
WHAT RESIDENTS NEED TO KNOW ABOUT JCAHO ACCREDITATION OF HOSPITALS

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Dr. Christie is a second-year internal medicine resident at a hospital that is due for survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 10 months. Unbeknownst to her, the hospital has arranged a "mock site visit" by a sister hospital to evaluate its readiness for the actual survey.

On the day of the mock visit, Dr. Christie is about to leave the inpatient unit to search for review articles on the treatment of a newly admitted patient when the nursing supervisor asks her to join the treatment staff in a nearby conference room. Dr. Christie learns that the mock surveyors have interviewed her patient and want to discuss the patient's medical record with the treatment staff. When the mock surveyors asked the patient for the name of his doctor, he gave Dr. Christie's name, not the attending physician's. Dr. Christie wonders: "Who are these people? What are they doing here? What do they want with me?"

After the mock visit, senior hospital administrators inform the physician leaders of each department that the exercise was intended to help the hospital staff assess its readiness for the actual JCAHO survey. A meeting with each department, including all residents, is scheduled for 2 weeks later, at which time the senior hospital staff will review the results of the mock visit and discuss plans for preparing for the JCAHO survey. When this information is shared with the rest of the internal medicine department, Dr. Christie overhears someone remark that the whole process seems to be nothing more than a hassle. Reserving her own judgment, Dr. Christie wonders how the accreditation process will affect or involve her and, ultimately, how it affects patient care.

Dr. Christie is about to participate in a professional process that was proposed in 1910 by a surgeon, Dr. Ernest Codman, who pioneered the "end-result system of hospital standardization" to assess outcomes of patient care. In 1918, the American College of Surgeons (ACS) developed its first set of "standards" and began conducting voluntary on-site inspections of hospitals. Thus, it was physicians—joined later by nurses and hospital administrators—who decided to take responsibility for creating safe hospitals and ensuring quality care. In 1951, the American College of Physicians, American Hospital Association, American Medical Association, and Canadian Medical Association (later replaced by the American Dental Association) joined with the ACS to create the JCAHO.

JCAHO is a private, not-for-profit organization that accredits acute care hospitals; ambulatory, behavioral health, long-term, and home health care facilities; clinical laboratories; health care networks; and hospices. Numerous accrediting bodies have been founded in the United States and elsewhere since JCAHO began monitoring the quality of hospitals, but JCAHO remains the largest. JCAHO accredits nearly 20,000 organizations, approximately one third of which are hospitals. More than 80% of all hospitals—accounting for 96% of hospital beds—in the United States are JCAHO accredited.

JCAHO regularly conducts on-site surveys, so clinical trainees are likely to experience JCAHO accreditation at least once during their postgraduate training. By participating in a hospital-wide effort to obtain JCAHO accreditation, a new physician can better appreciate the hospital as a *system* while learning about a national process that assesses how well that hospital supports the overall quality and safety of patient care. Busy practicing physicians often are only vaguely aware of accreditation requirements and the impact that accreditation has on patient care. In fact, many physicians may know only that JCAHO accreditation occurs every few years and that their hospital's administrators remind them to be up-to-date in certain routine chores, perhaps the most annoying of which is ensuring that all medical charts are signed.

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Table 1. Common Policies and Procedures Addressed by JCAHO Accreditation Standards

Protecting patient confidentiality, privacy, and security
Enlisting patient participation in the course of treatment, including obtaining informed consent
Ensuring safe and appropriate prescribing, dispensing, administration, and monitoring of medication
Educating patients and their families
Assessing patients (eg, history and physical examination)
Providing for adequate and competent staff
Documenting patient care in the medical record
Medical staff functioning, including interactions with the organization's administration

JCAHO = Joint Commission on Accreditation of Healthcare Organizations.

