

Facts about patient safety

The Joint Commission is committed to improving safety for patients and residents in health care organizations. This commitment is inherent in its mission to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. At its heart, accreditation is a risk-reduction activity; compliance with standards is intended to reduce the risk of adverse outcomes. JCAHO demonstrates its commitment to patient safety through numerous efforts that include:

- Setting state-of-the-art standards
- Enforcing its Sentinel Event Policy
- Issuing *Sentinel Event Alert*
- Establishing National Patient Safety Goals
- Sponsoring the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Patient Surgery™
- Monitoring sentinel event responses
- Providing educational resources
- Disseminating Speak Up consumer information
- Supporting safety-related legislative initiatives

Patient safety-related standards

Almost 50 percent of JCAHO standards are *directly* related to safety, addressing such issues as medication use, infection control, surgery and anesthesia, transfusions, restraint and seclusion, staffing and staff competence, fire safety, medical equipment, emergency management, and security. Additional patient safety standards went into effect for hospitals in 2001, and similar standards went into effect for behavioral health care and long term care organizations in 2003, and for ambulatory care and home care organizations in 2004. These standards address a number of significant patient safety issues, including the responsibility of organization leadership to create a culture of safety; the implementation of patient safety programs; the response to adverse events when they occur; the prevention of accidental harm through the prospective analysis and redesign of vulnerable patient systems (e.g. the ordering, preparation and dispensing of medications); and the organization's responsibility to tell a patient about the outcomes of the care provided to the patient—whether good or bad.

Sentinel Event Policy

JCAHO's Sentinel Event Policy, implemented in 1996, is designed to help health care organizations to identify sentinel events and take action to prevent their recurrence. A sentinel event is an unexpected occurrence involving death or serious physical—including loss of limb or function—or psychological injury, or the risk thereof. "Risk thereof" means that, although no harm occurred this time, any recurrence would carry a significant chance of a serious adverse outcome. Any time a sentinel event occurs, the health care organization is expected to complete a thorough and credible root cause analysis, implement improvements to reduce risk, and monitor the effectiveness of those improvements. The root cause analysis is expected to drill down to underlying organization systems and processes that can be altered to reduce the likelihood of a failure in the future and to protect patients from harm when a failure does occur. The Sentinel

Event Policy also encourages organizations to report to JCAHO sentinel events that have resulted in death or serious injury, along with their root causes and related preventive actions, so that JCAHO can learn about the underlying causes of the sentinel events, share “lessons learned” with other health care organizations, and reduce the risk of future sentinel event occurrences. For questions about the Sentinel Event Policy, organizations can call JCAHO’s Sentinel Event Hotline, (630) 792-3700.

Sentinel Event Alert

Sentinel Event Alert is a periodic newsletter that identifies specific sentinel events, describes their common underlying causes, and suggests steps to prevent occurrences in the future. Information for *Sentinel Event Alert* comes mainly from JCAHO’s sentinel event database, as well as from experts and other organizations. JCAHO’s database includes the sentinel events that have been reported to JCAHO, the root causes of these events, and strategies that health care organizations have used to reduce risk to patients. JCAHO began publishing *Sentinel Event Alert* in 1998 in order to share the most important “lessons learned” from its database and provide important information relating to the occurrence and management of sentinel events in health care organizations. *Sentinel Event Alert* has raised awareness in the health care community and the federal government about the occurrence of adverse events and ways that these events can be prevented in the future. Past issues are available on JCAHO’s website, www.jcaho.org. Topics have included medication errors, wrong-site surgery, restraint-related deaths, blood transfusion errors, inpatient suicides, infant abductions, fatal falls and operative/post-operative complications.

