NOVA

Office of
Hospital Accreditation
February 1981
Hospital Vol. IV, No. 1
Laboratory Vol. II, No. 1

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THE SUBJECT IS, ...DOCUMENTATION.....IF YOU'RE BORED AND ARE THE PAST RECIPIENT OF THREE YEAR ACCREDITATION, YOU CAN PROBABLY DO SOMETHING BETTER WITH YOUR TIME THAN READ THIS. IF YOU WOULD LIKE TO BE LOOKED UPON MORE FAVORABLY BY THE FOLKS WHO MAKE THE RECOMMENDATIONS FOR ACCREDITATION, ...WELL MAYBE YOU SHOULD TAKE A FEW MINUTES AND READ THIS THROUGH.

FOR STARTERS, IF YOU WERE SURVEYED BETWEEN (OR EXPECT TO BE) SEPTEMBER 8, 1980 AND MARCH 13, 1981, YOUR REVIEW BY THE COMMITTEE ON HOSPITAL ACCREDITATION WILL OCCUR AT THE APRIL MEETING, THE SECOND AND THIRD, TO BE EXACT.

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LET'S JUST SUPPOSE.....PHYSICAL PLANT

1. STOREROOMS WERE CROWDED WITH ITEMS PLACED DIRECTLY ON THE FLOOR.

2. THE MAIN OXYGEN CUT-OFF VALVE WAS NOT IDENTIFIED.

(RESPONSE)

STOREROOMS HAVE BEEN INVENTORIED AND REARRANGED. SEE ATT. A
MAIN VALVE IS NOW IDENTIFIED. SEE ATT. B

ATTACHMENT A - PICTURE OF STOREROOM WITH ITEMS ON SHELVES.
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PROFESSIONAL STAFF

1. ATTENDANCE AT STAFF AND DEPARTMENT MEETINGS DID NOT MEET THE 75% REQUIREMENT FOR ACTIVE STAFF MEMBERS.
2. TISSUE AUDIT COMMITTEE - THERE WAS NO DOCUMENTATION FOR A REVIEW OF CATEGORIES OF TISSUE. FINDINGS OF THIS COMMITTEE WERE NOT SUPPLIED TO THE DEPARTMENT OF SURGERY.

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MEETING ATTENDANCE IS BEING MORE COLSELY MONITORED. SEE ATT. C
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MEDICAL RECORDS

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   A. FAMILY HISTORIES WERE USUALLY NOTED AS "NON-CONTRIBUTORY"
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NOVA

Office of
Hospital Accreditation

May 1981
Laboratory Vol. II, No. 2

BEHIND CLOSED DOORS?

I HAD THE PRIVILEGE OF ATTENDING THE ACOHA MEETING IN WASHINGTON, D.C. AND ENTERED INTO MUCH DISCUSSION WITH A NUMBER OF YOU ABOUT THE INTERNAL WORKINGS OF THE COMMITTEE ON HOSPITAL ACCREDITATION.

THERE IS NO GREEN DUST THAT IS SPRAYED AROUND, NO MYSTIQUE OR WAVING OF A MAGIC WAND. THE COHA SPENDS TWO AND A HALF DAYS REVIEWING THE CHANGES IN POLICY THAT MAY OCCUR AND EVALUATING SURVEY REPORT BOOKS AND DOCUMENTATION THAT HAS BEEN SENT PRIOR TO THE MEETING.

ALTHOUGH SOME OF YOU ARE FAMILIAR WITH THE WORKINGS OF THIS COMMITTEE AS PAST AND PRESENT MEMBERS, THE MAJORITY OF THE PEOPLE ARE AWARE ONLY OF THE DECISIONS OF THIS COMMITTEE.

THIS ISSUE OF NOVA WILL BE DEVOTED TO TWO MAIN TOPICS. THE FIRST WILL BE A DUPLICATE OF THE SECRETARY'S REPORT/SUMMARY THAT I SUBMIT TO ALL MEMBERS OF THE COHA, FOLLOWING THEIR MEETING.

COMMITTEE ON HOSPITAL ACCREDITATION
SUMMARY OF THE APRIL 2-3, 1981 MEETING

REPORT OF THE SECRETARY TO THE COMMITTEE, JOAN GROSS

THE FOLLOWING IS A SUMMARY OF THE SPRING 1981 MEETING OF THE COMMITTEE ON HOSPITAL ACCREDITATION.

COHA RECOMMENDATIONS	4/81 COHA	10/80 COHA
RESURVEY WITHIN 3 YEARS	7% (3 HOSPITALS)	2% (1 HOSPITAL)
RESURVEY WITHIN 2 YEARS	44% (18 HOSPITALS)	24% (10 HOSPITALS)
RESURVEY WITHIN 1 YEAR	37% (15 HOSPITALS)	67% (28 HOSPITALS)
DENIALS	12% (5 HOSPITALS)	7% (3 HOSPITALS)

A REVIEW OF THIS YEAR'S STATISTICS IN COMPARISON WITH THOSE OF OCTOBER 1980 REFLECTS A SIGNIFICANT INCREASE IN THE NUMBER OF INSTITUTIONS THAT HAVE RECEIVED LONGER ACCREDITATION AND ALSO, ON THE LOW END, THOSE THAT HAVE BEEN RECOMMENDED FOR DENIAL OF ACCREDITATION.

THIS SHIFT IS PROBABLY THE DIRECT RESULT OF LAST OCTOBER'S MEETING. IN THE PAST, HOSPITALS HAVE ALWAYS BEEN REQUESTED TO SUBMIT "PROGRESS REPORTS" - THAT IS, REPORTS OF CORRECTIONS OF DEFICIENCIES OR PLANS FOR CORRECTIVE ACTION. ALTHOUGH PROGRESS REPORTS WERE SUBMITTED IN MANY INSTANCES, THEY, IN MOST CASES WERE VERY POORLY DOCUMENTED, CONTAINING A VARIETY OF MEMOS, ALL OF WHICH INDICATED THE BEST OF INTENTIONS WITH PRACTICALLY NOTHING IN THE WAY OF SUPPORTING DOCUMENTATION.

PROGRESS REPORTS AND DOCUMENTATION WERE TOPICS THAT WERE DISCUSSED AT GREAT LENGTH DURING THE OCTOBER 1980 MEETING, TO THE POINT OF THE POSSIBILITY OF A MANDATORY PROGRESS REPORT OR, NOT ACCEPTING ANY REPORT WITHOUT SUPPORTING DOCUMENTATION. NEITHER OF THESE WERE ACTED UPON AND INSTEAD, A CONCENTRATED EFFORT WAS MADE TO RELAY THE TYPE OF DOCUMENTATION THAT THE COMMITTEE WANTED.

A COVER LEETER IS ALWAYS SENT TO THE HOSPITALS, ACCOMPANYING THEIR AREAS OF NONCOMPLIANCE, FOLLOWING THE SURVEY. THIS LETTER WAS MODIFIED TO STRESS THE INCLUSION OF SUPPORTING DOCUMENTATION WITH THEIR PROGRESS REPORT.

NOVA, THE NEWSLETTER THAT IS SENT QUARTERLY FROM THIS OFFICE USUALLY MENTIONS SUPPORTING DOCUMENTATION, PROGRESS REPORTS, WITH GREAT REGULARITY AND THE FEBRUARY 1981 ISSUE THAT WAS SENT TO ALL HOSPITAL ADMINISTRATORS AND LABORATORY DIRECTORS CONTAINED FOUR PAGES THAT ADDRESSED ONLY SUPPORTING DOCUMENTATION AND PROGRESS REPORTS. THE RESULT OF ALL OF THIS EMPHASIS IS PROBABLY EVIDENT IN THE FACT THAT ALMOST TWICE AS MANY HOSPITALS RECEIVED TWO YEAR INSTEAD OF ONE YEAR ACCREDITATION.

THE TWO REFERENCE COMMITTEES WORKED VERY DILIGENTLY IN REVIEWING THE VOLUMINOUS REPORTS AND IN DOING SO, WERE ALSO ABLE TO EVALUATE THE LACK OF EFFORT BY SOME INSTITUTIONS TO ELIMINATE DEFICIENCIES.

BEFORE ANY FURTHER TOPICS ARE COVERED, CONGRATULATIONS ARE TO BE FORWARDED TO ROYCE E. SKAGGS, D.O. FROM SAGINAW OSTEOPATHIC HOSPITAL. DR. SKAGGS HAS THE DISTINCTION OF BEING THE FIRST OSTEOPATHIC PHYSICIAN TO BE ACCEPTED AS A CONTRIBUTOR TO THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS CHECK SAMPLE PROGRAM. ACCORDING TO DR. HENRY OLEN, DME, DR. SKAGGS IDENTIFIED TWO RARE VARIANTS OF THE BRENNER TUMOR OF THE OVARY. HIS PAPER DESCRIBED (ONLY) THE 19TH EXAMPLE DOCUMENTED IN JOURNALS.

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KEEP THOSE CARDS AND LETTERS COMING! AFTER EACH SURVEY, THE ADMINISTRATOR WILL RECEIVE THE AREAS OF NONCOMPLIANCE, ALONG WITH A COVER LETTER. THIS LETTER STATES THAT DEFICIENCIES IN THE LABORATORY ARE TO BE ADDRESSED WITHIN 30 DAYS OF RECEIPT.

IN THE PAST, MANY INSTITUTIONS WERE DELINQUENT IN THEIR RESPONSE AND THE CORRECTIONS AND/OR CORRECTIVE ACTION WERE SENT IN LONG AFTER THE ESTABLISHED TIME FRAME OR EVEN WORSE, NOT AT ALL.

THIS PROCEDURE IS GOING TO BE CHANGED. DISCUSSION AT COMMITTEE LEVEL (COHA) WAS LIVELY AND A POLICY WAS FORMULATED THAT WILL MONITOR THE RESPONSE BY THE FACILITY. A SECOND LETTER WILL BE FORWARDED IF NO ACTION IS TAKEN IN DOCUMENTING CORRECTION OF AREAS OF NONCOMPLIANCE IN THE LABORATORY. THIS LETTER WILL SERVE AS A REMINDER THAT DOCUMENTED CORRECTIVE ACTION WITHIN 30 DAYS IS REQUIRED BY THE AMERICAN OSTEOPATHIC ASSOCIATION AS A PART OF ITS RESPONSIBILITY IN MAINTAINING DEEMED STATUS, GRANTED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS). A LACK OF RESPONSE MAY RESULT IN A LOSS OF ACCREDITATION, NOT ONLY IN THE AREA OF THE LABORATORY, BUT FOR THE ENTIRE HOSPITAL AS WELL.

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OTHER ACTION TAKEN BY THE COHA CONCERNING LABORATORIES WILL BE REFLECTED IN THE REVISIONS THAT WILL BE MAILED UPON FINAL ADOPTION BY THE BOARD OF TRUSTEES OF THE AMERICAN OSTEOPATHIC ASSOCIATION.

THE COHA HAS REVISED ITS CURRENT STANDARDS IN THE AREA OF LABORATORY PERSONNEL TO MORE CLOSELY REFLECT THE STANDARD REQUIRED BY HHS. NO LONGER WILL A MEDICAL LABORATORY SPECIALIST WITH A MASTER'S DEGREE BE QUALIFIED TO SUPERVISE AND BE RESPONSIBLE FOR THE LABORATORY. THE NEW STANDARD, CONSISTENT WITH FEDERAL GUIDELINES, WILL REQUIRE A DOCTORAL DEGREE, (WITH AOA ACCREDITATION REQUIREMENTS STATING THAT HE/SHE BE A PATHOLOGIST).

ON OCCASION, I HAVE HAD QUERIES REGARDING ADDITIONAL PERSONNEL BROUGHT INTO THE LABORATORY BY THE PATHOLOGIST-SURVEYOR. THIS TOPIC WAS FIRST DISCUSSED AT A COMMITTEE ON HOSPITAL ACCREDITATION MEETING IN APRIL, 1980.

AT THAT TIME, THERE WAS A CONSENSUS BY THE COMMITTEE THAT THE LABORATORY SURVEYS WERE NOT AS COMPREHENSIVE AS THEY SHOULD BE. IT WAS ALSO NOTED THAT THE SURVEY, USUALLY LIMITED TO ONE DAY, WOULD ALLOW FOR GREATER INCONSISTENCIES BETWEEN THE AOA SURVEY TEAM AND THE ON-GOING CDC MONITORING INSPECTIONS. (THIS FACT WAS GLARINGLY REFLECTED IN A SUBSEQUENT MEETING IN CHICAGO WITH THE CENTER FOR DISEASE CONTROL.)

A REFERENCE COMMITTEE OF THE COHA EVALUATED THE PROBLEM AND AFTER FURTHER REVIEW BY THE FULL COMMITTEE, PRESENTED A RESOLUTION TO THE BOARD OF TRUSTEES OF THE AOA WHICH WAS ADOPTED IN JULY, 1980.

SINCE MANY OF THE PATHOLOGIST-SURVEYORS WERE UNABLE TO SPEND A SECOND DAY REVIEWING THE PERFORMANCE OF A LABORATORY, THIS NEW RESOLUTION, ON A SLIDING SCALE RELATING TO BED SIZE, ALLOWED THE OPTION OF ADDITIONAL SURVEY PERSONNEL. IN EACH OPTION, E.G., HOSPITALS WITH LESS THAN 100 BEDS, HOSPITALS WITH 100-200 BEDS, ETC., THE PATHOLOGIST-SURVEYOR COULD ENLIST THE ASSISTANCE OF ANOTHER PATHOLOGIST AND/OR OPTION OF UP TO THREE MEDICAL TECHNOLOGISTS.

ADDITIONALLY, THERE MAY BE INSTANCES, PARTICULARLY IN LARGER INSTITUTIONS WHEN A PATHOLOGIST-SURVEYOR IS UNABLE TO OBTAIN ANY EXTRA PERSONNEL. HE/SHE MAY ELECT, IN LIEU OF THE OPTION, TO COMPLETE THE SURVEY OF THE LABORATORY ON THE FOLLOWING DAY.

BEST WISHES,

Joan

JOAN GROSS, SECRETARY
COMMITTEE ON HOSPITAL ACCREDITATION

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NOVA

Office of
Hospital Accreditation

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BEHIND CLOSED DOORS?

I HAD THE PRIVILEGE OF ATTENDING THE ACOHA MEETING IN WASHINGTON, D.C. AND ENTERED INTO MUCH DISCUSSION WITH A NUMBER OF YOU ABOUT THE INTERNAL WORKINGS OF THE COMMITTEE ON HOSPITAL ACCREDITATION.

THERE IS NO GREEN DUST THAT IS SPRAYED AROUND, NO MYSTIQUE OR WAVING OF A MAGIC WAND. THE COHA SPENDS TWO AND A HALF DAYS REVIEWING THE CHANGES IN POLICY THAT MAY OCCUR AND EVALUATING SURVEY REPORT BOOKS AND DOCUMENTATION THAT HAS BEEN SENT PRIOR TO THE MEETING.