However, accreditation has a much broader impact on a physician's function within a health care organization. Making an effort to understand and participate in accreditation-related activities during postgraduate training may facilitate a new physician's transition into practice. The knowledge gained may provide insight into the structure and functions of health care organizations and the professional expectations of physicians related to improving the safety and quality of patient care.

This article describes the JCAHO accreditation process and suggests ways in which residents may be involved in it. The scenario used in the article may not reflect every resident's experience with accreditation. Some residents may have little if any direct involvement with the survey or the preparation for it, but all residents will be affected by their training organization's efforts to obtain JCAHO accreditation. The scenario is intended to illustrate how residents may gain experience from active participation in the accreditation process.

Overview of JCAHO Accreditation

Mission

Since its inception, JCAHO has been dedicated to continuously improving the quality and safety of patient care. At the heart of JCAHO programs are sets of standards with which hospitals and other health care organizations seek to comply; **Table 1** lists common policies and procedures that are addressed by JCAHO accreditation standards. Accreditation is based on the assumption that organizations that meet the standards improve their ability to provide quality patient care—that is, they increase the likelihood of obtaining favorable patient outcomes and decrease the risk of obtain-

ing poor patient outcomes. Many organizations seek accreditation because it indicates their compliance with national standards for safety and quality that have been developed by leading health care professionals.

During the past 15 years, the JCAHO accreditation process has evolved from a generally prescriptive system that focused on organizational structures to one that is flexible and process oriented. The standards and the on-site survey have become increasingly focused on the processes that are most important to the quality and safety of patients. JCAHO welcomes and regularly solicits feedback from health care professionals, accredited organizations, and the public regarding how to improve its accreditation processes. Recent changes to the accreditation process include the addition of requirements for measurement of important processes and outcomes, through ongoing data collection and analysis.

Value and Application

JCAHO accreditation is used in many ways by various interested groups. The federal government uses JCAHO accreditation to license laboratories and to determine whether hospitals, ambulatory surgery centers, home health care organizations, and hospices are eligible to participate in the Medicare and Medicaid programs. Most states use JCAHO accreditation to license hospitals. Managed care plans use JCAHO accreditation to determine whether provider organizations are eligible to participate in their delivery networks. Employers use accreditation by JCAHO (or other accrediting bodies such as the National Committee for Quality Assurance) to determine which health plans to offer to their employees, and the public can use accreditation to choose among health care providers.

As the use of JCAHO accreditation has expanded, those who rely on it have sought to influence how health care organizations are evaluated and to have their perceptions and priorities regarding safety and quality incorporated into the evaluations. Consequently, the governing board and advisory committees of JCAHO and most other accrediting bodies now include employer and consumer representatives, government representatives, and health care practitioners and administrators.

Components of the Accreditation Process

JCAHO accreditation is a voluntary process for which health care organizations must apply. For many, the process is focused on a 10- to 12-month preparatory period, the on-site survey itself, and in most cases a follow-up activity (eg, a survey) approximately 6 months

later, leaving a 2-year interlude during which full compliance with accreditation standards may not be emphasized. The on-site survey is an added cost to health care organizations, which may range from \$15,000 to over \$45,000 for hospitals. On-site surveys often are sources of stress for an organization's staff, but they are designed to accomplish 2 important goals in a relatively short time span: 1) to comprehensively evaluate how well an organization performs important patient care and organization management functions and 2) to simultaneously provide consultation and education in areas requested by an organization's staff or identified by the surveyors [1].

Focus on Systems

During medical school and postgraduate training, the focus is on becoming a knowledgeable and competent physician. In most health care settings, however, physicians are members of a team, which functions within an organization that supports the team's work. Thus, patient outcomes are influenced not only by the performance of individual physicians, but also by the performance of the systems in which they function—that is, the other health care providers (eg, nurses, pharmacists, physical therapists, social workers, other physicians) and the routine policies, procedures, and equipment of the organization. Improving how well physicians and the organizations in which they function perform the processes of care has been shown to increase the likelihood of obtaining favorable outcomes and to decrease the risk of obtaining avoidable adverse outcomes [2].

