D.17 SYNOPSIS OF JOINT COMMISSION REQUIREMENTS

ADVERSE EVENTS – are untoward incidents; therapeutic misadventures, iatrogenic injuries or other unexpected occurrences directly associated with Care Lines or Management Systems provided within the jurisdiction of a medical center, outpatient clinic or other VHA facility. Adverse events may result from acts of commission or omission. Adverse events may also include environmental events. Events can be reported utilizing other forms of communication, i.e., MS Exchange, Telephone.

CLOSE CALL – Events or situations that could have resulted in an adverse event, which includes environmental issues, accident, injury, or illness, but did not because of chance or timely intervention. This category includes errors that could have been adverse sequences if only the specifics of the situation had been different. Close calls are opportunities for learning and afford the chance to develop preventive strategies and actions. Close calls receive the same level of scrutiny as adverse events that result in actual injury.

INTENTIONAL UNSAFE ACTS – any event that results from a criminal act; a purposefully unsafe act; an act related to alcohol or substance abuse; or, events involving alleged or sustained abuse of any kind.

MEDICAL DEVICE – Any item that is used for diagnosis, treatment, or prevention of a disease, injury, illness, or other condition; and, is not a drug.

PATIENT ABUSE – Patient Abuse includes acts against patients that involve physical, psychological or verbal abuse. Patient's perspective of how he/she is being treated is an essential component of the determination of a patient abuse. However, the fact that a patient has limited or no cognitive ability does not exclude the possibility of abuse.

ROOT CAUSE ANALYSIS (RCA) – is a process for identifying the basic or causal factors that underlie variation in performance associated with adverse events or close calls. An RCA will be conducted when it has been determined by the Patient Safety Manager, Risk Manager, and/or Safety Officer that the event or close call is considered a real or potential catastrophic event or if in the best interest of the facility to do an RCA.

SENTINEL EVENTS – As defined by the Joint Commission, are unexpected occurrences involving death (death not related to the natural course of the patient's illness or underlying condition) or psychological injury, or risk thereof. Serious injury specifically includes loss of a limb or function. Major permanent loss of function means sensory, motor, physiologic, or intellectual impairment not previously present that requires continued treatment or life-style change. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcomes. Additional examples of sentinel events are:

- Infant abduction or discharge to the wrong family
- Rape (by another patient of staff)
- Hemolytic transfusion reaction involving administration of blood/blood products, having major blood group incompatibility
- Surgery on the wrong patient or wrong body part regardless of the magnitude of the procedure

SERIOUS ILLNESS OR INJURY – as defined by the Medical Device Act is an Illness or injury that is life threatening; results in the permanent impairment of a body function or permanent damage to the body structure; or necessitates medical or surgical intervention to preclude permanent damage to a body structure.

Pre-Award Submission Performance Improvement Information Required for all Non-Joint Commission Accredited Organizations

1. Performance Improvement Plan:
    a. Policy/Official Document that describes the organization's approach to continuous improvement.
    b. Most recent annual appraisal of performance improvement to Executive Leadership and Board of Directors.
    c. Current measures

2. Employee Competence
    a. Most recent report to Executive Leadership and Board of Directors concerning competence of employees.
    b. Education Plan

3. Credentialing and Privileging
    a. Policy/Official Document that describes the organization's approach to credentialing and privileging of providers.
    b. Examples of source documents

4. Patient Safety
    a. Policy/Official Document that describes the organization's approach to patient safety.
    b. Documentation that describes the organization's most recent initiative to improve patient safety.

5. Pain Program
    a. Policy/Official Document that describes the organization's approach to assessing and managing pain.

6. Infection Control
    a. Policy/Official Document that describes the organization's approach to infection control.
    b. Measures/monitors currently in place to assess effectiveness of infection control program.