ALTHOUGH SOME OF YOU ARE FAMILIAR WITH THE WORKINGS OF THIS COMMITTEE AS PAST AND PRESENT MEMBERS, THE MAJORITY OF THE PEOPLE ARE AWARE ONLY OF THE DECISIONS OF THIS COMMITTEE.

THIS ISSUE OF NOVA WILL BE DEVOTED TO TWO MAIN TOPICS. THE FIRST WILL BE A DUPLICATE OF THE SECRETARY'S REPORT/SUMMARY THAT I SUBMIT TO ALL MEMBERS OF THE COHA, FOLLOWING THEIR MEETING. THE SECOND WILL EXPLAIN THE ACCREDITATION PROCESS AND THE OPTIONS THAT ARE AVAILABLE TO YOU.

COMMITTEE ON HOSPITAL ACCREDITATION
SUMMARY OF THE APRIL 2-3, 1981 MEETING

REPORT OF THE SECRETARY TO THE COMMITTEE, JOAN GROSS

THE FOLLOWING IS A SUMMARY OF THE SPRING 1981 MEETING OF THE COMMITTEE ON HOSPITAL ACCREDITATION.

COHA RECOMMENDATIONS	4/81 COHA	10/80 COHA
RESURVEY WITHIN 3 YEARS	7% (3 HOSPITALS)	2% (1 HOSPITAL)
RESURVEY WITHIN 2 YEARS	44% (18 HOSPITALS)	24% (10 HOSPITALS)
RESURVEY WITHIN 1 YEAR	37% (15 HOSPITALS)	67% (28 HOSPITALS)
DENIALS	12% (5 HOSPITALS)	7% (3 HOSPITALS)

A REVIEW OF THIS YEAR'S STATISTICS IN COMPARISON WITH THOSE OF OCTOBER 1980 REFLECTS A SIGNIFICANT INCREASE IN THE NUMBER OF INSTITUTIONS THAT HAVE RECEIVED LONGER ACCREDITATION AND ALSO, ON THE LOW END, THOSE THAT HAVE BEEN RECOMMENDED FOR DENIAL OF ACCREDITATION.

THIS SHIFT IS PROBABLY THE DIRECT RESULT OF LAST OCTOBER'S MEETING. IN THE PAST, HOSPITALS HAVE ALWAYS BEEN REQUESTED TO SUBMIT "PROGRESS REPORTS" - THAT IS, REPORTS OF CORRECTIONS OF DEFICIENCIES OR PLANS FOR CORRECTIVE ACTION. ALTHOUGH PROGRESS REPORTS WERE SUBMITTED IN MANY INSTANCES, THEY, IN MOST CASES WERE VERY POORLY DOCUMENTED, CONTAINING A VARIETY OF MEMOS, ALL OF WHICH INDICATED THE BEST OF INTENTIONS WITH PRACTICALLY NOTHING IN THE WAY OF SUPPORTING DOCUMENTATION.

PROGRESS REPORTS AND DOCUMENTATION WERE TOPICS THAT WERE DISCUSSED AT GREAT LENGTH DURING THE OCTOBER 1980 MEETING, TO THE POINT OF THE POSSIBILITY OF A MANDATORY PROGRESS REPORT OR, NOT ACCEPTING ANY REPORT WITHOUT SUPPORTING DOCUMENTATION. NEITHER OF THESE WERE ACTED UPON AND INSTEAD, A CONCENTRATED EFFORT WAS MADE TO RELAY THE TYPE OF DOCUMENTATION THAT THE COMMITTEE WANTED.

A COVER LETTER IS ALWAYS SENT TO THE HOSPITALS, ACCOMPANYING THEIR AREAS OF NONCOMPLIANCE, FOLLOWING THE SURVEY. THIS LETTER WAS MODIFIED TO STRESS THE INCLUSION OF SUPPORTING DOCUMENTATION WITH THEIR PROGRESS REPORT.

NOVA, THE NEWSLETTER THAT IS SENT QUARTERLY FROM THIS OFFICE USUALLY MENTIONS SUPPORTING DOCUMENTATION, PROGRESS REPORTS, WITH GREAT REGULARITY AND THE FEBRUARY 1981 ISSUE THAT WAS SENT TO ALL HOSPITAL ADMINISTRATORS AND LABORATORY DIRECTORS CONTAINED FOUR PAGES THAT ADDRESSED ONLY SUPPORTING DOCUMENTATION AND PROGRESS REPORTS. THE RESULT OF ALL OF THIS EMPHASIS IS PROBABLY EVIDENT IN THE FACT THAT ALMOST TWICE AS MANY HOSPITALS RECEIVED TWO YEAR INSTEAD OF ONE YEAR ACCREDITATION.

THE TWO REFERENCE COMMITTEES WORKED VERY DILIGENTLY IN REVIEWING THE VOLUMINOUS REPORTS AND IN DOING SO, WERE ALSO ABLE TO EVALUATE THE LACK OF EFFORT BY SOME INSTITUTIONS TO ELIMINATE DEFICIENCIES.

ACCREDITATION MECHANICS

THERE ARE TWO SEPARATE COMMITTEES THAT EVALUATE HOSPITAL SURVEY REPORTS AND RECOMMEND ACCREDITATION STATUS TO THE BOARD OF TRUSTEES OF THE AMERICAN OSTEOPATHIC ASSOCIATION.

THE FIRST COMMITTEE IS THE COMMITTEE ON HOSPITAL ACCREDITATION, WHICH MEETS TWICE A YEAR, MORE COMMONLY KNOWN AS THE COHA. THIS COMMITTEE IS COMPRISED OF TEN MEMBERS WITH REPRESENTATION AND EXPERTISE IN THE AREAS OF OB/GYN, INTERNAL MEDICINE, GENERAL PRACTICE, SURGERY, PATHOLOGY, COLLEGES (AACOM) AND HOSPITAL ADMINISTRATION (AOHA).

AT THE TIME OF THE COHA MEETING, THIS IS FURTHER DIVIDED INTO TWO REFERENCE COMMITTEES AS EACH IS REPONSIBLE FOR REVIEWING THE REPORTS FROM APPROXIMATELY 20 FACILITIES. IN TERMS OF TIME, AN AVERAGE OF ONE THIRD OF AN HOUR IS DEVOTED TO EACH HOSPITAL. EACH REFERENCE COMMITTEE HAS A COMPOSITION OF BOTH PHYSICIAN AND HOSPITAL ADMINISTRATOR.

THE SECOND STANDING COMMITTEE IS THE APPEAL COMMITTEE, STRUCTURED TO BE INDEPENDENT FROM THE COHA AND COMPRISED OF ONE PHYSICIAN MEMBER OF THE COHA, A HOSPITAL ADMINISTRATOR WHO IS NOT A MEMBER OF THE COHA AND A (PHYSICIAN) MEMBER-AT-LARGE.

THIS COMMITTEE MEETS AT REQUEST, USUALLY TWO MONTHS AFTER THE COHA MEETING.

IN ESSENCE, AN INSTITUTION IS SURVEYED AND A RECOMMENDATION IS SUBMITTED BY THE COMMITTEE ON HOSPITAL ACCREDITATION (COHA) TO THE BOARD OF TRUSTEES OF THE AMERICAN OSTEOPATHIC ASSOCIATION (B/T - AOA).

IN THEORY, THIS IS A RELATIVELY DIRECT PROCEDURE. HOWEVER, THERE ARE OPTIONS AVAILABLE AND THE FOLLOWING WILL DESCRIBE VARIOUS SITUATIONS AND PERHAPS ATTEMPT TO CLARIFY THE PROCESS FOR YOU.

A HOSPITAL IS RECOMMENDED FOR EITHER ACCREDITATION (ONE, TWO OR THREE YEARS), DENIAL WITH THE APPLICATION OF A CLAUSE X OR DENIAL OF ACCREDITATION.

NOTIFICATION OF THE DECISION IS SENT TO THE ADMINISTRATOR WITH COPIES TO HIS CHIEF OF STAFF AND PRESIDENT OF HIS GOVERNING BODY. THE COHA RECOMMENDATION IS THEN PRESENTED IN THE FORM OF A RESOLUTION TO THE B/T - AOA FOR ADOPTION.

IF THE ADMINISTRATOR DISPUTES THE RECOMMENDATION OF THE COHA HE/SHE HAS THE RIGHT TO FORMALLY APPEAL TO THE APPEAL COMMITTEE ON HOSPITAL ACCREDITATION.

THE ADMINISTRATOR IS NOTIFIED AS TO THE DATE/TIME FOR HIS/HER PRESENTATION. A DECISION TO APPEAL MAYBE BASED ON:

1. ERROR IN FACT - A DISAGREEMENT WITH SURVEYOR FINDINGS AT THE TIME OF SURVEY.
2. DOCUMENTED CORRECTION OF DEFICIENCIES NOTED AT THE TIME OF SURVEY.
3. A COMBINATION OF ERROR IN FACT AND CORRECTION OF DEFICIENCIES.

A REVIEW OF THE PRESENTATION BY THE APPEAL COMMITTEE WILL RESULT IN A RESOLUTION TO THE B/T - AOA.

CONTINUED DISAGREEMENT BY THE HOSPITAL ADMINISTRATOR LEAVES A FINAL ACTION - AN APPEAL BEFORE THE FULL BOARD OF TRUSTEES OF THE AOA.

IN SUMMATION, EVERY INSTITUTION HAS THE PRIVILEGE OF APPEALING ANY DECISION, NOT ONLY TO THE APPEAL COMMITTEE, BUT TO THE FULL B/T - AOA, AS WELL.

NO MATTER WHAT PATHWAY IS CHOSEN, A HOSPITAL RETAINS ITS ACCREDITATION UNTIL SUCH TIME AS A FINAL DECISION IS HANDED DOWN BY THE B/T - AOA.

DENIAL WITH APPLICATION OF A CLAUSE X? DURING THE REVIEW PROCESS BY THE COHA, A FEW SPECIFIC AREAS MAY STAND OUT AS BEING (RELATIVELY SIMPLE, CORRECTABLE) MAJOR AREAS OF NON-COMPLIANCE. A RECOMMENDATION OF A DENIAL WITH A CLAUSE X, IN EFFECT, MEANS THAT AN INSTITUTION IS REQUIRED TO HAVE AN ON-SITE VISIT WITH THE REPORT REFERRED BACK TO THE NEXT COHA FOR ANOTHER REVIEW.

DOCUMENTATION OF CORRECTIVE ACTION IS SUBMITTED TO THE OFFICE OF HOSPITAL ACCREDITATION, (USUALLY WITHIN 45 DAYS) AND AN ON-SITE VISIT IS ARRANGED. THIS RECOMMENDATION BY THE ON-SITE SURVEYOR IS PRESENTED AT THE FOLLOWING COHA MEETING FOR ITS CONCURRENCE AND RECOMMENDATION TO THE B/T - AOA AT THEIR NEXT MEETING. AND, ANY HOSPITAL DENIED AFTER AN ON-SITE VISIT MAY STILL APPEAL TO THE FULL B/T - AOA.

A HOSPITAL THAT IS INITIALLY RECOMMENDED FOR A DENIAL OF ACCREDITATION MAY EITHER FORMALLY WITHDRAW FROM THE ACCREDITATION PROGRAM AND APPLY FOR STATE LICENSURE OR INSTITUTE THE APPEAL PROCESS.

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ARE YOU DUE FOR A SURVEY ONE OF THESE DAYS?.... ALTHOUGH THE COHA IN THEIR GENERAL POLICIES AND PROCEDURES MANUAL STATES THAT "THE OFFICE OF HOSPITAL ACCREDITATION SHALL NOTIFY ALL HOSPITALS AT LEAST TWO WEEKS (TWO WEEKS!) IN ADVANCE OF FORTHCOMING SURVEYS", YOU CAN EXPECT OFFICIAL NOTIFICATION APPROXIMATELY SIX WEEKS PRIOR TO THE SURVEY DATE.

MY SURVEY SCHEDULE IS USUALLY IN A TENTATIVE FORM FOLLOWING EACH COHA MEETING AND ANYONE THAT IS INTERESTED MAY CONTACT ME INQUIRING AS TO THEIR PROJECTED DATE OF SURVEY.

USUALLY, ONCE A D.O. TEAM CAPTAIN IS CHOSEN, IT IS NOT CHANGED BUT THE REASON THAT YOU ARE NOT PRE-NOTIFIED OF THE INDIVIDUAL ADMINISTRATOR/SURVEYOR IS BECAUSE OF THE UNEXPECTED PRIORITIES THAT HE/SHE MAY INCUR. SOMETIMES THERE ARE THREE AND FOUR CHANGES IN THE ADMINISTRATOR/SURVEYOR PRIOR TO THE SURVEY OR, UNPREDICTABLY, THE ADMINISTRATOR'S NAME MAY BE VALID, EVEN WHEN SCHEDULED SIX MONTHS IN ADVANCE.

IN A MORE CIRCUITOUS ROUTE, YOU MAY EVEN HAVE AN IDEA AS TO THE SURVEY DATE AS MUCH AS THE SIX MONTHS IN ADVANCE BY "READING THE MAIL". SINCE THE PATHOLOGIST HAS THE OPTION OF SURVEYING A LABORATORY PRIOR TO THE ACTUAL SURVEY DATE, ONCE THIS OFFICE SCHEDULES A PATHOLOGIST FOR YOUR HOSPITAL, A CONFIRMATION LETTER IS SENT TO HIM/HER. YOU ARE COPIED WITH THIS LETTER AND AS I RELAY SOME DATA TO THE PATHOLIGST CONCERNING YOUR HOSPITAL, E.G., YOUR NAME, ADDRESS, BED SIZE, ETC., I ALSO INCLUDE "TO BE SURVEYED ON OR BEFORE...." IF THE DATE NOTED FALLS ON A TUESDAY, THE FULL SURVEY WILL BEGIN ON THE PREVIOUS DAY AND CONCLUDE ON WEDNESDAY MORNING. IF THE DATE NOTED FALLS ON A FRIDAY, YOU CAN EXPECT THE FULL SURVEY TEAM ON THE PREVIOUS WEDNESDAY AFTERNOON.

TO BE MORE EXPLICIT, A LABORATORY MAY BE SURVEYED UP TO AND INCLUDING THE SECOND FULL DAY OF SURVEY.

IN TERMS OF PRODUCTIVITY, APRIL 1981 WON HANDS DOWN. IT ALL STARTED WITH THE COMMITTEE ON HOSPITAL ACCREDITATION MEETING WHICH TOOK A BITE OUT OF THE BEGINNING OF THE MONTH.

THIS WAS FOLLOWED IN SHORT ORDER BY THE AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS CONCLAVE. THE CEREMONY WAS A VERY BEAUTIFUL EVENT AND THE FOLLOWING DAYS WERE FILLED WITH A FRENZY OF MEETINGS AND ACTIVITIES.

