate to be included here.

As a result of the potential dangers associated with ionizing radiation, the Centers for Medicare & Medicaid Services (CMS) will require the accreditation of facilities providing advanced imaging services (CT, magnetic resonance imaging [MRI], positron emission tomography [PET], nuclear medicine) in non-hospital, freestanding settings beginning January 1, 2012. In addition, the state of California has mandated that...
facilities that furnish CT X-ray services become accredited by July 1, 2013. This California law also requires the documentation of the dose of each CT exam; annual verification of each dose by a medical physicist; and reporting dose errors to patients and physicians. In addition, in May, the American College of Radiology (ACR) launched its Dose Index Registry (DIR), a warehouse of ACR registry databases that compares radiology facilities regionally and nationwide according to facility type. The fee-for-service registry includes a tool that can be used to target specific areas for improving practice.

**Addressing Contributing Factors to Eliminate Avoidable Radiation Dosing**

There are actions that organizations can take to eliminate avoidable radiation. First, staff should be aware of the contributing factors to, and activities that can help eliminate, avoidable radiation doses, which include the following:

- A comprehensive patient safety program, including education about dosing in imaging departments.
- Awareness of the potential dangers from diagnostic radiation among organization leadership, hospital staff, and patients.
- Adequate awareness among physicians and other clinicians about the levels of radiation typically used and related risks.1,6,14,15
- Training on how to use complex new technology.4
- Guidance in the appropriate use of potentially dangerous procedures and equipment.16
- Adequately trained and competent staff.
- Knowledge regarding typical doses.
- Clear protocols that identify the maximum dose for each type of study.
- Consulting with a qualified medical physicist when designing or altering scan protocols.
- Communication among clinicians, medical physicists, technologists and staff.
- Safety, operational, and functional checks of the equipment before initial use and periodically thereafter.

**Joint Commission–Suggested Actions**

Health care organizations can reduce risks due to avoidable diagnostic radiation by raising awareness among staff and patients of the increased risks associated with cumulative doses and by providing the right test and the right dose through effective processes, safe technology, and a culture of safety.

**Right test**

1. In order to reduce the exposure of the patient to ionizing radiation, use other imaging techniques, such as ultrasound or MRI, whenever these tests will produce the required diagnostic information at a similar quality level.17

2. Create and implement processes that enable radiologists to provide guidance to and dialogue with referring physicians regarding the appropriate use of diagnostic imaging using the ACR’s Appropriate Criteria.17

**Right dose**

3. Adhere to as low as reasonably achievable (ALARA) guidelines as required by the Nuclear Regulatory Commission. ALARA involves making sure doses are as low as possible while achieving the purposes of the study.18

4. Adhere to the Society for Pediatric Radiology’s Image Gently guidelines when providing imaging radiation (or fluoroscopy) to children11,19,20 and, for adults, adhere to the Image Wisely guidelines (developed by the ACR and the Radiological Society of North America in collaboration with the American Association of Physicists in Medicine and the American Society of Radiologic Technologists).22

5. Provide physicians and technologists with reference doses based on anatomy, purpose of the study, and patient size. Establish appropriate dose ranges for high-volume and high-dose diagnostic imaging studies.

6. Radiologists should assure that the proper dosing protocol is in place for the patient being treated.

7. Institute a process for the review of all dosing protocols either annually or every two years to ensure that protocols adhere to the latest evidence.

8. Investigate patterns outside the range of appropriate doses. Track radiation doses from exams repeated due to insufficient image quality or lack of availability of previous studies to identify the causes. Address and resolve these problems through education and other measures.4

9. Record the dosage or exposure as part of the study's summary report of findings.

**Effective Processes**

10. Create and implement policies and procedures delineating those responsible for approving changes to password-protected diagnostic imaging protocols and for monitoring new developments in diagnostic imaging. Provide for over-
New Alert Warns of Risks from Diagnostic Imaging (continued)

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sight of these policies and procedures and related activities, including control of the password, by a multidisciplinary group with expertise in radiation (such as a radiation safety committee), including a medical physicist.4

11. Develop and implement policies and procedures that delineate physical protective risk reduction measures to be taken by staff delivering radiation to patients, including appropriate lead shielding for both patients and employees and radiation-protection training for all technologists.4,21

12. Expand the radiation safety officer's role to explicitly include patient safety and involve the officer in the organization's patient safety committee.

13. Ensure all physicians and technologists who prescribe diagnostic radiation or use diagnostic radiation equipment receive dosing education and are trained on the specific model of equipment being used.4,17,21 Institute a process for annual education, review and competency testing.