Therefore, JCAHO uses a “systems” approach to assess how well an organization provides for quality health care and positive patient outcomes. It evaluates both the processes of care and the intermediate outcomes that ultimately lead to patient outcomes. By focusing on processes, JCAHO seeks to evaluate both what a provider organization does for patients and how well it performs those services (ie, the extent to which the organization “does the right things well”). JCAHO accreditation thus is intended to assist health care organizations operate in a manner that requires, facilitates, and protects the quality and safety of patient care. Working with patients and health care professionals, JCAHO has identified 9 dimensions of performance for health care systems (Table 2).

Need for integrated policies and procedures. Health care organizations can improve overall patient care by both establishing reliable and integrated policies and procedures and ensuring that they are followed by hospital staff. Health care teams often adjust their care

Table 2. Dimensions of Performance Monitored by JCAHO Standards

Doing the right thing

The *efficacy* of the procedure or treatment in relation to the patient's condition.

The *appropriateness* of a specific test, procedure, or service to meet the patient's needs.

Doing the right thing well

The *availability* of a needed test, procedure, treatment, or service to the patient who needs it.

The *timeliness* with which a needed test, procedure, treatment, or service is provided to the patient.

The *effectiveness* with which tests, procedures, treatments, and services are provided.

The *continuity* of the services provided to the patient with respect to other services, practitioners, and providers and over time.

The *safety* of the patient and others to whom the services are provided.

The *efficiency* with which care and services are provided.

The *respect and caring* with which care and services are provided.

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approach to meet the individual needs and preferences of patients. To do so confidently, the providers must be able to rely on the consistency and stability of the policies and procedures of the organization in which they operate. For example, patient care may suffer when medical records are documented inconsistently, when nurses' critical observations of patients are not readily available in the medical record, or when physicians' instructions are not communicated clearly and quickly to the nurses and pharmacy. Therefore, health care institutions should strive to develop system-wide policies such as integrated information systems and uniform charting and record-keeping.

Need for an organized medical staff. To function effectively as a system, a hospital needs an organized medical staff. The medical staff includes fully licensed physicians and other licensed individuals who are permitted to provide specific patient care services without clinical direction or supervision [3]. The medical staff typically serves many functions, such as determining or recommending to the hospital's governing board patient care policies, criteria for appointment to the medical staff, and criteria for the granting of specific clinical privileges (eg, to perform cardiac surgery). JCAHO

requires that every 2 years the medical staff reviews individual providers' credentials and performance for the purpose of renewing their clinical privileges. This process is critical for ensuring that the licensed clinical practitioners who provide care within the hospital are competent to do so: The best designed systems are of little help to patients unless the care providers within them are fully qualified and competent.

Most hospitals establish interdisciplinary committees to develop and oversee policies and procedures related to patient care (eg, infection control, surgical review, medical records, performance improvement). Usually, representatives of both the medical staff and hospital administration are appointed to these committees. Knowledge of JCAHO standards is useful to the members of these committees as they seek to improve or supplement patient care programs, facilities, equipment, and staff. In some institutions, residents are encouraged to participate in these committees.

At the internal medicine departmental meeting 2 weeks later, the senior hospital staff discuss the upcoming JCAHO visit and the results of the mock survey. The senior staff in attendance are the hospital's chief executive officer, chief operating officer, chairperson of the governing body, president of the medical staff, vice president for nursing, and chief quality officer (CQO). They explain that JCAHO will be assessing how well the hospital meets the standards outlined in *2000 Hospital Accreditation Standards* [1]; these standards range from basic safety precautions to more specific clinical and process goals.

The senior staff acknowledge that the last survey resulted in "accreditation with recommendations for improvement." They are concerned with determining whether the hospital has held the gains made as a result of the process improvements designed to address those recommendations. Although the senior staff desire to put the hospital's "best foot forward" for the surveyors, they stress the importance that the hospital continually meet the standards for quality patient care and view preparation for the survey as an opportunity to conduct a thorough review of the hospital's processes.