A VACATION DAY AND A HOLIDAY (GOOD FRIDAY), BROUGHT THE WEEK TO A HALT.... IN TIME TO ATTEND A FOUR DAY WORKSHOP IN CHICAGO WHICH WAS SPONSORED BY THE GOVERNMENT, THE HEALTH CARE FINANCING ADMINISTRATION, (HCFA). THIS SEMINAR WAS AN INTENSIVE CONFERENCE WHICH DETAILED A SYSTEMS ANALYSIS APPROACH TO LIFE SAFETY CODE ENFORCEMENT/COMPLIANCE.

THE COURSE WAS ORIGINALLY DESIGNED BY A TASK FORCE WHICH INCLUDED REPRESENTATIVES OF THE FEDERAL GOVERNMENT, PRIVATE INDUSTRY AND INDIVIDUALS WITH EXPERTISE IN LIFE SAFETY CODE REQUIREMENTS.

FSES, (FIRE SAFETY EVALUATION SYSTEM) IS AN ALTERNATE MEANS BY WHICH AN INSTITUTION CAN COME INTO COMPLIANCE WITH THE LSC, (LIFE SAFETY CODE), EMPLOYING COST-EFFECTIVE MEASURES.

AT PRESENT, FSES IS AN ACCEPTED MEANS OF SURVEY, ADOPTED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. THIS METHOD OF COMPLIANCE IS NOW BEING PRESENTED TO THE VARIOUS STATE AND LOCAL AGENCIES, ALONG WITH THE AOA AND THE JOINT COMMISION. IT IS NOT MEANT TO REPLACE THE PRESENT LSC BUT TO ACCOMPLISH THE SAME DEGREE OF COMPLIANCE ON A ZONE-BASIS EVALUATION.

ONCE AGAIN, I HAVE BROKEN THE "FOUR PAGE RULE" AND COULD EASILY RUN OVER THESE SIX PAGES WITHOUT EVEN HALF TRYING. IF YOU ARE INTERESTED IN FURTHER INFORMATION ON FSES, CONTACT ME. IN THE MEANTIME, I HOPE THAT YOUR SUMMER IS A GOOD ONE!

BEST WISHES,

Joan

JOAN GROSS, SECRETARY
COMMITTEE ON HOSPITAL ACCREDITATION

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BEFORE, DURING AND AFTER.....

YOU'VE JUST GOTTEN THE NEWS - YOUR LABORATORY IS SCHEDULED FOR A SURVEY. IT DOESN'T MATTER (MUCH), A. YOU'VE BEEN SURVEYED BEFORE, B. HAD ALL OF YOUR DOCUMENTATION, MANUALS IN ORDER, C. ALL PROFICIENCY TESTS WERE WITHIN NORMAL LIMITS, D. THEY CAN COME INTO YOUR LABORATORY ANY TIME, YOU'RE ALWAYS PREPARED, E. NONE OF THE ABOVE.

IF YOU TEND TO FALL INTO THE "E" CATEGORY, LET'S DO A RUN THROUGH OF THE WHOLE PROCEDURE AND POSSIBLY SAVE SOME GRIEF FOR ALL CONCERNED. YOUR ADMINISTRATOR WILL BE NOTIFIED OF THE SCHEDULING OF THE PATHOLOGIST FOR THE LAB. AN EQUITABLE DATE WILL BE ARRANGED IN ORDER THAT ALL KEY PERSONNEL ARE THERE THAT DAY AND THE POST SURVEY CONFERENCE WILL BE WELL ATTENDED. CHANCES ARE, THE LABORATORY WILL BE SURVEYED IN ADVANCE OF THE FULL HOSPITAL SURVEY. (THIS WAS THROUGH AN AGREEMENT MADE WITH THE AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS WHEN THEY ASSUMED THE RESPONSIBILITY TO BECOME MEMBERS OF THE SURVEY TEAM FOR THE AMERICAN OSTEOPATHIC ASSOCIATION.

AS SOON AS YOU ARE NOTIFIED OF A SURVEY DATE, START ACCUMULATING YOUR RECORDS AND DATA FOR REVIEW BY THE SURVEYOR. YOU WILL BE ASKED FOR MANY DOCUMENTS AND BY A LITTLE PREPLANNING, LIFE CAN BE A BIT EASIER.

PRIOR TO THE SURVEY, MAKE A LIST OF ALL LABORATORY PERSONNEL INCLUDING THEIR NAME, CLASSIFICATION (SUPERVISOR, TECHNICIAN OR TECHNOLOGIST, ETC.), CERTIFICATION AND REGISTRATION NUMBERS. REVIEW THE SERVICES THAT YOU OFFER AND THE ETV'S.

CONTINUED.....

ADMINISTRATION HAS A COPY IN THEIR FILES AS THIS RECORD WAS A PART OF THE ANNUAL APPLICATION FOR THE HOSPITAL. UP-DATE THESE DATA TO REFLECT YOUR PRESENT SCOPE OF SERVICES, IF NECESSARY. GET COPIES FROM ADMINISTRATION OF THE FIRE DRILLS THAT WERE HELD IN THE LABORATORY DURING THE PAST YEAR. CHECK TO SEE THAT ALL FIRE EXITS ARE CLEARLY MARKED, SUFFICIENT FIRE EXTINGUISHERS ARE AVAILABLE (AND EVERYONE HAS BEEN INSTRUCTED IN THEIR USE). PRINTED INSTRUCTIONS FOR EMERGENCY ACTION ARE POSTED - WHICH COVER THAT ACCIDENTAL SPILL, BURN OR CUT. "DUST OFF" THE FIRE BLANKETS, CHECK THE SHOWER - DOES IT ONLY SPRAY MUD AND RUSTY WATER? - AND INSPECT THE EYEWASH STATIONS.

MAKE COPIES OF ALL OF YOUR OUTSIDE MAINTENANCE CONTRACTS FOR THE SERVICING OF YOUR EQUIPMENT. THE EASIEST WAY TO KEEP TRACK OF THESE IS TO KEEP THEM WITH THE ROUTINE PREVENTIVE MAINTENANCE LOG BOOKS THAT YOU HAVE FOR YOUR LAB.

IF YOU DEPEND ON AN OUTSIDE SOURCE FOR BLOOD/BLOOD DERIVATIVES, ASK ADMINISTRATION FOR A COPY OF THEIR AGREEMENT WITH THAT SOURCE, REVIEWED AND APPROVED BY THE MEDICAL STAFF AND THE GOVERNING BODY. YOU MIGHT ALSO ASK FOR THE COPIES OF THE TRANSFUSION REVIEW COMMITTEE MINUTES WHICH WILL DOCUMENT A REVIEW OF ALL TRANSFUSIONS, TRANSFUSION REACTIONS AND RECOMMENDATIONS AND CRITERIA ESTABLISHED BY THE MEDICAL STAFF REGARDING IMPROVEMENTS IN TRANSFUSION PROCEDURES.

AND WHILE YOU'RE IN ADMINISTRATION, ASK FOR A COPY (DEVELOPED BY THE PATHOLOGIST, WITH THE APPROVAL OF THE STAFF), LISTING THE TISSUES WHICH ROUTINELY REQUIRE MICROSCOPIC EXAMINATION. SO ENDS ALL OF THE PRELIMINARY PREPARATIONS. NOW YOU CAN SIT BACK AND RELAX, HAPPILY AWAITING THE ARRIVAL OF THE SURVEYOR.

THE MOMENT OF TRUTH IS UPON YOU. THE SURVEYOR ARRIVES AT THE LAB, POSSIBLY WITH ANOTHER PATHOLOGIST OR TECHNOLOGIST. HE/SHE, IN ADDITION TO THE PREVIOUSLY MENTIONED ITEMS WILL BE ASKING FOR A MYRIAD OF OTHER LOG BOOKS AND MANUALS. HE WILL WANT TO SEE BENCH MANUALS COVERING ALL OF THE PROCEDURES PERFORMED IN YOUR LABORATORY. HE WILL WANT TO SEE THAT THEY WERE SIGNED AND DATED BY YOUR PATHOLOGIST, INDICATING REVIEW AND APPROVAL. THESE MANUALS SHOULD ALSO CONTAIN REFERENCE MATERIAL AND MAY CONTAIN PACKAGE (KIT) INSERTS. HOWEVER, INSERTS DO NOT QUALIFY FOR A PROCEDURE MANUAL. THE SURVEYOR WILL ALSO ASK TO SEE THE FLOOR MANUAL, THE DOCUMENT THAT SHOULD BE AVAILABLE AT EACH NURSING STATION, ADVISING

CONTINUED....

THE NURSING PERSONNEL OF THE PROPER METHODS FOR COLLECTING SPECIMENS, PRESERVATION OF THE SPECIMEN AND SUBSEQUENTLY, TRANSPORTING THEM TO THE LABORATORY. ALSO TO BE INCLUDED IS PATIENT PREPARATION DATA IN ORDER TO ASSURE VALIDITY OF THE TEST. A SIGNATURE AND DATE BY YOUR PATHOLOGIST WILL AGAIN DOCUMENT REVIEW AND APPROVAL.

THE SURVEYOR WILL CHECK REAGENTS AND MEDIA, NOTING THE DATE THAT THEY WERE RECEIVED, OPENED AND EXPIRATION DATES, STRENGTHS OF SOLUTIONS, INITIALS OF PERSONNEL INVOLVED IN THE PREPARATION OF VARIOUS REAGENTS AND DILUTIONS, RESTRICTIONS, E.G., REFRIGERATION, INCUBATION STORAGE OR OTHER PERTINENT DATA.

SO MUCH FOR THE GOOD NEWS. NOW THE EARNEST SEARCH FOR DOCUMENTATION WILL BEGIN. LOG BOOKS. YOU WILL NEED LOGS OF ROOM TEMPERATURE CHECKS, LINEARITY AND CALIBRATION CHECKS, CONTROL RUNS, PREVENTIVE MAINTENANCE PLANS, REFRIGERATION/FREEZER, INCUBATOR WATER-BATH TEMPERATURE LOGS, RPM'S OF CENTRIFUGES AND ROTATORS, DOCUMENTATION OF STOP-WATCH, THERMOMETER AND TIMER CHECKS AND ON AND ON. ALL OF THIS WITHOUT EVEN MENTION OF ACTUAL LOGS OF PATIENT RUNS, FLOW SHEETS, PROFICIENCY TESTS, AND DAILY WORK SHEETS. IF YOU ARE DOING ALL OF THE ABOVE AND NOT KEEPING A WRITTEN RECORD, YOU WILL BE CITED BY THE SURVEYOR AS "NOT BEING IN COMPLIANCE. TO QUOTE, "NOT DOCUMENTED, NOT DONE".

YOU HAVE SURVIVED THE SURVEY, ITSELF, AND ARE NOW DOWN TO THE WIRE. IT'S TIME FOR THE POST-SURVEY CONFERENCE. ASSEMBLED ARE THE SURVEYOR, KEY LABORATORY PERSONNEL, HOSPITAL ADMINISTRATOR, ETC. THE SURVEYOR WILL REVIEW THE RESULTS OF THE VISIT. HE WILL ALLOW TIME FOR YOU TO ASK QUESTIONS AND, IF NECESSARY, SUPPLY HIM WITH THE ADDITIONAL DOCUMENTATION THAT HE REQUESTED BUT YOU WERE UNABLE TO LOCATE. HE WILL CONCLUDE THE CONFERENCE AND LEAVE THE SURVEY BOOK WITH YOUR HOSPITAL ADMINISTRATOR WHO WILL HOLD IT FOR THE ARRIVAL OF THE FULL HOSPITAL SURVEY TEAM.

THE AREAS OF NONCOMPLIANCE FOR THE LABORATORY WILL BE SENT TO THE ADMINISTRATOR ALONG WITH THE DEFICIENCIES FROM THE COMPLETE HOSPITAL SURVEY. IT IS HIS REPONSIBILITY TO ADDRESS THE LABORATORY DEFICIENCIES WITHIN 30 DAYS FROM RECEIPT OF THE LETTER. MOST LIKELY, YOUR ADMINISTRATOR WILL HAVE YOU PREPARE THE RESPONSE. HOWEVER, PLEASE KEEP IN MIND THAT THE ENTIRE HOSPITAL, A PART OF WHICH IS THE LABORATORY, IS THE RESPONSIBILITY OF THE ADMINISTRATOR AND IT IS HE WHO WILL SUBMIT YOUR CORRECTIONS AND PLAN OF CORRECTIVE ACTION. YOUR RESPONSIBILITY IS TO PROVIDE HIM WITH THE INFORMATION/DATA AND SUPPORTING DOCUMENTATION FOR THE "PROGRESS REPORT".

CONTINUED....

THE COMMITTEE ON HOSPITAL ACCREDITATION WHO REVIEWS THESE PROGRESS REPORTS IS RESPONSIVE TO COMPREHENSIVE REPORTS, COMPLETE WITH THE SUPPORTING DOCUMENTATION. IN PREPARATION FOR YOUR RESPONSE, ADDRESS EACH AREA INDIVIDUALLY, MAKING COMMENT AS TO THE CORRECTION. AT THE COMPLETION OF THESE STATEMENTS, SUBMIT THE APPROPRIATE DOCUMENTATION IN THE SAME ORDER. FOR EXAMPLE, IF YOU HAVE BEEN CITED FOR LACK OF A CONTRACT FOR BLOOD PROCUREMENT, SEND A COPY OF THE AGREEMENT; NO PREVENTIVE MAINTENANCE DOCUMENTATION - INCLUDE REPRESENTATIVE SHEETS OF THE PLAN THAT YOU HAVE INSTITUTED (NOT THE BLANK SHEETS THAT YOU ARE PLANNING TO USE); IF YOU HAVE NOT HAD LOG SHEETS FOR YOUR CALIBRATIONS AND LINEARITY CHECKS, AGAIN, SEND REPRESENTATIVE SHEETS OF WHAT YOU ARE NOW DOING; THIS STATEMENT IS APPLICABLE TO EVERY LOG BOOK THAT YOU SHOULD HAVE BEEN USING. TAKE PICTURES. IF YOU HAVE BEEN CITED FOR NOT HAVING EMERGENCY EQUIPMENT, E.G., A SHOWER OR AN EYEWASH STATION, TAKE A PHOTO OF THIS NEW EQUIPMENT (OR SENT IN THE PURCHASE ORDER, AS YOU AWAIT ITS DELIVERY). IF YOU HAVE BEEN CITED FOR NOT HAVING ANY CERTIFICATION OF STOP-WATCH CHECKS, SEND A COPY OF A LETTER FROM THE COMPANY THAT CHECKED THE ACCURACY OF THE TIME PIECE. IF YOU HAVE BEEN CITED AS NOT HAVING AVAILABLE CALIBRATION FIGURES FOR THE OCULAR MICROMETER, YOU CAN SEND ME THE PICTURE TAKEN FROM ANY LAB REFERENCE BOOK (I MUST HAVE ABOUT 150 OF THOSE ON FILE). AGAIN, UPON COMPLETION OF THE STATEMENTS AND COMPILING THE CORRESPONDING DOCUMENTATION, SEND IT TO YOUR ADMINISTRATOR FOR REVIEW AND COVER LETTER OVER HIS SIGNATURE. THIS DOCUMENTATION IS TO BE IN DUPLICATE, WITH ALL HOSPITAL IDENTIFICATION BLOCKED OUT.