Sentinel Event Advisory Group

In April 2002, JCAHO appointed a group of experienced physicians, nurses, pharmacists and other patient safety experts to advise JCAHO in the development of its first set of National Patient Safety Goals (NPSGs). Named for JCAHO’s widely read patient safety advisory, the Sentinel Event Advisory Group conducts thorough reviews of all *Alert* recommendations and identifies those that are candidates for inclusion in the annual NPSGs. The NPSGs recommended by the Advisory Group are forwarded to JCAHO’s Board of Commissioners for approval.

National Patient Safety Goals

In July 2002, JCAHO approved its first set of six National Patient Safety Goals (NPSGs) with 11 related specific requirements for improving the safety of patient care in health care organizations. All JCAHO accredited health care organizations are surveyed for implementation of the goals and requirements—or acceptable alternatives—as appropriate to the services the organization provides. The goals and requirements are drawn from a “pool” of recommendations identified by the Sentinel Event Advisory Group as evidence- or consensus-based, cost-effective and practical. Each year, new recommendations from *Sentinel Event Alert* newsletters published in the previous year are added to the pool. Future requirements will be drawn from the pool. In 2004, JCAHO began developing program-specific NPSGs for each of its accreditation and certification programs in order to make the goals and requirements more relevant to the non-hospital accreditation programs. In the development of these program-specific NPSGs, JCAHO is taking a two phase approach: Phase I involved “editing” the 2004 NPSGs to make them more applicable to each accreditation and certification program. Phase II will involve identifying one or two new program-specific evidence- or experience-based goals and requirements to be implemented in 2005, along with the “core” NPSGs. The Sentinel Event Advisory Group will also review these proposed program-specific NPSGs.

The Universal Protocol

In July 2003, JCAHO’s Board of Commissioners approved the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™. The Universal Protocol was created to address the

continuing occurrence of these tragic medical errors in JCAHO accredited organizations. Compliance with the Universal Protocol by all accredited hospitals, ambulatory care and office-based surgery facilities is currently being strongly encouraged and will be required beginning July 1, 2004. The Universal Protocol draws upon, and expands and integrates, a series of existing requirements under JCAHO's 2003 and 2004 National Patient Safety Goals. It will be applicable to all operative and other invasive procedures. The principal components of the Universal Protocol include: 1) the pre-operative verification process; 2) marking of the operative site; 3) taking a 'time out' immediately before starting the procedure; and 4) adaptation of the requirements to non-operating room settings, including bedside procedures. The protocol is endorsed by nearly 50 professional health care associations and organizations.

Office of Quality Monitoring

JCAHO's Office of Quality Monitoring receives, evaluates and tracks complaints and reports of concerns about health care organizations relating to quality of care issues. Information often comes from patients, their families or the public, as well as from an organization's own staff, government agencies and others. The Office has a toll free hot line, (800) 994-6610, and also receives written reports by mail or e-mail. When a report is submitted, JCAHO reviews any past reports and the organization's most recent accreditation decision. Depending on the nature of the reported concern, JCAHO will take one of the following actions:

- Incorporate the reported concern into the quality monitoring database that is used to track health care organizations over time to identify trends or patterns in their performance.
- Ask the organization to provide a written response to the reported concern.
- Review the reported concern and compliance with related standards at the time of the organization's next accreditation survey, if it is scheduled in the near future.
- Conduct an unannounced on-site evaluation of the organization if the report raises serious concerns about a continuing threat to patient safety or continuing failure to comply with standards.

Patient safety resources

Joint Commission Resources (JCR) is a not-for-profit subsidiary of JCAHO that provides services independently and confidentially, disclosing no information about its clients to JCAHO or others. JCR offers a number of seminars, programs, publications, web-based training, good practices, custom education and consultation on patient safety, including: environment of care, restraint and seclusion, failure mode and effects analysis, prevention of medical errors, medication use, preventing sentinel events, risk reduction strategies, and how to conduct root cause analyses. JCR publishes *Joint Commission Perspectives on Patient Safety*, a monthly newsletter dedicated to providing information on the prevention of errors in health care settings. A bimonthly newsletter, *Environment of Care News*, focuses on patient and facility safety issues. For more information or to place an order, visit JCR's website, www.jcrinc.com, or call the JCR toll-free customer service line at (877) 223-6866. JCAHO's website also provides information on sentinel events and the Sentinel Event Policy; how to complete root cause analyses; sentinel event reporting forms; and issues of *Sentinel Event Alert*.