The senior staff further emphasize that the survey process has moved away from evaluating specific clinical departments and services as if they were stand-alone units in the hospital. Rather, JCAHO is more interested in assessing the performance of important patient-centered functions that support the quality and safety of patient care throughout the hospital. As a result, to prepare for the on-site visit, the CQO has

created working groups to address several classes of JCAHO standards, including Assessment and Care of Patients, Patient Education, and Management of Information.

At the close of the meeting, the CQO recommends that resident physicians from several departments participate in these working groups. Dr. Christie is asked to represent the resident staff on the Medical Records Committee of the Management of Information working group. She is concerned that participating on the committee will be a time burden but agrees to the request.

JCAHO Standards

Development of Standards

Many physicians wonder who writes JCAHO standards. When the need for new or revised standards is identified by practicing health care professionals, accredited organizations, professional associations, or consumers, JCAHO actively seeks input regarding the content of the standards (eg, from professional experts, external task forces, and focus groups). Draft standards are then developed and reviewed by appropriate internal committees, revised, posted on the JCAHO Web site, and externally reviewed by thousands of health care professionals and administrators, professional societies and associations, consumer groups, and regulatory agencies. The draft standards are revised based on these external reviews and submitted for final review by a committee of JCAHO's Board of Commissioners, which approves standards for use in the accreditation process.

Types of Standards

JCAHO standards for hospitals fall into 3 functional categories (**Table 3**). The first 2 categories include systems and processes that directly affect patients (patient-focused) or are not apparent to patients but are necessary for patient-focused functions to be effective (organization-focused). The third category describes organizational structures that are critical to the other 2 functional systems and processes. Each standard is identified by a unique number and is described in detail in JCAHO's *2000 Hospital Accreditation Standards* [1]. **Table 4** lists examples of specific hospital standards, along with their accompanying statements of intent.

JCAHO standards generally define the end points of processes, allowing for flexibility and innovation in the way an organization achieves them. That is, the standards specify *what* is to be accomplished, not *how* it should be accomplished. However, JCAHO standards vary somewhat in their degree of flexibility. *Prescriptive standards* often describe specific safety

issues about which there is a general consensus among health care professionals regarding necessary procedures or protocols. Therefore, prescriptive standards allow organizations little leeway for achieving compliance. For example, Care of Patients standard TX.7.1.3.1.7 states that patient restraint or seclusion must be ordered by a licensed independent practitioner [1]. JCAHO allows little flexibility for compliance with this standard, because the safe use of restraint to protect patients or others from harm is an important, specific patient safety issue.

Other JCAHO standards allow an organization much greater flexibility in terms of implementation and compliance. For example, continuous quality improvement is an important element of JCAHO's approach to accreditation. Health care organizations are expected to develop their own methods for identifying processes in need of improvement and for systematically improving those processes. In contrast to the standard regarding patient restraint, Improving Organization Performance standard PI.5 states that improved performance should be "achieved and sustained" [1]. This standard sets a clear expectation for the hospital but allows it to determine which processes require improvement (eg, policies for avoiding medication errors or wrong-site surgeries) and how those processes should be improved.

In fact, most JCAHO standards provide this degree of flexibility, thus allowing the organization to tailor processes to the surrounding organizational systems and to design, evaluate, and implement new processes to improve patient safety and the quality of care. Interested physicians thus have the opportunity to participate in the design and redesign of processes to comply with less prescriptive standards.

At their first meeting, the Medical Records Committee discusses Assessment of Patients standard PE.1.7.1: "The patient's history and physical examination, nursing assessment, and other screening assessments are completed within 24 hours of admission as an inpatient" [1]. Dr. Christie and her resident colleagues frequently have commented that the availability of such information in the medical record varies among clinical services and that its absence makes the provision of effective and efficient patient care more difficult for medical staff. Dr. Christie volunteers to participate on a multidisciplinary team to address this standard.

