



# Jake's Java Break

## Accreditation Tidbits for Medical Staff Members

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### Have Your Say

There is a current field evaluation of proposed revisions to the **Medication Use Standards** in progress until **28 January 02**. If you would like to see how this works and make suggestions, review the proposed revisions to the Medication Use Standards online: [http://www.jcaho.org/standard/hap\\_meduse\\_fr\\_ltr.html](http://www.jcaho.org/standard/hap_meduse_fr_ltr.html).

#### Standards Development

Standards are derived in consultation with health care experts, providers, purchasers and consumers, and are based on changes in health care, survey data, and input from legislative bodies and professional organizations, to name a few.

### JCAHO Thumbnail Sketch

#### What is JCAHO, anyway?

The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), inception in 1951, recently revised its mission “to continuously improve **the safety** and quality of care provided to the public.” To earn accreditation based on adherence to its standards, organizations participate in risk-reduction activities by striving to continuously improve the services they provide and by examining systems and processes for risk factors that may lead to medical errors.



### JCAHO-Speak

#### What are all those letters and numbers in the proposed Medication Use Standards?

Standards are organized in the Comprehensive Accreditation Manual for Hospitals as follows: LL.N.N.N.N (two letters followed by a series of up to 4 sets of numbers. “TX” signifies Care of Patients standards in the Patient-Focused Functions. “TX.3” standards describe appropriate medication use processes in the organization. Standards labeled “TX.3.N” and “TX.3.N.N” are subordinate standards in that category.



### Medical Staff Issues

#### Many JCAHO Survey “Dings” Stem from Ordinary Medical Staff Actions

Did you know that seven of the top ten most common Type I recommendations hospitals received nationwide the first half of 2001 had to do with aspects of medical care and documentation largely under the direct control of physicians? The standards for these seven medical-staff-related issues were:

- Delinquency of medical records
- Timeliness of verbal order signatures
- Medication control (such as narcotics on an anesthesia cart)
- H&P on chart within 24 hours and is  $\leq$  30 days old
- H&P on chart before surgery, and of quality (legible and clinically pertinent)
- Post-operative note physically on chart immediately after surgery
- Pre-procedural assessment of a patient is documented before anesthesia or sedation occurs

How are these standards evaluated? During a hospital survey, JCAHO surveyors select a small number of both “open” records of patients currently hospitalized and of “closed” records of patients previously discharged. Then they look for evidence of compliance with the standards such as those listed above and derive a score based on what they see. The score is determined by a “numerator over denominator” count of those few charts. The sample size is small (perhaps ~10 records), so a missing element on any one record could have a significantly negative effect on the score. Since the purpose of a medical record is to record the timely and safe clinical care of a patient, especially when care is transferred from one provider or care setting to another (e.g., from operating room to post-anesthesia care), we must ensure that good medical care consists not only of delivering appropriate treatment, but also includes maintaining a health record that describes all the information the healthcare team needs for patient care continuity.

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