The Speak Up initiatives

In March 2002, JCAHO, together with the Centers for Medicare and Medicaid Services (CMS), launched a national program to urge patients to take a role in preventing health care errors by becoming active, involved and informed participants on the health care team. The program features brochures, posters and buttons on a variety of patient safety topics. In 2003, the Speak Up initiative was expanded to *Help Prevent Errors in Your Care: For Surgical Patients*. This program includes tips to help patients prepare for surgery and make sure that they have the correct procedure performed at the correct site on their body. In March 2004, *Preparing to be a Living Organ Donor* was launched. This campaign was created to help individuals prepare to become living organ donors and to make the process as safe as possible by

becoming active, involved and informed. It includes basic facts about living organ donation and questions to ask the doctor. More patient safety topics will be addressed in the future, including infection control and stroke.

Legislative efforts

JCAHO believes that it is necessary to create a non-punitive environment in which medical/health care errors and patient safety information can be reported. Since 1997, JCAHO has advised Congress on the need for federal statutory protection of reported information—especially root cause analysis information—and has sought legislation that will facilitate the study and reporting of medical/health care error information by clinician and provider organizations, as well as provide adequate protection of that information from disclosure in civil law suits. Since 1998, JCAHO's sentinel event confidentiality language has been included in proposed legislation. While this language would provide for protection of medical/health care error reporting, final passage has not yet occurred. Following the release of the Institute of Medicine (IOM) report on medical errors in November 1999, JCAHO President Dennis S. O'Leary and others testified in a series of hearings on patient safety before Senate committees. IOM report findings affirm the need to protect patient confidentiality. Since the IOM report, there have been a number of legislative proposals to address patient safety and medical errors, and several bills have been introduced in Congress. On the state level, JCAHO actively works with state regulatory and patient safety authorities to reduce duplicative expectations for accredited organizations subject to voluntary or mandatory reporting requirements.

Patient safety coalitions

JCAHO is involved in coalitions with common interest in a number of issues affecting patient safety, including:

- JCAHO helped form the National Coordinating Council on Medication Error Reporting & Prevention, a coalition comprised of 22 member organizations, including the United States Pharmacopoeia, the American Medical Association and the American Hospital Association. NCC MERP has developed principles for constructing patient safety reporting programs.
- JCAHO is involved in a Medication Error Coalition whose efforts have resulted in the proposed Snowe-Graham legislation that seeks to secure adequate funding to employ the latest technology in hospitals and provide training to support that technology.
- JCAHO was a founding member of the National Patient Safety Foundation (NPSF) and the National Patient Safety Partnership (NPSP). JCAHO serves on the board of the NPSF, which has a clearinghouse of information pertinent to issues in patient safety and funds innovative research dedicated to reducing risk. The NPSP is composed of federal and private bodies hosted by the Veterans Health Administration.
- JCAHO is a member of the National Quality Forum (NQF). JCAHO serves on the NQF's board and is committed to working with the NQF to find a common pathway for creating consensus around nationally agreed upon measures for quality and safety. The NQF has a steering committee, on which JCAHO participates, that has identified a series of serious reportable events to be used by organizations that set up reporting systems, whether voluntary or not. JCAHO's National Patient Safety Goals are designed to align with the NQF's core "safe practices"—all of the seven goals for 2004 align with the safe practices.
- JCAHO is an affiliate of Consumers Advancing Patient Safety (CAPS), a national consumer-led organization formed to be a collective voice for individuals, families and healers who suffer harm in health care encounters. Paul Schyve, M.D., senior vice president, is a member of the Founding Advisors Board of CAPS.