ONCE THE REPORT IS RECEIVED IN THIS OFFICE, IT IS AGAIN CHECKED FOR HOSPITAL IDENTIFICATION, GIVEN A CODED IDENTIFICATION NUMBER AND FILED WITH THE PROCESSED SURVEY REPORT BOOKS WHICH HAVE ALSO BEEN CODED, ELIMINATING ALL HOSPITAL I.D. AND, IF YOU WISH, AS TIME PASSES AND THE DATE OF THE COMMITTEE NEARS, YOU WOULD LIKE TO SEND IN AN ADDITIONAL UP-DATED PROGRESS REPORT, THIS TOO, WILL BE HANDLED IN A LIKE MANNER.

AND, AS A REMINDER, EVERY HOSPITAL THAT WAS SURVEYED BETWEEN MARCH 2, 1981 AND SEPTEMBER 11, 1981 WILL BE REVIEWED BY THE COMMITTEE ON HOSPITAL ACCREDITATION AT ITS OCTOBER MEETING. YOUR PROGRESS REPORT WITH SUPPORTING DOCUMENTATION MAY BE SUBMITTED AS LATE AS SEPTEMBER 18, 1981.

BEST WISHES,

JOAN GROSS, SECRETARY
COMMITTEE ON HOSPITAL ACCREDITATION

NOVA

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THAT BIG MEETING.....

JULY 16, 1981 MARKED THE DATE FOR THE ANNUAL BOARD OF TRUSTEES MEETING OF THE AMERICAN OSTEOPATHIC ASSOCIATION, FOLLOWED BY THE HOUSE OF DELEGATES ON THE 19TH OF JULY.

IT WAS AN EXCITING MEETING, AS IT USUALLY IS, WITH CHANGES IN THE PRESIDENCY, OFFICERS, NEW POLICIES AND THE ANNOUNCEMENT OF THE RETIREMENT OF THE EXECUTIVE DIRECTOR OF THE AOA, EDWARD P. CROWELL, D.O.

A NUMBER OF RESOLUTIONS WERE PRESENTED TO THE BOARD OF TRUSTEES BY THE COMMITTEE ON HOSPITAL ACCREDITATION. I WILL MENTION THEM BRIEFLY IN AGGREGATE AND I WILL COMMENT ABOUT SOME OF THEM INDIVIDUALLY AT GREATER LENGTH. HOWEVER, BEFORE I DO, I WOULD LIKE TO DISCUSS THE DISTRIBUTION OF THESE REVISIONS, DOCUMENTS AND POLICY CHANGES.

NONE OF THE ITEMS CAN BE PRINTED IN ADVANCE. EVERYTHING SUBMITTED TO THE BOARD OF TRUSTEES OF THE AOA IS SUBJECT TO THEIR APPROVAL. ONCE A DOCUMENT IS REVIEWED BY THEM AND IS ADOPTED, IT MAY THEN BE READIED FOR PRINTING AND EVENTUAL DISSEMINATION. ALL OF THE MATERIAL APPROVED AT THIS MEETING SHOULD BE IN THE MAILS TO YOU BY THE END OF THIS MONTH OR THE VERY BEGINNING OF SEPTEMBER.

THREE NEW MANUALS WERE PRESENTED TO THE BOARD. THE FIRST WAS FOR ACCREDITING FREE-STANDING AMBULATORY SURGICAL CARE CENTERS, THE SECOND WAS FOR ACCREDITING FREE-STANDING PSYCHIATRIC CENTERS AND THE LAST WAS A TOTAL REVISION OF THE REHABILITATION CENTER MANUAL.

AN ENTIRELY NEW INFECTION CONTROL DOCUMENT WAS ADOPTED AND IT WILL SUPERCEDE AND COMPLETELY REPLACE THE PRESENT STANDARDS AS THEY APPEAR IN APPENDIX "B" OF THE ACCREDITATION REQUIREMENTS OF THE AMERICAN OSTEOPATHIC ASSOCIATION.

NUMEROUS REVISIONS WERE MADE IN THE AREA OF THE LABORATORY. HOWEVER, ALL OF THE CHANGES RELATED TO ONE SUBJECT, EVEN THOUGH THAT ONE SUBJECT WAS MENTIONED IN VARIOUS SECTIONS. THE REVISION WAS TO THE STANDARD FOR PERSONNEL, ELIMINATING ALL REFERENCES TO A "MEDICAL LABORATORY SPECIALIST", QUALIFIED BY A MASTER'S DEGREE. THIS STATEMENT WAS INCONSISTENT WITH THE CONDITIONS OF PARTICIPATION (ADOPTED BY THE BOARD OF TRUSTEES OF THE AOA IN 1978) WHICH REQUIRED A DOCTORAL DEGREE. BY ACTION OF THE COMMITTEE ON HOSPITAL ACCREDITATION WITH RECOMMENDATION AND SUBSEQUENT ADOPTION BY THE BOARD OF TRUSTEES OF THE AOA, ALL REFERENCES TO A "MEDICAL LABORATORY SPECIALIST" ARE DELETED AND ARE NOW MADE TO THE PATHOLOGIST.

THE BOARD ALSO ADOPTED A RESOLUTION REQUIRING THAT ALL SECONDARY DIAGNOSES ARE TO ALSO INCLUDE REFERENCE TO SOMATIC DYSFUNCTION. THIS IS STATED UNDER MEDICAL RECORDS IN VARIOUS PLACES. IT WILL BE THE RESPONSIBILITY OF THE PHYSICIAN TO RECORD THIS ON THE FACE SHEET AND ALL OTHER APPLICABLE AREAS ON THE PATIENT CHART.

TWO REVISIONS WERE MADE WITH REGARD TO ALLIED HEALTH PERSONNEL. THE FIRST CONCERNED PODIATRISTS, ELIMINATING THE REQUIREMENT FOR MEMBERSHIP IN NATIONAL, STATE AND LOCAL ASSOCIATIONS AS AN ACCREDITATION STANDARD. THE OTHER CHANGE WAS FOR THE RECOGNITION OF THE MEDICAL AND/OR OSTEOPATHIC PRACTICE ACT, STATED IN THE GUIDELINES FOR PHYSICIAN ASSISTANTS.

ALL OF THE INSTITUTIONS THAT WERE RECOMMENDED FOR ACCREDITATION TO THE BOARD OF TRUSTEES BY THE COMMITTEE ON HOSPITAL ACCREDITATION WERE GRANTED ACCREDITED STATUS. CORRESPONDENCE REGARDING THAT DECISION WAS MAILED IN THE WEEK FOLLOWING THE MEETING. THIS NOW BRINGS THE TOTAL FACILITIES ACCREDITED BY THE AMERICAN OSTEOPATHIC ASSOCIATION TO 157. AND, THERE ARE TWO ADDITIONAL FACILITIES WHICH WILL BE PRESENTED TO THE COHA AT THE TIME OF THEIR OCTOBER MEETING. IT IS WITH GREAT PRIDE THAT WE CONTINUE TO SEE THESE INCREASES.

BOARD ACTION CONFIRMED THE NAMES OF TWO NEW FACILITIES TO THE LIST OF ACCREDITED INSTITUTIONS. THESE WERE O'BLENESS MEMORIAL HOSPITAL IN ATHENS, OHIO AND THE GARDEN CITY OSTEOPATHIC HOSPITAL ALCOHOL TREATMENT CENTER, LOCATED IN GARDEN CITY, MICHIGAN.

*****

IT HARDLY SEEMS POSSIBLE BUT PLANS ARE ALREADY BEING FORMED FOR THE OCTOBER MEETING OF THE COMMITTEE ON HOSPITAL ACCREDITATION. AND SO, ONCE AGAIN, A REMINDER THAT IF YOU WERE SURVEYED OR EXPECT TO BE SURVEYED BETWEEN THE DATES MARCH 2, 1981 AND SEPTEMBER 11, 1981, YOUR SURVEY REPORT WILL BE REVIEWED AT THAT MEETING. YOUR COMPREHENSIVE PROGRESS REPORT WITH SUPPORTING DOCUMENTATION MAY BE SUBMITTED AS LATE AS SEPTEMBER 18, 1981. ALL PROGRESS REPORTS, IN ADDITION TO A STATEMENT OF CORRECTION OR PLAN OF CORRECTIVE ACTION ARE TO INCLUDE SUPPORTING DOCUMENTATION, E.G., A PURCHASE ORDER, PICTURES, MEETING MINUTES, ETC. THIS REPORT IS TO BE SENT IN DUPLICATE, ON PLAIN PAPER WITH ALL IDENTIFICATION REMOVED. ELIMINATE ANY REFERENCE TO THE NAME OF THE FACILITY, STATE, PHYSICIANS' NAMES, ETC. YOUR COVER LETTER ON HOSPITAL STATIONERY WILL SERVE TO IDENTIFY THE REPORT FOR PROCESSING AS IT IS CODED IN PREPARATION FOR PRESENTATION TO THE COMMITTEE ON HOSPITAL ACCREDITATION. COMPREHENSIVE PROGRESS REPORTS ARE HIGHLY REGARDED BY THE COHA AND I STRONGLY URGE YOU TO HAVE THIS DOCUMENTATION AVAILABLE FOR THEM.

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THE ORDER DEPARTMENT DISTRIBUTES ALL ACCREDITATION MANUALS AND SURVEY REPORT BOOKS. IF YOU WISH TO ORDER ADDITIONAL COPIES OF ANY OF THE MANUALS OR THE REPORT BOOKS, PLEASE DIRECT YOUR CALLS OR CORRESPONDENCE TO THAT DEPARTMENT. YOU CAN CONTACT THEM THROUGH EXTENSION 5861 OR SEND YOUR WRITTEN REQUEST TO THEM, "ORDER DEPARTMENT", AMERICAN OSTEOPATHIC ASSOCIATION, 212 EAST OHIO STREET, CHICAGO, IL 60611

*****

THE REVISION SETS ARE BEING EDITED AND READIED FOR PUBLICATION AND DISTRIBUTION. IF, IN THE PAST YOU HAVE NOTIFIED ME THAT YOU HAVE SIX MANUALS, YOU WILL RECEIVE A BULK MAILING OF SIX REVISION SETS. PLEASE DISTRIBUTE YOUR REVISION PACKAGES TO THE APPROPRIATE DEPARTMENTS IN ORDER THAT THEY MAY CONTINUE TO HAVE AN UP-TO-DATE MANUAL.

.....DID YOU KNOW.....

.....THAT THE BOARD OF TRUSTEES OF THE AOA INCREASED THE PER DIEM FOR THE SURVEYOR TO $90.00 AND RAISED THE MILEAGE TO $.22 PER MILE? IT IS HOPED THAT THIS WILL ELIMINATE YOUR PERSONAL EXPENSES AS THE PER DIEM IS TO COVER THE COST OF YOUR HOTEL AND MEALS DURING THE SURVEY.

.....THAT THERE ARE THREE INVOICES SENT FOLLOWING A SURVEY VISIT. THEY ARE, SURVEYOR "A", THE PHYSICIAN TEAM CAPTAIN, SURVEYOR "B", THE ADMINISTRATOR-SURVEYOR AND SURVEYOR "C", THE PATHOLOGIST-SURVEYOR.

.....THAT OBSERVERS ARE STILL NEEDED IN ORDER TO MAINTAIN AN ADEQUATE NUMBER OF ADMINISTRATOR-SURVEYORS FOR THE EVER GROWING LIST OF INSTITUTIONS THAT ARE BEING ADDED TO THE ACCREDITATION PROGRAM. IF YOU WISH TO BECOME AN OBSERVER AND EVENTUALLY, AN ADMINISTRATOR-SURVEYOR, PLEASE CONTACT ME AND I WILL TRY TO FIND A SLOT IN THE SCHEDULE THAT WILL ACCOMODATE YOU. IT WILL BE NECESSARY FOR YOU TO ACCOMPANY THE SURVEY TEAM TO FOUR INSTITUTIONS AS AN OBSERVER AS PART OF THE TRAINING. IT WILL PROVIDE YOU WITH A UNIQUE LEARNING EXPERIENCE ON A ONE-TO-ONE BASIS, GUARANTEED TO CHANGE YOUR PERSPECTIVE ON THE (OFTEN DREADED) HOSPITAL SURVEY. YOU'LL COME AWAY WITH A GREATER UNDERSTANDING OF SOME OF THE PREPARATION INVOLVED WITH SURVEYS, ALONG WITH THE NEED FOR, WHAT MAY SEEM UNNECESSARY REQUIREMENTS AND DOCUMENTATION. IT'S LIKE A LIGHT AT THE END OF A TUNNEL, ALL OF A SUDDEN, THINGS START TO FALL IN PLACE. DON'T DEPRIVE YOURSELF OF THIS EDUCATIONAL EXPERIENCE.

.....THAT I WELCOME YOUR SUGGESTIONS, CRITICISM AND COMMENTS FOR THE IMPROVEMENT OF FUTURE ISSUES OF NOVA. THESE TWO (ONE FOR THE HOSPITAL AND ONE FOR THE LABORATORY) QUARTERLY NEWSLETTERS ARE SENT TO YOU WITH THE INTENT OF PROVIDING YOU WITH INFORMATION AND CLARIFICATION. IF YOU WOULD LIKE TO HAVE CHANGES MADE OR ADDITIONS TO THE FORMAT, PLEASE CONTACT ME.

BEST WISHES,

Joan

JOAN GROSS, SECRETARY
COMMITTEE ON HOSPITAL ACCREDITATION

NOVA

July 1981

MEMORANDUM

TO: CHIEF EXECUTIVE OFFICER,
OSTEOPATHIC HOSPITALS

FROM: JOAN GROSS, SECRETARY
COMMITTEE ON HOSPITAL ACCREDITATION

ALL REVISIONS SINCE THE FEBRUARY 1976, 11TH EDITION PRINTING, MAY BE NOTED BY REVIEWING THE FOLLOWING PAGE NUMBERS IN YOUR ACCREDITATION REQUIREMENTS OF THE AOA.

1.....
2.....10/77,...5/79,...10/79
3.....10/76
4.....
5.....
6.....
7.....
8.....3/78,...10/80
9.....10/76
10.....
11.....3/78,...4/80
11(a)...4/80
12.....
13.....
14.....5/79
15.....3/78,...7/79
16.....
17.....2/77
18.....
19.....10/77
20.....7/79
20(a)...10/76,...7/79
21.....10/77,...10/80
22.....
23.....
24.....10/76
25.....
26.....
27.....
28.....10/76
29.....
30.....
31.....
32.....5/79
33.....5/79
34.....10/76,...3/78,...5/79
35.....7/78
36.....
37.....
38.....
39.....10/76
40.....
41.....
42..... 7/81
43.....10/76
44.....10/77, 7/81
45.....10/79
46.....10/77,...10/79
47.....2/77,...10/77
48.....7/81
49.....
50.....
51.....
52.....