Several days later, while reviewing information regarding diabetes management in the hospital library, Dr. Christie notices a book titled *How to Meet the Most Frequently Cited Hospital Standards* [4], which is published by JCAHO. In the chapter dealing with

Table 3. Types of JCAHO Standards for Hospitals

Patient-focused functions
Patient Rights and Organization Ethics
Assessment of Patients
Care of Patients
Education
Continuum of Care
Organization-focused functions
Improving Organization Performance
Leadership
Management of the Environment of Care
Management of Human Resources
Management of Information
Surveillance, Prevention, and Control of Infection
Structures with functions
Governance
Management
Medical Staff
Nursing

JCAHO = Joint Commission on Accreditation of Healthcare Organizations. (Data from The Joint Commission on Accreditation of Healthcare Organizations. 2000 Hospital accreditation standards. Oakbrook Terrace [IL]: The Commission; 2000.)

Assessment of Patients standards, she finds several examples that pertain to standard PE.1.7.1. One example describes a multidisciplinary, organization-wide, functional approach for completing the charting requirements within the 24-hour time period that accounts for the needs of various clinical services such as medical/surgical and critical care units. Dr. Christie decides to discuss this information at the next Medical Records Committee meeting, and the response to a perceived need for improvement is initiated.

The JCAHO Hospital Accreditation Process

Preparing for the On-Site Survey

Ideally, a hospital is prepared for JCAHO accreditation at all times, and accreditation dovetails with the hospital's efforts to continuously improve the quality and safety of the patient care it provides. The processes designed to meet JCAHO standards—especially those addressing organizational leadership and performance, information management, and the medical staff—should be established well in advance of the on-site survey such that they are part of the daily functioning of the hospital, including the activities of residents. The accreditation process should be a time to gather information about

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Table 4. Examples of JCAHO Standards

Examples of Assessment of Patients standards

- PE.1.8: Before surgery, the patient's physical examination and medical history, any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record.
- PE.1.8.1: Any patient for whom anesthesia is contemplated receives a preanesthesia assessment.
- PE.1.8.2: Before anesthesia, the patient is determined to be an appropriate candidate for the planned anesthesia.
- PE.1.8.3: The patient is reevaluated immediately before anesthesia induction.
- PE.1.8.4: The patient's postoperative status is assessed on admission to and discharge from the postanesthesia recovery area.

Intent

- When a patient undergoes surgery or other procedure, hospital staff members evaluate the patient's status continuously before, during, and after the procedure. In an emergency, when there is no time to record the complete history and physical examination, a note on the preoperative diagnosis is recorded before surgery.
- A preanesthesia assessment is an essential element of continuing evaluation for patients who will undergo anesthesia. Data collected during the assessment process provide information that clinicians need to determine risks and choose the most appropriate form of anesthesia, administer it safely, and interpret findings while monitoring the patient. A licensed independent practitioner with appropriate clinical privileges concurs with or makes this determination based on the preanesthesia assessment.

Example of a Management of Information standard

- IM.7.7: Verbal orders of authorized individuals are accepted and transcribed by qualified personnel who are identified by title or category in the medical staff rules and regulations.

Intent

- Practitioners often give orders verbally in the course of patient care. The quality of patient care may suffer if such orders are not received and recorded in a standard way. Each verbal order is dated and is identified by the names of the individuals who gave, received, and implemented it.
- Individuals who receive verbal orders are qualified to do so and are authorized by the medical staff to do so as identified by title or category of personnel.
- When required by state or federal law and regulation, verbal orders are authenticated within the specified time frame.