See relevant Joint Commission requirements: Standards HR.01.02.01, HR.01.02.05, HR.01.04.01, HR.01.05.03 (all programs), HR.02.02.01 (ambulatory), MS.03.01.01, MS.03.01.03, MS.06.01.03 (hospital)

Safe technology

14. Perform an organization-wide audit/survey of diagnostic imaging equipment that have the potential of emitting high amounts of cumulative radiation (related Standard EC.02.04.01, EP 2). Implement a system for centralized quality and safety performance monitoring of this inventoried equipment under the supervision of a qualified medical physicist or your organization's multidisciplinary group with radiation expertise or both. (This equipment may no longer solely be within the province of the radiology department and may be located within a variety of hospital or clinical departments, including the cardiac catheterization suite and the operating room. In the ambulatory setting, this equipment may be found in physician or dental offices.)

15. Have a qualified medical physicist test all diagnostic imaging equipment initially and at least annually or every two years thereafter to assure proper installation and calibration, and review scanning protocols and doses.4 Such tests should be conducted in accordance with applicable state and federal laws and regulations. Where no such regulations exist, tests should be conducted in accordance with the applicable standards as promulgated by the American Association of Physicists in Medicine.4

16. Ensure that recommended quality control, testing (including daily functional tests) and preventive maintenance activities are performed in accordance with manufacturer's guidelines. The health care organization, in consultation with the medical physicist, should identify in writing these activities, their frequencies, and who will perform them.

17. Invest in technologies that optimize or reduce dose.4,19,22,23 See relevant Joint Commission requirements: Standards EC.02.02.01, EC.02.04.01, EC.02.04.03, EC.04.01.01 through EC.04.01.05 (all programs); EC.02.04.01, EP 7, and EC.02.04.03, EP 15 (ambulatory)

Safety culture

18. Use the following Joint Commission standards to support the use of safe and effective diagnostic radiation: Standards LD.03.01.01, LD.03.04.01, LD.03.05.01, LD.03.06.01 (all programs). The concepts in these standards promote a safety culture, which is necessary for the safe use of diagnostic radiation. A safety culture is expressed in the beliefs, attitudes, and values of an organization's employees regarding the pursuit of safety. It is present in the organization's structures, practices, controls, and policies, which are used to achieve greater safety.

For more information about safety culture, see Sentinel Event Alert Issue 43: Leadership committed to safety.

In addition, The Joint Commission:

19. Endorses the creation of a national registry to track radiation doses as the start of a process to identify optimal and reference doses.1,7,16

20. Encourages manufacturers to incorporate dosage safeguards into equipment and to capture dose information in the patient's electronic medical record and national dose registry.13

21. Supports stricter regulations designed to eliminate avoidable imaging and monitor the appropriateness of self-referred imaging studies (referral of a patient to a facility in which the referring physician has a financial interest).16

This Alert's content is based in part on input from the following: Jason H. Launders, senior project officer and medical physicist, ECRI Institute; Ronni Solomon, executive vice president and general counsel, ECRI Institute; Frank Federico, executive director, Strategic Partners, Institute for Healthcare Improvement; and W. Geoffrey West, PhD, DABR, CHP, president and chief medical physicist, West Physics Consulting, LLC.

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Applicability Identified for Long Term Acute Care Hospitals

The Joint Commission has added long term acute care hospitals to the “Standards Applicability Grid” (SAG) chapter in the 2011 Update 2 to the Comprehensive Accreditation Manual for Hospitals (CAMH) published in October and the E-dition® update to be released in November. As mentioned in the July issue of Perspectives® (page 8), the new SAG chapter identifies relevant elements of performance (EPs) based on a hospital’s services and includes applicability for acute care, psychiatric, and surgical specialty hospitals—and now long term acute care hospitals.

E-dition provides a filtered list of applicable EPs for hospitals when users click on “Service Profile” in the upper right corner of the Web site and then select the appropriate hospital type. The list of applicable EPs can also be obtained by clicking on “Accreditation Process Information” on the left side navigation bar and then selecting “Standards Applicability Process.”

For more information, please contact Laura Smith, associate project director, Division of Healthcare Quality Evaluation, The Joint Commission, at lsmith@ jointcommission.org.

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References

Resources
Coming Soon!

Accreditation and Certification Resources for 2012

Pre-order the Joint Commission accreditation and certification resources that feature everything your organization needs for continuous compliance. Each manual integrates the applicable standards, National Patient Safety Goals, rationales, elements of performance, scoring, decision rules, and policies and procedures.

Check out http://www.jcrinc.com/2012-Accreditation-and-Certification-Manuals/ for the products we have to offer, including the following:

- Comprehensive Accreditation Manuals (available December 2011)
- Subscription Update Services (released in Spring and Fall 2012)
- Accreditation Standards Books (available November 2011)
- Accreditation Process Guide for Hospitals (available December 2011)
- Certification Manuals (available now)
- New! Disease-Specific Care Certification Workbook (e-book available November 2011)
- New! Joint Commission and CMS Crosswalk (available January 2012)

Visit our Web site at http://www.jcrinc.com or call our toll-free Customer Service Center at 877/223-6866. Our Customer Service Center is open from 8 A.M. to 8 P.M. ET, Monday through Friday.

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