53.....10/76
54.....10/76,...10/78 (1/79 B/T)
55.....4/81
56.....4/81
57.....1/78,...4/81
58(a)....10/79,...4/81
58(k)....10/79
59.....
60.....3/78
61.....3/78
62.....
63.....
64.....5/79,...10/79
65.....10/77
66(a)....10/77
67.....3/78
68.....3/78,...5/79
69.....10/77,...3/78
70.....
71.....
72.....
73.....
74.....
75.....

ALLIED HEALTH PROFESSIONS

AHP-2.....4/81
AHP-4.....4/80
AHP-5.....4/81

APPENDIX B.....5/79,...4/81

APPENDIX C.....4/79

APPENDIX D
D-2.....4/79

GLOSSARY

GL-3.....10/76
GL-4.....4/79
GL-5.....10/80
GL-6.....10/77

ABBREVIATIONS

ABB-1.....10/78,...5/79

NOVA

Office of
Hospital Accreditation

November 1981
Laboratory Vol. II, No. 4

THE TALLY SHEET.....

THE LABORATORY SURVEYS ARE MOVING RIGHT ALONG. THE PATHOLOGISTS THAT ARE PERFORMING THE SURVEYS ARE MEMBERS OF THE AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS, INC., ALL BOARD-CERTIFIED IN BOTH ANATOMICAL AND CLINICAL OR LABORATORY MEDICINE.

THE COLLEGE, (AOCP) HAS VOLUNTEERED TO PROVIDE THE SERVICES OF THEIR MEMBERSHIP AS A PART OF THE AMERICAN OSTEOPATHIC ASSOCIATION SURVEY TEAM.

BETWEEN THE TIME OF THE MID-YEAR (AOCP) TUTORIAL AT THE END OF FEBRUARY AND THEIR ANNUAL MEETING IN OCTOBER, 52 HOSPITALS HAD BEEN SURVEYED FOR PURPOSES OF ACCREDITATION AND AN ON-SITE WAS DONE AT ANOTHER LABORATORY. ALL OF THESE SURVEYS WERE CONDUCTED BY 18 PATHOLOGISTS. THE MOST AMAZING PART IS THAT FOUR PATHOLOGISTS SURVEYED 28 OF THE TOTAL LABORATORIES.

MOST OF THE SURVEYS WERE PERFORMED WITHOUT TOO MANY MISHAPS. THERE WERE, HOWEVER, A FEW INCIDENCES THAT CAME TO LIGHT. ONE PATHOLOGIST WANTED REIMBURSEMENT FOR A NEW CAR...HE HAD A BIT OF A PROBLEM ON HIS WAY HOME.....ONE HAD TO HITCH A RIDE BECAUSE THE GREYHOUND THOUGHT THEY HAD A BUS THAT WENT THERE, (BUT THEY REALLY DIDN'T)...ANOTHER MANAGED TO INGEST 40 CC. OF BUFFERED FORMALIN AND WAS A BIT UNDER THE WEATHER...(I MIGHT SUGGEST THAT CHECKS FOR ACIDITY AND DETERMINING QUALITY CONTROL CAN JUST AS EASILY BE ACCOMPLISHED BY THE USE OF A PH METER)...AND, ANOTHER PATHOLOGIST CANCELLED OUT WITH THE LAME EXCUSE OF HAVING TO HAVE FIVE (5) BYPASSES DONE! ALL IN ALL, THE SURVEYS WENT FAIRLY SMOOTHLY AND OF THE LABORATORIES THAT WERE REVIEWED FOR ACCREDITATION AT THE LAST COHA, NONE WERE DENIED ON THE BASIS OF THE LABORATORY.

THE AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS, INC.(AOCP) HELD ITS ANNUAL MEETING IN CONJUNCTION WITH THE CLINICAL ASSEMBLY IN BOSTON, MA ON OCTOBER 18-22, 1981. A PORTION OF THE AOCP MEETING WAS DEVOTED TO THE LABORATORY SURVEY PROGRAM OF THE AMERICAN OSTEOPATHIC ASSOCIATION AND I WAS PRIVILEGED TO PARTICIPATE IN THAT ASPECT OF THEIR MEETING.

THE AOCP HAS INSTITUTED SURVEYOR TRAINING COURSES AT EACH OF THEIR MID-YEAR AND ANNUAL MEETINGS. THIS LAST PROGRAM WAS TO BE A REVIEW OF PORTIONS OF THE MANUAL AND SURVEY REPORT THAT RELATED TO THE EXFOLIATIVE CYTOLOGY AND HISTOPATHOLOGY SECTIONS. I REPEAT, WAS BECAUSE ATTENDANCE DROPPED IMMEDIATELY FOLLOWING THE HOTEL FIRE.....

A PART OF THE PROGRAM DID TAKE PLACE. THAT WAS A REVIEW OF THE CENTER FOR DISEASE CONTROL "ACTIVITY" THAT INVOLVED THIS OFFICE AS WELL AS AN UP-DATE ON THE LABORATORY SURVEYS. AND I BELIEVE THAT SOME OF YOU WILL BE SENT SOME BACK-UP MATERIAL THAT WAS NOT HANDED OUT AFTER THE MEETING. THESE DATA WILL BE FORWARDED BY THE COLLEGE. THESE DIDACTIC SESSIONS SERVE A DUAL PURPOSE, NOT ONLY BY PROVIDING CLARIFICATION TO THE PATHOLOGIST/SURVEYOR BUT ALSO BY PROVIDING SOME INSIGHT TO THOSE THAT ARE TO BE SURVEYED. THE PLAN IS TO CONTINUE WITH THIS METHOD OF REVIEW ON AN ONGOING BASIS, COVERING THE VARIOUS SECTIONS OF THE LABORATORY STANDARDS AND THE CORRESPONDING SURVEY REPORT BOOK.

SPEAKING OF THAT MEETING, AN EXCELLENT SUGGESTION WAS MADE AND I SHALL FORWARD IT TO YOU. EVERY HOSPITAL HAS ALWAYS BEEN SENT A "DOCUMENT LIST" AT THE TIME OF THEIR SURVEY DATE NOTIFICATION. LISTED WERE VARIOUS ATTENDANCE RECORDS, MEETING MINUTES, STATE LICENCES, ETC., THAT THE HOSPITAL WAS INSTRUCTED TO HAVE IN READINESS AT THE TIME OF THE HOSPITAL SURVEY. IN RE-READING THAT LIST, I NOTED THAT THERE WERE NO DOCUMENTS LISTED FOR THE LABORATORY. THE LIST WAS THEN REVISED IN AUGUST 1981 TO INCLUDE THE VARIOUS LABORATORY DOCUMENTS THAT ARE TO BE AVAILABLE FOR THE PATHOLOGIST/SURVEYOR.

UNFORTUNATELY, THIS TYPE OF INFORMATION DOESN'T ALWAYS FILTER DOWN FROM THE ADMINISTRATOR. THE SUGGESTION FROM THE AOCP MEETING WAS THAT THE LABORATORY DOCUMENT LIST BE SPECIFICALLY SENT TO THE LABORATORY TO BE RETAINED FOR ANY FUTURE REFERENCE. THIS LIST WILL BE INCLUDED WITH THIS ISSUE OF NOVA ON A SEPARATE SHEET. I SUGGEST THAT YOU REFER TO IT FROM TIME TO TIME AS A REMINDER OF THE TYPE OF DOCUMENTATION AND RECORDS THAT YOU SHOULD BE MAINTAINING.

ALSO, IF YOU ARE NOTIFIED OF AN IMPENDING SURVEY, USE THE LIST TO ASSEMBLE ALL OF THE DOCUMENTATION THAT THE SURVEYOR WILL HAVE TO EVALUATE. MANY TIMES, A CITATION IS GIVEN DUE TO LACK OF DOCUEMNTATION, ONLY TO FIND OUT AFTER THE SURVEYOR HAS LEFT THAT THE RECORDS WERE BEING KEPT BUT COULD NOT BE LOCATED. POOR "HOUSEKEEPING" CAN BE THE CAUSE OF A LOT OF UNNECESSARY WORK IN COMPILING A PROGRESS REPORT AFTER THE SURVEY.

IF YOU WERE SUDDENLY NOTIFIED THAT YOUR LABORATORY WAS TO BE SURVEYED TOMORROW, WOULD YOU BE READY? IN THE PAST, HOSPITALS HAVE BEEN ENCOURAGED TO HOLD A "MOCK" SURVEY. THAT IS, HAVE AN INDIVIDUAL AS THE SURVEYOR AND COMPLETE A SURVEY, USING A COPY OF THE SURVEY REPORT BOOK THAT THE PATHOLOGIST WILL USE. IT MAY OPEN A FEW EYES. (BACK TO THE DOCUMENT LIST!) WHEN WAS THE LAST TIME THAT YOU DELETED PROCEDURES FROM THE BENCH MANUAL THAT ARE NO LONGER OFFERED....OR ADDED THE NEWER, MORE SOPHISTICATED TESTS NOW TAKING THEIR PLACE? AND, WHILE YOU HAVE THE BENCH MANUAL OUT, WHAT IS THE DATE OF THE LAST REVIEW BY THE PATHOLOGIST (IF ANY)? HOW MUCH ALCOHOL DO YOU REALLY HAVE....OR XYLENE...OR TANKS FOR THE FLAME? THERE IS SUPPOSED TO BE AN ACCEPTABLE STORAGE AREA, OTHER THAN ANY PLACE YOU CAN STASH IT IN THE LAB. ARE YOUR FLOW CHARTS CURRENT? DO YOU STILL HAVE YOUR LUNCH NEXT TO THE CULTURES? HAVE YOU EVER CHECKED YOUR TIMERS AND STOP WATCHES WITH A CERTIFIED SOURCE? ARE REAGENTS AND MEDIA DATED UPON RECEIPT? DO YOU RUN BOTH POSITIVE AND NEGATIVE CONTROLS? HAS YOUR REFERENCE LABORATORY PROVIDED YOU WITH INSTRUCTION MANUALS FOR DISTRIBUTION, TELLING BOTH YOU AND NURSING PERSONNEL THE METHOD OF PATIENT PREPARATION AND SPECIMEN COLLECTION? IF YOU'VE NEVER HAD A FIRE IN THE LAB, YOU'RE LUCKY, BUT IF YOU DID HAVE ONE, DO YOU KNOW WHERE THE FIRE EXTINGUISHER IS, AND BETTER YET, DO YOU KNOW HOW TO WORK IT? THE LABORATORY IS CONSIDERED A HIGH HAZARD AREA. THAT'S THE REASON FOR FIRE DRILLS, COMPLETE WITH DOCUMENTATION, SPECIFICALLY IN THE LAB. DO YOU PARTICIPATE IN PROFICIENCY TESTING PROGRAMS THAT REFLECT THE SCOPE OF SERVICES OFFERED BY YOUR LAB? DO YOU DOCUMENT CORRECTION OF UNACCEPTABLE RESULTS, NOT ONLY IN YOUR OWN RECORDS, BUT TO ME, AS WELL? YOU DON'T HAVE TO WAIT UNTIL I SEND YOU A LETTER REMINDING YOU..... DO YOU HAVE AN ERROR FILE IN BLOOD BANK? DO YOU HAVE REGULARLY SCHEDULED IN-SERVICE TRAINING PROGRAMS, IRREGULARLY SCHEDULED OR ARE THEY NONEXISTENT? IS YOUR PREVENTATIVE MAINTENANCE PROGRAM A FACT OR IS IT FICTION? DO YOU READ YOUR PRO TIMES IN SECONDS OR PERCENT? SECONDS IS THE PREFERRED METHOD AND YOU DON'T HAVE TO DO THE MANUFACTURER'S DILUTION CURVE. DO YOU CHECK YOUR HIGH AND LOW BLOOD COUNTS MANUALLY? REPEAT, MANUALLY, NOT RE-RUN ON THE COULTER OR OTHER AUTOMATED METHOD. IF ALL OF THIS SOUNDS LIKE "NIT-PICKIN", THEY ARE ALL REQUIRED STANDARDS. DON'T BLAME THE SURVEYOR, CLEAN UP YOUR OWN SHOP AND MAKE LIFE EASIER FOR ALL.

CLEANING UP SHOP DOESN'T ONLY LIE WITH YOU. I'VE BEEN DOING A BIT OF THINKING AND ONE OF THE CHANGES THAT WILL BE MADE IS, WHEN A SURVEYOR IS ACKNOWLEDGED AS FORMALLY ACCEPTING A SURVEY ASSIGNMENT, THE HOSPITAL ADMINISTRATOR IS AUTOMATICALLY COPIED WITH THAT LETTER. STARTING WITH THE FIRST OF THIS YEAR, THE LABORATORY DIRECTOR WILL ALSO BE COPIED IN ORDER THAT HE/SHE, TOO WILL BE AWARE OF THE NAME OF THE SURVEYOR. THIS MAY NOT BE AN EARTH-SHATTERING INNOVATION BUT IN ONE SMALL WAY, PROGRESS. AND, JUST AS YOU NOW HAVE A "DOCUMENT LIST", EACH SURVEYOR WILL RECEIVE ONE ALONG WITH THE BLANK SURVEY REPORT BOOK. THE SURVEYOR WILL HAVE THIS LIST FOR EACH SURVEY AND MOST LIKELY ASK FOR EACH OF THE ITEMS LISTED. WILL YOU HAVE THEM READY?

IT'S DIFFICULT TO TRY AND DETERMINE WHAT ARE YOUR SPECIFIC AREAS OF CONCERNS, WHETHER YOU ARE THE SURVEYOR OR THE LABORATORY BEING SURVEYED. IF YOU HAVE ANY SUGGESTIONS, PLEASE DON'T HESITATE TO MAKE THEM KNOWN. IF THEY ARE FEASIBLE, A NOTE OR A TELEPHONE CALL WILL BE WELCOME.

ANOTHER REMINDER, PROGRESS REPORTS WITH SUPPORTING DOCUMENTATION ARE REQUIRED WITHIN 30 FOLLOWING RECEIPT OF THE AREAS OF NONCOMPLIANCE FROM THE FULL HOSPITAL SURVEY. YOU ARE INFORMED OF THE DEFICIENCIES IN THE LABORATORY FOLLOWING THE LAB SURVEY. SINCE YOU ARE SURVEYED USUALLY WELL IN ADVANCE OF THE REST OF THE HOSPITAL, YOU HAVE FAR MORE THAN THE 30 DAYS TO BEGIN TO ASSEMBLE YOUR RESPONSE. EVERY PIECE OF DOCUMENTATION THAT YOU SUBMIT IS REVIEWED BY A PATHOLOGIST WHO IS A MEMBER OF THE COMMITTEE ON HOSPITAL ACCREDITATION. AT THE TIME OF THIS EVALUATION, NOTATION IS MADE AS TO WHETHER THE LABORATORY IS IN SUBSTANTIAL COMPLIANCE. THIS IS THEN MADE AVAILABLE TO THE COMMITTEE AS THEY REVIEW THE SURVEY REPORTS OF THE ENTIRE HOSPITAL. LACK OF SUPPORTING DOCUMENTATION CAN RESULT IN YOUR ENTIRE HOSPITAL BEING DENIED ACCREDITATION.