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the organization's good work and to identify ongoing needs and challenges to continuous quality improvement. In some instances, an organization may struggle to meet accreditation standards, seeking instead to "spruce things up" in the months preceding the on-site survey. Such an approach is not the intent of the accreditation process and does not serve the best interests of patients. In addition, the hectic atmosphere created by rushing to prepare for a survey contributes to the perception that accreditation is more a hassle than a benefit.

Common physician misperceptions. Some physicians may share the impression that accreditation is primarily a hassle because they associate it with the 10-month preparatory period, rather than seeing accreditation standards as a guide for daily practice. For example, some physicians do not realize that many of their organization's existing systems and processes are reflections of JCAHO standards, such as policies

regarding laboratory protocols, the accuracy and safety of the radiology department, the accessibility and confidentiality of patient care information, the availability of library resources, and the safety systems that protect patients from fire. Other physicians may not value accreditation because they do not realize that improvements to hospital policies and procedures result from accreditation activities. Still others may be resistant to accreditation-related changes or have experienced resistance from the organization's administrators when trying to implement such changes.

Compliance with accreditation standards requires time, effort, and commitment to self-study and self-improvement at the organizational level. Old habits are difficult enough to break on the individual level—whether they involve nail biting, cigarette smoking, or suboptimal prescribing practices. Correcting poor habits is especially challenging for a complex system

such as a hospital. JCAHO standards provide a framework for identifying and correcting those bad habits in health care processes in order to improve the safety and quality of patient care. The actual costs of accreditation, therefore, are not merely the money spent to prepare for an on-site survey, which for most hospitals is less than that spent on financial auditing over a 3-year period [JCAHO, unpublished data, 1998]. The costs of accreditation also lie in what organizations must do to comply with standards (ie, the time and hard work of the staff and administration). If compliance with JCAHO standards does not help health care organizations "do the right things well," JCAHO is committed to changing its own system to better achieve its goals of improving patient care.

The On-Site Survey

An on-site assessment of a hospital's compliance with standards is conducted every 3 years. The duration of the survey and the number of surveyors who conduct it vary according to the size of the hospital seeking accreditation; a typical hospital survey is conducted over 3 days by a team of 3 surveyors. Survey teams may include administrators, nurses, laboratory technicians, physicians, and other experienced health care professionals with clinical, administrative, and quality improvement experience. To be qualified to conduct on-site surveys, surveyors must complete both a 3-week training program and a preceptorship, and thereafter they must participate in ongoing continuing education (eg, attend JCAHO conferences and teleconferences). Surveyors are evaluated based on supervisors' observations and input from accredited organizations.

In preparation for the on-site survey, surveyors are provided with information regarding the hospital's performance. These data include a summary of major adverse events and the hospital's follow up during the previous 3 years, a summary of consumer complaints received by JCAHO during the previous 3 years, media reports about the hospital, and performance measurement data. Selected outcomes and other performance measurement data must be collected by each hospital seeking accreditation and reported monthly to a "performance measurement system" of its choice (ie, any of 250 independent companies that JCAHO evaluates against established criteria and contracts to collect and analyze data). These data are then analyzed and reported to JCAHO quarterly. JCAHO currently is identifying a core set of performance measures that will be standardized nationally across all measurement systems, thereby allowing comparison among hospitals regardless of which performance measurement systems

a hospital chooses to use. To date, 29 core measures have been developed for the following categories: acute myocardial infarction, heart failure, community-acquired pneumonia, pregnancy and related conditions, and surgical procedures and complications.

On-site surveys begin with an opening conference with hospital administrators and clinical leaders that includes a performance improvement overview. The opening conference is followed by document review, interviews with organization leaders, visits to patient care settings to observe patient care and talk with patients, and interviews with multidisciplinary staff groups who have responsibilities related to a given function. Surveyors look for congruence among these data sources and for evidence that processes have been in place for at least 12 months and will continue to be effective in the future.