ONCE AGAIN, THE END OF ANOTHER NOVA, NOW ENTERING ITS THIRD YEAR OF EXISTENCE! I WILL CLOSE BY EXTENDING MY VERY BEST WISHES FOR A HAPPY, HEALTHY NEW YEAR!

SINCERELY,

JOAN GROSS, SECRETARY
COMMITTEE ON HOSPITAL ACCREDITATION

LABORATORY DOCUMENT LIST

1. A LIST OF NAMES OF ALL LABORATORY PERSONNEL; INCLUDE STATUS, E.G., SUPERVISOR, TECHNOLOGIST, ETC., CERTIFICATION AND REGISTRATION NUMBERS.

2. A LIST OF THE CATEGORIES OF SERVICES OFFERED, E.G., HEMATOLOGY, CHEMISTRY, ETC., AND THE ETV (ESTIMATED TOTAL VOLUME) OF EACH SERVICE.

3. CRITIQUES OF FIRE DRILLS HELD SPECIFICALLY IN THE LABORATORY.

4. COPIES OF AGREEMENTS WITH OUTSIDE SOURCES FOR BLOOD AND BLOOD DERIVATIVES, E.G, COMMUNITY BLOOD BANKS, ETC.

5. COPIES OF OUTSIDE MAINTENANCE (EQUIPMENT) CONTRACTS.

6. MANUAL FOR INSTRUCTIONS TO THE STAFF AND NURSING PERSONNEL ON THE COLLECTION OF PATIENT SPECIMENS, SIGNED AT LEAST ANNUALLY BY THE PATHOLOGIST, INDICATING CURRENT UP-DATE.

7. BENCH MANUALS FOR EACH DEPARTMENT IN THE LABORATORY, DESCRIBING EACH PROCEDURE, SIGNED AT LEAST ANNUALLY BY THE PATHOLOGIST, INDICATING CURRENT UP-DATE.

8. COLLECTION OF ALL WORK SHEETS, PREVENTIVE MAINTENANCE LOGS, TEMPERATURE LOGS AND ACCESSION LOG BOOKS AS THEY PERTAIN TO EACH PIECE OF EQUIPMENT AND DEPARTMENT.

9. A LIST OF TISSUES DEVELOPED BY THE PATHOLOGIST (WITH APPROVAL OF THE MEDICAL STAFF) STATING WHICH SPECIMENS WILL (OR WILL NOT) REQUIRE BOTH A MACROSCOPIC AND MICROSCOPIC EXAMINATION.

****

ALLOW SUFFICIENT TIME FOR A POST-SURVEY CONFERENCE

PATHOLOGY AND LABORATORY MEDICINE SERVICES

			YES	NO
	1.	Facilities		
54.26	(a)	Are there clinical laboratory facilities?	(a) ____	____
	1'	Available on a twenty-four basis?	1' ____	____
54.31	(b)	Are any laboratory services performed outside of the hospital done by a laboratory approved or licensed by state or federal government?	(b) ____	____
54.35	(c)	Are facilities for procurement, safekeeping and transfusion of blood provided or readily available?	(c) ____	____ /
	1'	Source_____		
	2'	Refrigerator_____		
	3'	Alarm system_____		
	4'	Number of units_____		
	5'	Temperature recording_____		
	6'	Transfusion Reactions_____		
	(d)	Is all laboratory equipment routinely checked and calibrated at intervals appropriate to the equipment?	(d) ____	____
54.44	(e)	Is there a preventive maintenance program?	(e) ____	____ /
	2.	Personnel		
55.17	(a)	Do qualified personnel supervise and conduct laboratory services?	(a) ____	____
	1'	Qualifications of laboratory supervisor:		
		_____		
		_____		
55.20	(b)	Are the services of a pathologist provided on a:		
	1'	Full-time basis(number of full-time)_____	1' ____	____
	2'	Part-time basis(number of part-time)_____	2' ____	____
	3'	Consultative basis	3' ____	____
	a'	Are there written reports?	a' ____	____
	b'	Are reports submitted monthly?	b' ____	____

ALLOW SUFFICIENT TIME FOR A POST-SURVEY CONFERENCE

			YES	NO
		4' Number of registered technicians_____		
58.15	(c)	Does the Pathologist furnish the professional and nursing staff with an instruction manual covering the methods of specimen collection and standard procedures pertinent to the laboratory?	(a) ____	____
56.12	3.	Safety Controls		
	(a)	Are printed instructions for emergency action posted prominently within the laboratory?	(a) ____	____
	(b)	Are fire drills held periodically?	(b) ____	____
	(c)	Are fire extinguishers available in all sections of the laboratory?	(c) ____	____
		1' Are all personnel instructed in their use?	1' ____	____
	(d)	Are all fire exits clearly marked and free of obstacles?	(d) ____	____
	(e)	Are precautions taken to prevent the spread of virulent micro-organisms from patients or specimens to laboratory personnel, from personnel to patients, and from one laboratory employee to another?	(e) ____	____
	(f)	Is all electrical equipment used in the laboratory properly grounded?	(f) ____	____
		1' Are personnel using electrical equipment instructed in its proper use?	1' ____	____
	(g)	Are isotopes handled in accordance with the regulations of the Nuclear Regulatory Commission?	(g) ____	____
		1' Are technical personnel working with isotopes instructed in their proper use and potential hazards?	1' ____	____
57.36	4.	Reports and Records		
	(a)	Are all laboratory reports signed or initialed by the person performing the test?	(a) ____	____
		1' Is a copy filed with the patients' chart and a copy kept in the laboratory?	1' ____	____

(PLEASE CIRCLE ONE)

NOTE: IS LABORATORY CONSIDERED TO BE "IN SUBSTANTIAL COMPLIANCE"? **YES** -or- **NO**

Code	Yes	No	N/A	
				IX. Laboratories (405.1028) The hospital has a clinical laboratory with the necessary personnel, space, facilities and equipment to perform those services commensurate with the hospital's needs for its patients. Anatomical pathology services and blood bank services are available either in the hospital or by arrangement with other facilities.
				(a) *Scope of Laboratory Services*—Clinical laboratory services adequate to meet the demands of the medical staff are available 24 hours a day, 7 days a week, including holidays. Basic laboratory services necessary for routine examinations are maintained in the hospital.
				(1) Adequate space, facilities and equipment are provided by the hospital. All equipment is in good working order, routinely checked, and precise in terms of calibration.
				(2) Where services are provided by an outside laboratory, the conditions, procedures, and availability of work done are in writing and available in the hospital.
				(b) *Clinical Laboratory Examinations*—Provision is made to carry out adequate clinical laboratory examinations including chemistry, microbiology, hematology, serology, and clinical microscopy. In the case of work performed by an outside laboratory, the original report from this laboratory is contained in the medical record.
				(c) *Personnel*—Personnel adequate to supervise and conduct the services are provided.
				No. of registered and/or licensed medical technologists: A. FULL-TIME _____ B. PART-TIME _____ NO. OF OTHER MEDICAL TECHNOLOGISTS C. FULL-TIME _____ D. PART-TIME _____
				(1) Services are under the supervision of a physician with training and experience in clinical laboratory services or a laboratory specialist qualified by a doctoral degree.
				(2) The laboratory does not perform procedures and tests which are outside the scope of training of the laboratory personnel.
				(3) There is a sufficient number of clinical laboratory technologists, registered and/or licensed through accrediting bodies recognized by the U.S. Office of Education, Div. of Institutional Eligibility and Accreditation or applicable State agencies.

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
				(d) *Routine Examinations* - Routine examination required on all admissions are determined by the medical staff and are consistent with the scope & nature of the hospital. These include at least a urinalysis and a hemoglobin or hematocrit. The required list of tests is in written form and available to all members of the medical staff.	
				(e) *Laboratory Report*—The director is responsible for the report and sees to it that all tests are ordered by a physician and that signed reports are filed with the patient's medical record and duplicate copies kept in the department.	11
				• (f) *Pathologist Services*—Laboratory services are under the direct supervision of a pathologist on a full-time, regular part-time or regular consultative basis. If the latter pertains, the hospital provides for, at a minimum, monthly consultative visits by a pathologist. The pathologist participates in meetings and is responsible for the qualifications of his staff and their inservice training.	
				G. NO. OF BOARD CERTIFIED PATHOLOGISTS: A. FULL-TIME_____ B. PART-TIME _____ C. CONSULTING _____ (SPECIFY FREQUENCY OF VISITS:) _____ SPECIALTY: 1. CLINICAL ☐ 2. ANATOMICAL ☐	
				(g) *Tissue Examinations*—All tissues removed from patients at surgery are macroscopically, and if necessary, microscopically examined by a pathologist. A tissue file is maintained in the hospital, and a pathologist or designated physician in the pathologist's absence, is responsible for verifying the receipt of tissues for examinations and signing the reports.	11
				(1) A list of tissues which routinely require microscopic examination is developed in writing by a pathologist or designated physician with the approval of the medical staff.	111 111 111
				(2) In the absence of a pathologist or suitable physician substitute, there is an established plan for sending to a pathologist outside the hospital all tissues requiring examination.	1
				(h) *Reports of Tissue Examination* - Signed reports of tissue examinations are filed with the patient's medical record and duplicate copies kept in the laboratory. Provision is made for the prompt filing of examination results in the patient's medical record and notification of the physician requesting the examination.	1
				(i) *Blood and Blood Products*—Facilities for procurement, safekeeping and transfusion of blood and blood products are provided or readily available. The hospital maintains, as a minimum, proper blood storage facilities under adequate control and supervision of the pathologist or other authorized physician.	

NAME OF FACILITY

CODE	MET OR	NOT MET	N/A	REQUIREMENT	REMARKS
				(1) For emergency situations the hospital maintains at least a minimum blood supply in the hospital at all times, can obtain blood quickly from community blood banks or institutions, or has an up-to-date list of donors and equipment necessary to bleed them.	//
				(2) Where the hospital depends on outside blood banks, there is an agreement governing the procurement, transfer and availability of blood which is reviewed and approved by the medical staff, administration and governing body.	///
				(3) There is provision for prompt blood typing and cross-matching, and for laboratory investigation of transfusion reactions, either through the hospital or by arrangements with others on a continuous basis, under the supervision of a physician.	
				(4) Blood storage facilities in the hospital have an adequate alarm system, which is regularly inspected and is otherwise safe and adequate.	//
				(5) Records are kept on file indicating the receipt and disposition of all blood provided to patients in the hospital.	
				(6) Samples of each unit of blood used at the hospital are retained according to the instructions of the committee indicated in subparagraph (7) of this paragraph for further testing in the event of reactions. Blood not so retained which has exceeded its expiration date is disposed of promptly.	/
				(7) A committee of the medical staff or its equivalent reviews all transfusions of blood or blood derivatives and makes recommendations concerning policies governing such practices.	////
				(8) The review committee investigates all transfusion reactions occurring in the hospital and makes recommendations to the medical staff regarding improvements in transfusion procedures.	//// /
				IV. TESTS PERFORMED (405.1314)	
				(a) Proficiency Testing. The laboratory successfully participates in State-operated or State-approved proficiency testing programs meeting standards prescribed by the Secretary and covering all the specialties or subspecialties in which the laboratory is approved to perform tests. Records of proficiency testing performance are maintained and available for review by the State agency.	///
				VII. QUALITY CONTROL (405.1317)	
				(a) General. Quality controls are imposed and practiced by the laboratory to provide for and assure reliable test results.	//

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E88				(1) There is documentation of preventive maintenance, periodic inspection, and testing for proper operation of equipment and instruments; validation of methods, (accuracy, linear range, comparison with other methods and normal ranges); evaluation of reagents and volumetric equipment; surveillance of results; and remedial action taken in response to detected defects.	
E89				(2) The lab monitors temperature-controlled spaces and equipment (including water baths, incubators, sterilizers, and refrigerators) to assure proper performance and evaluates analytical measuring devices, such as photometers and radioactive counting equipment, with respect to all critical operating characteristics.	
E90				(3) All reagents and solutions are labeled to indicate identity, and when significant, titer, strength, or concentration, recommended storage requirements, preparation or expiration date, and other pertinent information. Materials of substandard reactivity and deteriorated materials are not used.	
E91				(4) Testing personnel have readily available to them (at the bench) detailed instructions relating to the analytical methods (including kit procedures) to be used (properly designated, dated and signed to reflect the most recent supervisory reviews and changes in procedures), use of reagents, control and calibration procedures, and pertinent literature references.	
E92			X	(5) Analytical studies, inspection reports, proficiency test results, and other pertinent evaluative information (e.g., validation methods) are available and discussed with personnel to improve the accuracy of staff performance.	
E93				(6) Records are available to the Secretary reflecting dates and where appropriate, the nature of inspection, validation, remedial actions (in response to controls and standards out of limits and errors detected on supervisory review) monitoring, evaluation and changes and dates of changes in laboratory procedures.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E94				(7) Records show that the laboratory has adequate procedures governing collection, preservation, and transportation of specimens to assure adequate stability of specimens.	
E95				*(b) Methodologies.* There is an acceptable quality control program covering all types of analysis performed by the laboratory for verification and assessment of accuracy, measurement or precision, and detection of error.	
				(b)(1) MICROBIOLOGY	
E96				Chemical and biological solutions, reagents, and antisera are tested and inspected each day of use for reactivity and deterioration.	
E97				(i) BACTERIOLOGY AND MYCOLOGY *Media and Antisera* (1) Appropriate stock cultures are maintained.	
E98				(2) Media and typing sera dated upon receipt.	
E99				(3) Strips, discs, antisera and other biochemical test reagents are checked with positive and negative controls each day of use.	
E100				(4) An acceptable method of susceptibility testing is used.	
E101				(5) Antibiotic discs are stored properly and used within the expiration date.	
E102				(6) Disc potency and media are checked.	
E103				(7) With Kirby-Bauer or Agar Overlay methods, discs are checked each day of use with test organisms (*E. coli* ATCC, *S. aureus* ATTC, and *P. aeruginosa* ATCC.)	
E104				(8) Proper size Petri dishes are used.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E105				(9) Disc zones are measured and recorded.	
E106				(10) Barium sulfate turbidity standard is employed for Kirby-Bauer method.	
E107				(11) An adequate and appropriate incubation system (aerobic, CO_2, candle jar, anaerobic jar) is used.	
E108				(12) Blood, AFB, and mycology cultures are retained for an adequate period of time.	
E109				(13) Flow charts indicate all steps to be employed to isolate and identify organisms, and all tests, media, reagents, etc. to be used.	
E110				(14) Daily log or worksheets reflect all tests and test results which led to the isolation and identification of all microorganisms from patient specimens.	
E111				*Safety Precautions* (1) The bench area is away from the lab traffic area and smoking, eating, and drinking are prohibited in the work area. Food is not stored in the laboratory refrigerator. Counter tops are wiped daily with disinfectant and hands are washed after working with specimens. Protective clothing is used where applicable and is not removed from the work area.	
E112				(i) Staining materials are tested for intended reactivity by concurrent application to smears of microorganisms with predictable staining characteristics.	
E113				(i) Each batch of medium is tested before or concurrently with use with selected organisms to confirm required growth characteristics, selectivity, enrichment, and biochemical response.	
E114				Quality Control Requirements for (b)(1)(i) Bacteriology and Mycology are Met.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
				(ii) PARASITOLOGY	
E115				(1) Instructions are available to ensure adequate and thorough microscopic examination of each preparation.	
E116				(2) Calibration figures are available at the bench for the ocular micrometer.	
E117				(3) Stool specimens collected off premises are submitted according to test requirements.	
E118				(4) Permanent stains (such as trichrome or hematoxylin) are used for the examination of protozoa.	
E119				(5) Preparation of blood films is adequate.	
E120				(ii) A reference collection of slides, photographs, or gross specimens of identified parasites is used in the laboratory for appropriate comparison with diagnostic specimens.	
E121				(ii) A calibrated ocular micrometer is used for determining the size of ova and parasites, if size is a critical factor.	
E122				Quality Control Requirements for Parasitology (b)(1)(ii) are Met.	
				(iii) VIROLOGY	
E123				(1) Systems used for the isolation of viruses and reagents for the identification of viruses cover the entire range of viruses which are etiologically related to clinical diseases for which services are offered.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E124				(2) Records are maintained which reflect the systems used and the reactions observed.	
E125				(3) In tests for the identification of viruses, controls are used which will identify erroneous results.	
E126				Quality Control Requirements for (b)(1)(iii) Virology are Met.	
				(b)(2) SYPHILIS SEROLOGY	
E127				*VDRL* (1) Antigen is prepared fresh each day of use.	
E128				(2) The needle delivery is verified each day with the antigen in use.	1
E129				(3) The rotator is checked for r.p.m. each *day* of use.	1
E130				(4) Appropriate needles and slides are used for serum and cerebrospinal fluid tests.	
E131				(5) Room temperature is checked during test performance and recorded.	1111 1111 1
E132				(6) Controls of graded reactivity are included with each run.	1
E133				(7) New lots of antigens and controls are checked in parallel with lots of acceptable reactivity before use.	1111

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E134				*RPR* (1) The needle delivery is verified each day of use.	1111
E135				(2) The rotator is checked for r.p.m. each day of use.	111
E136				(3) Room temperature is checked during test performance and recorded.	1111 1111 111
E137				(4) Controls of graded reactivity are included with each run.	
E138				(5) New lots of antigens and controls are checked in parallel with lots of acceptable reactivity before use.	1111 1111 11
E139				*FTA — ABS* (1) Reactive and minimally reactive controls are used in diluent and sorbent.	
E140				(2) Nonspecified serum and stain are controlled in diluent and sorbent.	
E141				(3) Conjugate is titered and parallel tested before use.	
E142				(4) Antigen, sorbent, and controls are parallel tested before use.	
E143				(i) Serologic tests on unknown specimens are run concurrently with a positive serum of known titer or controls of graded reactivity plus a negative control to detect variations in reactivity levels.	
E144				(i) Test results are not reported unless the predetermined reactivity pattern of the controls is obtained.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E145				(i) Controls for all test components (antigens, complement, erythrocyte indicator systems, etc.) are employed to insure reactivity and uniform dosage.	
E146				(ii) Each new lot of reagent shall be tested concurrently with one of known acceptable reactivity before the new reagent is placed in routine use.	
E147				(iii) Equipment, glassware, reagents, controls, and techniques for tests for syphilis conform to those recommended in the "Manual of Tests for Syphilis 1969," U.S. Public Health Service Publication No. 411, January 1969.	
E148				Quality Control Requirements for (b)(2) Syphilis Serology are Met.	
				(b)(2) NON-SYPHILIS SEROLOGY	
E149				(1) Each qualitative test (e.g., febrile agglutination screen, infectious mononucleosis screen, CRP, RA, LE Latex and ANA) is run concurrently with a positive and negative serum control.	//
E150				(2) Each quantitative test (e.g., presumptive Heterophile, Differential Heterophile, ASO titer, Rubella, Hepatitis B surface antigen or antibody, and Serum Specific Protein) is run concurrently with positive serum control of graded reactivity and a negative serum control.	///
E151				(3) Additional controls to check all components for tests such as complement fixation, hemagglutination inhibition are run as specified in manufacturer's instructions and documented.	/
E152				(4) Work records reflect the actual degree of reactivity or titer of the positive controls, and results of the negative controls run concurrently with unknown specimens.	///
E153				(5) Components of each kit of reagents are not interchanged with other kit reagents of different lot numbers.	/

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E154				*Rubella* (1) Positive, low and negative controls are used each run.	
E155				(2) Antigen is titered.	
E156				(3) Antigen is back titrated in triplicate.	
E157				(4) A serum control is run for each patient.	
E158				(5) An erythrocyte control is used.	
E159				(i) Serologic tests on unknown specimens are run concurrently with a positive control serum of known titer or controls of graded reactivity plus a negative control in order to detect variations in reactivity levels.	
E160				(i) Test results shall not be reported unless the predetermined reactivity pattern of the controls is obtained.	
E161				(i) Controls for all test components (antigens, complement, erythrocyte indicator systems, etc.) shall be employed to insure reactivity and uniform dosage.	
E162				(ii) Each new lot of reagent shall be tested concurrently with one of known acceptable reactivity before the new reagent is placed in routine use.	//
E163				Quality Control Requirements for (b)(2) Non-Syphilis Serology are Met.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
				(b)(3) CHEMISTRY	
E164				A. For each procedure in chemistry: (1) Linearity is checked.	///
E165				(2) Recalibration is performed routinely or when necessary.	//
E166				(3) Standard(s) are included with each run, each electrophoretic support or membrane, each thin layer plate, each chromatogram, and each screening procedure.	///
E167				(4) Control(s) are included with each run, each electrophoretic support or membrane, each thin layer plate, each chromatogram, and each screening procedure.	
E168				(5) Standards are used for calibration curve that covers at least three points.	////
E169				(6) Two controls are used if standard is not readily available.	
E170				(7) Instrument readings and final results are recorded for all standards, controls and patients.	////
E171				B. Automated or Semiautomated testing systems: (1) There is written protocol for operation of instruments.	/
E172				(2) System is checked periodically for reproducibility and linearity.	/
E173				(3) Calibration is checked frequently with controls.	/
E174				(4) Operational characteristics of instruments are checked daily.	////
E175				(5) Control and standard data are analyzed daily to detect defects.	////
E176				(6) Standard and control charts (graphs, printouts, etc.) are retained for quality control requirements.	//
E177				(7) Control limits, established by the laboratory, manufacturer, and/or commercial statistical data are available for bench personnel.	///

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E178				C. For each radioisotopic procedure, records are available to document that: (1) Counting equipment is checked for stability once each day, with a radioactive standard or reference source.	
E179				(2) Background counts are performed once each day at the proper window setting for the type of isotope being studied and written criteria is available for unacceptable changes in background levels.	///
E180				(3) A plan for documentation of remedial action is available if controls are "out-of-limits".	/// ////
E181				(4) A statistically valid number of counts are made to determine results.	
E182				(5) Each instrument and device is rechecked or recalibrated each day of use.	/
E183				(6) Records document a routine precision of each method.	/
E184				(7) Standard and reference material are included with each run.	
E185				(8) Limits for controls are recorded and displayed.	
E186				(9) Safety precautions are exercised for HAA testing.	/
E187				D. Drug Testing: (1) Control material is processed in the same manner as specimens for all drug testing.	
E188				(2) Minimum limits have been established for each drug detected by the laboratory.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E189				(3)(i) Each instrument or other device shall be recalibrated or rechecked at least once on each day of use.	I
E190				(3)(i) Records which document the routine precision of each method and its recalibration schedule shall be maintained and be available to laboratory personnel and the Secretary.	I
E191				(3)(i) At least one standard and one reference sample (control) shall be included with each run of unknown specimens where such standards and reference samples are available.	I
E192				(3)(i) Control limits for standards and reference samples shall be recorded and displayed and shall include the course of action to be instituted when the results are outside the acceptable limits.	III
E193				Quality Control Requirements for (b)(3) Clinical Chemistry are Met.	II
				(b)(3) URINALYSIS	
E194			X	(1) Positives are confirmed by recognized methods.	IIII
E195				(2) Acceptable limits for reference samples are available to bench personnel.	IIII
E196				(3) Equipment for specific gravity is calibrated and records are available.	IIII IIII
E197				(ii) Screening or qualitative chemical urinalysis shall be checked daily by use of suitable reference samples.	IIII
E198				Quality Control Requirements for (b)(3)(ii) Urinalysis are Met.	III

HCFA CFR No.	FDA CFR No.	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
					(b)(4) IMMUNOHEMATOLOGY	
E203	640.5(b)				B2. ABO TESTING: Red cells are tested with Anti-A and with Anti-B and serum is tested with known A. and known B cells?	
E204	640.5(c)				B3. Rh TESTING: a. Red cells are tested with (anti-D)?	
E205	640.5(c)				b. (D) negatives are confirmed by further testing?	I
E206	405.1317 (b)(4)(ii)				A control system of patient's cells suspended in his own serum or in albumin shall be employed when the test is performed in a protein medium.	I/I/I
E203 E204	640.5(b)(c)				B9. REAGENTS: a. Only licensed antisera used for ABO, and Rh tests?	
E88	640.5(b)(c)				b. All test methods conform to manufacturer's current specifications?	
E90	610.53				c. All reagents used are in date?	
E207	405.1317 (b)(4)(iii)				The potency and reliability of reagents which are used for antibody detection and compatibility determinations must be tested for reactivity on each day of use and when a new lot of reagents is first used.	I/I/I
	[illegible]				B4. AUTOMATED TESTS: a. Is an automated system used?	
	[illegible]				b. If so, write name and model in comments.	
E90	606.140(a) and (b)				c. All tubing lines and reagent bottles are properly identified?	
E87	606.140(a) and (b)				d. There is evidence that every weak automated reaction is routinely checked by manual test?	
E87	606.140(a) and (b)				e. Appropriate controls are tested at beginning and end of each run to confirm channel identification and specific reactivity of every reagent used?	
E90	606.160(a) and (b)(7)(v)				f. All reagents are dated when put into use?	
E86 E89	606.65(c)				B11. QUALITY CONTROL CHECKS: a Specificity and reactivity of reagents are recorded daily?	
E86 E89	606.60(b)				b Standardization and/or calibration of laboratory equipment performed?	
E86 E89	606.60				H3 QUALITY CONTROL: a Equipment is calibrated as required?	
E93	606.160(b)(5)				b Records maintained?	

	FDA CFR No.	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
					(b)(4) IMMUNOHEMATOLOGY	
A149	606.151(a)				TRANSFUSION AND COMPATIBILITY TESTING G1. RECIPIENT SAMPLE ID: Labeling of recipient's blood sample insures positive ID?	
A150	606.151(b)				G2. BLOOD SAMPLES: Donor and recipient blood samples saved for at least 7 days after transfusion?	
A144 E208	606.151(b)				G3. MAJOR CROSSMATCH METHOD: a. Recipient's serum samples less than 48 hours old?	
A147 E63	606.151(c)				b. Demonstrates agglutinating, hemolytic, and coating antibodies, and includes the antiglobulin method?	
					G4. ANTIBODY TESTING OF DONOR BLOOD: a. Do the labels indicate that donor blood is tested for unexpected antibody?	
A147 E63	606.151(d)				b. If not, do records show a minor crossmatch (i.e., donor's serum and recipient cells) is performed?	2/11 Minor II
E93	606.160(a)(1)				G7. COMPATIBILITY TEST RECORDS: a. Maintained as required?	
E93	606.160(b)(4)(i)				b. Records include results of compatibility tests, testing of patient samples, antibody screening and identification?	
E93	606.160(b)(4)(iii)				c. Include results of ABO and Rh confirmatory testing?	
A149	606.160(b)(4)				d. Include date of receipt of recipient's sample?	
E89 E207	606.65(c)				e. Q.C. records of reagents used for compatibility testing?	D
E93	606160(a)(1)				B10.LABORATORY RECORDS: a. Records are maintained as required?	
E93	606.160(b)(2)(i)				b. Records include test results as well as interpretations?	
E90	606.160(a)(2)				c. Manufacturer, lot number, and expiration date of reagents are recorded?	
A144	606.160(b)(2)(v)				d. Include identification of persons responsible for labeling all products?	
E88	606.160(b)(7)(iii)				e. Error file is maintained?	
					f. Corrective action documented?	
A144 E62	606.160(d)				H19. RECORDS: a. Retained for at least 5 years after processing?	
A149 E62	606.160(c)				b. Traceable to donor?	
E208	405.1317 (b)(4)				Quality Control Requirements immunohematology are Met.	1

SUPPLEMENTAL FORM FOR LABORATORIES PERFORMING HEPATITIS AND SYPHILIS TESTING

	FDA CFR No.	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
					(b)(4) IMMUNOHEMATOLOGY	
A144	610.40(a)				B5. HB_sAg TESTING: a. Each unit of blood tested for HB_sAg by FDA required test?	
					b. Circle type of test: RIA FIPHA ELSIA RPLA :3rd Gen	
A144	610.40(b)				c. Test made on sample taken time of donation?	
					B6. HB_sAg TEST LOCATION: a. Performed on premises?	
					b. If not, list laboratory performing test: 1. Name 2. Address 3. City 4. State 5. Zip	
					c. If performed on premises: 1. Observed?	
A144 E87	600.11(e)(1) 606.40(a)(7)				2. HB_sAg testing in segregated area?	
A144 E87	606.40(d)(1)				3. Supplies and reagents used in HB_sAg testing are properly disposed of?	
A137 A149	610.40(b)(3)				B7. HB_sAg TEST RESULT: a. Written test results are in the possession of the collection facility before units are issued?	
A144 E87	640.5(a)				B8. SEROLOGICAL TEST FOR SYPHILIS: a. All units tested?	
					b. Indicated name of test performed.	
E88	610.40(b)				B9. REAGENTS: a. Only licensed antisera used for HB_sAg.	
E88	610.40(b)				b. All test methods conform to manufacturer's current specifications?	
E90	610.53				c. All reagents used are in date?	
E208	405.1317 (b)(4)				Quality Control Requirements immunohematology are Met.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
				(b)(5) HEMATOLOGY	
E209				A. Automated — Semi Automated Hematology: (1) Calibration of instruments is rechecked each day of use with calibration materials.	//
E210				(2) Background counts on diluent are run daily and recorded.	////
E211				(3) High and low counts are verified manually for accuracy.	//// //// ////
E212				(4) Instruments are serviced according to manufacturer's specifications and documentation is available.	//
E213				(5) Manual or other backup methods are available.	//
E214				(6) Standards and/or controls covering the full range of expected values are used daily.	//
E215			X	(7) Commercial control or repeat patient specimen are used to check precision on each subsequent run following initial set-up.	//