Surveyors communicate their observations at daily briefings and, when requested by the hospital, during a medical staff luncheon. Final compliance scores are not compiled until all assessment interviews, activities, and patient care setting visits have been completed. Compliance with each standard and its intent is rated on a 5-point scale, with a score of "1" designating full compliance with a standard. At an exit conference with organization leadership, the survey team presents the complete survey findings, a preliminary written report, and a projected accreditation decision [5].

Performance Reports and Follow-up Surveys

A final accreditation report is issued within 45 days after the conclusion of the survey. To become accredited, an organization must demonstrate overall compliance with the full set of applicable standards but need not be in full compliance with each standard. Compliance scores of 2 through 5 indicate some degree of noncompliance and are noted in the final accreditation report. A surveyed organization may challenge the findings of the surveyors if it believes the results to be inaccurate.

After the review process is completed, JCAHO compiles a summary Performance Report that discloses the organization's performance scores in the areas reviewed during the on-site survey and compares them with the results of similar organizations. Currently, 45 performance areas are included in the report for hospitals. Performance Reports are released to the public and posted on the Quality Check™ area of the JCAHO Web site (www.jcaho.org).

A common result of the full accreditation survey is identification of "recommendations for improvement," which are based on findings of less than full compliance

with 1 or more standards. Recommendations for improvement require the organization to demonstrate compliance with the standards in question within a specified time frame. Follow-up evaluations of recommendations for improvement may take the form of progress reports prepared by the hospital or focused surveys by JCAHO. For example, hospitals frequently are cited for incomplete compliance with Care of Patients standard TX.3.5: "Preparation and dispensing of medication(s) is appropriately controlled" [1]. Such an evaluation may result when an organization does not have a well-defined policy regarding the mixing of medication and intravenous fluid, including where the mixing should occur and which staff should be involved. However, a review of the literature suggests that errors may be reduced if intravenous mixing is done in the pharmacy rather than on inpatient units [6]. Based on this evidence, a hospital may revise its policies to address both the appropriateness of mixing sites and the competence of the personnel who are responsible.

Other surveys that focus on specific issues (eg, episodes of wrong-site surgery) may occur in the interval between the triennial full accreditation surveys. These surveys include *for cause surveys*, which often are unannounced and evaluate issues identified in consumer complaints received by JCAHO, in media reports, or in information from state or federal regulatory agencies. In addition, significant changes in the structure of an organization or the services it provides may require a partial *extension survey* to review newly added services, such as a dialysis unit. Finally, as part of the process for oversight and validation of the accreditation process itself, 5% of accredited organizations are randomly selected for a 1-day, unannounced survey. This type of survey addresses key performance areas of national importance (eg, credentialing) as well as other issues specific to the organization being surveyed (eg, previous recommendations for improvement).

Within 2 months, the JCAHO survey preparation team makes considerable progress in improving the consistency with which patients are assessed and documented following admission in various clinical settings. Several residents and members of the medical staff comment to Dr. Christie and the leaders of the Medical Records Committee that they appreciate their efforts and have noticed improvements in this aspect of patient care.

Approximately 6 months before the on-site survey, each working group makes a presentation to the entire hospital staff. The Management of Information working group describes how the appropriate standards are being addressed and provides the staff with a handout summarizing its work. Each working group also develops videotaped or computer-based training sessions for new hires.

In addition, residents are given a pocket-sized booklet that contains an overview of the hospital's quality improvement processes; the location of common items such as disaster and hazardous materials manuals; and reminders about fire safety, universal precautions, and documentation guidelines. These items are reviewed during business meetings and resident and staff orientations. Finally, residents are reminded to write legibly to avoid errors in patient care and to wear a clearly visible name tag to increase the safety and security of staff and patients in the hospital.

As the on-site survey nears, Dr. Christie considers what she has learned during the months of preparing for JCAHO accreditation. She is confident that she understands the hospital's quality improvement and patient safety systems and processes and is surprised to admit that she is looking forward to the JCAHO visit.

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