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E216				B. Hemoglobin — Manual or Automated: (1) Instruments calibration is checked each day of use.	/
E217				(2) Certified standards are used for calibration curve that covers at least three levels of concentration.	///
E218				(3) Standards and/or controls covering the full range of expected values are used daily.	///
E219				(4) Storage of hemoglobin reagent (Drabkin) is appropriate.	/
E220				(5) Cuvettes are matched.	///
E221				C. Hematocrit: (1) The speed of the microhematocrit centrifuge is checked periodically to assure constant packing of cells and results are recorded.	//// /
E222				(2) The timer is accurate and checks to verify accuracy are recorded.	//// ///
E223				(3) Tubes are filled from capillary or EDTA blood and are properly sealed.	/
E224				(4) Tests are run routinely in duplicate and results are recorded.	////
E225				D. Blood Counting: (1) Pipettes are certified or accurately calibrated.	/
E226				(2) Hemacytometer counting chamber and cover slip are in satisfactory condition.	/

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E227				E. Differential Leukocyte Counts: (1) Smears are made from fresh blood or from blood with an anticoagulant.	
E228				(2) The stain quality and cell distribution are satisfactory.	IIII
E229				(3) Abnormal differentials are reviewed by the technical supervisor or pathologist.	IIII I
E230				(4) Abnormal morphology of WBC and RBC are routinely reported.	III
E231			X	(5) Platelet counts are estimated routinely.	II
E232			X	(6) A file of unusual slides is maintained.	IIII
E233				F. Coagulation Studies: (1) One stage prothrombin times are performed in duplicate and verified by record.	IIII I
E234				(2) Normal and abnormal control plasma are run with each batch of tests.	II
E235			X	(3) Controls and specimens contain the same anticoagulant.	
E236				(4) The prothrombin time is reported either in seconds and/or percent.	
E237				(5) The manufacturer's thromboplastin dilution curve is verified monthly.	IIII IIII III
E238				(6) Water bath and dry bath temperatures are checked daily.	III
E239				(7) Timers are checked monthly.	IIII IIII IIII IIII III
E240				(8) Accuracy of stop watches is checked.	IIII IIII IIII IIII II
E241			X	(9) Tests are performed within four hours of specimen collection.	
E242			X	(10) Plasma specimens are refrigerated before testing.	II

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E243				C. General: (1) Control limits are established by the manufacturer or laboratory and are posted in the bench area for use.	
E244				(2) Corrective measures are documented when controls are out of limits.	
E245			X	(3) Quality control graphs are used that identify by date and lot number the controls and/or standards used.	
E246				(b)(5) Instruments and other devices used in hematological examination of specimens shall be recalibrated, or retested or reinspected as may be appropriate each day of use.	
E247				(b)(5) Each procedure for which standards and controls are available shall be rechecked each day of use with standards or controls covering the entire range of expected values.	
E248				(b)(5) Tests such as the one-stage prothrombin time test shall be run in duplicate unless the laboratory can demonstrate the low frequency of random error or high precision makes such testing unnecessary.	
E249				(b)(5) Reference materials, such as hemoglobin pools, and stabilized cells, shall be tested at least once each day of use to insure accuracy results.	
E250				(b)(5) Standard deviation, coefficient of variation, or other statistical estimates of precision shall be determined by random replicate testing of specimens.	
E251				(b)(5) The accuracy and precision of blood cell counts and hematocrit and hemoglobin measurements shall be tested each day of use.	
E252				Quality Control Requirements for (b)(5) Hematology are Met.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
				(b)(6)(i) EXFOLIATIVE CYTOLOGY	
E253				(1) Ventilation is adequate.	/// /
E254				(2) Flammable liquids are stored safely.	///
E255				(3) Fire extinguishers of the correct type are readily accessible.	/
E256				(4) Smears and specimens are properly labeled, fixed before submission, cross-referenced by name and receive daily accession number(s).	//
E257				(5) Request forms include the laboratory accession number, name and age of patient, name of physician who submitted specimen, date specimen was collected, source (anatomic site) of specimen, previous therapy, date and normalcy of last menstrual period, duration of current pregnancy, menopausal status, and essential history for non-gynecological specimens.	///
E258				(6) Report forms include date specimen received in laboratory, laboratory accession number, result of laboratory examination and date of reporting.	///
E259				(7) Flow charts for staining are available and accurately reflect procedure.	//
E260			X	(8) Staining dishes are adequately labeled and covered when not in use.	/// //
E261				(9) Stains and solutions are changed at appropriate intervals.	/
E262			X	(10) Staining quality is checked daily, and suboptimal stains corrected immediately.	////

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
E263			X	(11) Nongynecological specimens are processed spearately.	
E264			X	(12) A cross-reference system for positives is available.	
E265				(13) Positive cytologies are correlated with reports of tissue biopsies.	
E266				(14) Slide storage facilities are adequate and slides are readily retrievable.	
E267				(6)(i) The laboratory director or supervisor qualified in cytology shall rescreen for proper staining and correct interpretation at least a 10% random sample of gynecological smears which have been interpreted to be in one of the benign categories by personnel not possessing director or supervisor qualifications.	
E268				(6)(i) All gynecological smears interpreted to be in the "suspicious" or positive categories by screeners shall be confirmed by the laboratory director or qualified supervisor. The report shall be signed by a physician qualified in pathology or cytology.	
E269				(6)(i) All nongynecological cytology preparations, positive or negative, shall be reviewed by a director or supervisor qualified in cytology.	
E270				(6)(i) Nonmanual methods shall provide quality control similar to that provided in other nonmanual laboratory procedures.	
E271				(6)(i) All smears are retained for not less than 2 years from date of examination.	
E272				Quality Control Requirements for (b)(6)(i) Exfoliative Cytology are Met.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
				(b)(6)(ii) HISTO- and ORAL PATHOLOGY	
E273				(1) Ventilation is adequate.	
E274				(2) Flammable liquids are stored safely.	
E275				(3) Fire extinguishers of the correct type are readily accessible.	
E276			X	(4) Staining dishes are adequately labeled, and covered when not in use.	
E277				(5) Stains and solutions are changed at appropriate intervals.	
E278				(6) Flow charts for staining are available and accurately reflects procedures.	
E279				(7) Block and slide storage facilities are adequate and are readily retrievable.	
E280				(8) Control tissue are available for special stains.	
E281				(9) Tissue remnants are safely stored, properly labeled, and retained until final diagnosis.	
E282				(6)(ii) All special stains shall be controlled for intended reactivity by use of positive slides.	
E283				(6)(ii) Stained slides shall be retained for not less than 2 years from date of examination and blocks shall be retained for not less than 1 year from such date.	
E284				(6)(ii) Remnants of tissue specimens shall be retained in a fixative solution until those portions submitted for microscopy have been examined and a diagnosis made by a pathologist.	
E285				Quality Control Requirements for (b)(6)(ii) Histopathology are Met.	
E286				Quality Control Requirements for (b)(6)(ii) Oral Pathology are Met.	

NAME OF FACILITY

CODE	MET OR YES	NOT MET OR NO	N/A	REQUIREMENT	REMARKS
				(b)(7) RADIOBIOASSAY	
E287				(1) Written procedures exist and are followed for safety, storage of radionuclides, radioactive waste disposal, spills, monitoring methods (i.e., survey meters), administration of radioisotopes to patient (including patient preparation, dosage calculation, dose administration) and specimen collection.	
E288				(2) Background checks are performed each day at the proper window setting for the type of isotope being studied.	
E289				(3) Written criteria are available for unacceptable changes in background level.	
E290				(4) A statistically valid number of counts are made to determine results.	
E291				(b)(7) The counting equipment shall be checked for stability at least once on each day of use, with radioactive standards or reference sources.	
E292				(b)(7) Reference samples with known activity and within expected levels of normal samples shall be processed in replicate quarterly.	
E293				(b)(7) For each method, records which document the routine precision and the recalibration schedule shall be maintained and be available to the staff and to the Secretary.	
E294				Quality Control Requirements for (b)(7) Radiobioassay are Met.	

		YES	NO
	NUCLEAR MEDICINE DEPARTMENT/SERVICE		
	1. Safety		
69.23	(a) Are all isotopes handled in accordance with the regulations of the Nuclear Regulatory Commission?	(a) ____	____
69.28	1' Are technical personnel working with isotopes instructed in their proper use and potential hazards?	1' ____	____
69.31	(b) Is there an up-to-date procedural manual available?	(b) ____	____
	1' Are the following areas covered in the manual?		
	a' Monitoring	a' ____	____
	b' Decontamination	b' ____	____
	c' Storage of radioactive materials	c' ____	____
	d' Disposal of radioactive materials	d' ____	____
	e' Preparation of material for dosages	e' ____	____
	f' Calibration of equipment	f' ____	____
	g' Maintenance of equipment	g' ____	____

HOSPITAL _____

Series C CHEMISTRY										L
Glucose										
Calcium										
Bilirubin										
Potassium										
Sodium										
Urea										
Uric Acid										
Creatinine										
Chloride										
Phosphorus										
PBI										
T-4										
Thyroxine										
T-3										
Protein										
Iron										
Magnesium										
Lithium										
SGOT										
Cortisol										
Albumin										
Osmolality										
Triglyceride										
Cholesterol										
Series J BLOOD BANK										
ABO										
ABO										
RH										
RH										
Antibody ID										
Antibody ID										
Crossmatch										
Crossmatch										

Series H HEMATOLOGY										L
Hemoglobin										
Hematocrit										
RBC										
WBC										
Platelet										
Bl. Cell ID										
Bl. Cell ID										
COAGULATION										
Fibrinogen										
Prothrombin										
Prothrombin										
Part. Throm.										
Factor VIII										
SEROLOGY										
ASO Quan/Qual										
RA Quan/Qual										
Inf. Mono										
Rubella										
Rubella										
Syphilis										
Series H URINE										
Sp. Gravity										
Osmolality										
Protein-Quan.										
Protein-Qual.										
Bilirubin										
Hemoglobin										
Glucose										
Ph										
Sediment										
CSF-Fluid										
Pregnancy										
MICROBIOLOGY										
Bacti. ID										
Bacti. ID										
Fungus ID										
Fungus ID										
Mycology										
Mycology										
Parasitology										
Parasitology										
Anti-Micro										
Mini.Inhib.										

HOSPITAL

Series T TOXICOLOGY	L
T-1	
T-2	
T-3	
T-4	
T-5	
Series O BLOOD GAS	
Ph	
PCO2	
PO2	
Ph	
PCO2	
PO2	
Series G SPE. SEROLOGY	
ID 1	
ID 2	
ID 3	
ID 4	
ID 5	
Rubella	
RPR	
FTA - ABS	
Series F SPE. MYCOLOGY	
ID 1	
ID 2	
ID 3	
ID 4	
ID 5	
Series E SPE.MYCO/BACTI	
ID 1	
ID 2	
ID 3	
ID 4	
ID 5	
Smear	
Series M CER. SPIN. FL.	
ID 1	
ID 2	
ID 3	
ID 4	

Series B COMP.MIC/SER	L
Bacti. ID	
Bacti. ID	
Myco. ID	
Myco. ID	
Fungus ID	
Fungus ID	
Parasit. ID	
Parasit. ID	
ASO - Quant.	
ASO - Qual.	
RA - Sl./Tu	
Rubella	
Infec. Mono	
Antimicrobi.	
Mini.Inhib.	
Series D SPE. BACTI.	
ID 1	
ID 2	
ID 3	
ID 4	
ID 5	
Antimico sus.	
Series P SPE. PARASI.	
ID 1	
ID 2	
ID 3	
ID 4	
ID 5	
Series S DIAG.IMMUNO.	
Comp.Quan.3	
IGA mg/dl	
IGG mg/dl	
IGM mg/dl	
IGA iu/ml	
IGG iu/ml	
IGM iu/ml	
Infec.Mono.	
C-React.Pro.	
Anti-nu.Fac.	
HCG	
RubellaScreen	
RubellaScreen	
RA-slide/tu	
ASO-Quan/1	
Antimitoch.	
AlphaAntiTr.	
AlphaFetoPro	
Comp.Quan.4	
IgD	

HOSPITAL _____

Series U URINE CHEMIS	L
Amylase	
Calcium	
Phosphorus	
Sodium	
Potassium	
Creatinine	
Osmolality	
Total Protein	
Glucose	
Urea	
Series V ENZYME SERIES	
1	
2	
3	
4	
5	
6	
Series Z THERA. DRUG	
1	
2	
3	
4	
5	
6	
Series I INSTRU. SPECIAL	
Series R INSTRU. SPECIAL	
Series W VIRAL HEPATITIS	
Series TSA THYROID	
Series TSB CARDIOVASCULAR	
Series X SP. RUBELLA	
IMMUNE STATUS	
IMMUNE STATUS	
SP. TITER	
SP. TITER	
TITER DIFFER	
SCREENING	
SCREENING	

Series K LIGAND	L
HCG	
Cortisol	
Digoxin	
Estriol	
Ferritin	
Folic Acid	
Gentamicin	
Insulin	
Latent Iron	
HTSH	
T-3 Uptake	
Free Thyrox	
Thyroxine/T	
Triiodothyro	
Serum Vita	
Series Y ADVANCED LIGAND	
1	
2	
Series N AD.URINE CHEM	
1	
2	
3	
4	
5	
Series BT BASIC TOXICOL	

NOVA

Office of Hospital Accreditation

November 1981
Hospital Vol. V, No. 4

THE MOMENT OF TRUTH.....

THE COMMITTEE ON HOSPITAL ACCREDITATION CONVENED ON OCTOBER 1-2, 1981 FOR THE PURPOSE OF REVIEWING SURVEY REPORTS FOR THE PAST SIX MONTHS. JUST AS YOU HAVE BEEN APPRISED OF THE FINDINGS OF THE LAST COHA, SO SHALL I PRESENT A BRIEF SUMMARY OF THE OCTOBER MEETING.

A TOTAL OF 50 FACILITIES WERE REVIEWED BY THE COMMITTEE IN OCTOBER. THIS IS A PART OF 159 INSTITUTIONS THAT WILL BE ACCREDITED BY THE AMERICAN OSTEOPATHIC ASSOCIATION. IN FACT, THE LIST CONTINUES TO GROW, AND AS OF THIS DATE, TWO NEW HOSPITALS HAVE ALREADY BEEN PLACED ON THE JANUARY THROUGH JUNE 1982 SURVEY SCHEDULE. BOTH HOSPITALS HAVE HAD THEIR PRE-SURVEY CONSULTATIONS AND WILL HAVE THEIR FIRST FULL SURVEY.

COHA RECOMMENDATIONS AND A COMPARISON WITH THE APRIL MEETING IS AS FOLLOWS:

	10/81 COHA	4/81 COHA
RESURVEY WITHIN 3 YEARS	18% (9 HOSPITALS)	7% (3 HOSPITALS)
RESURVEY WITHIN 2 YEARS	32% (16 HOSPITALS)	44% (18 HOSPITALS)
RESURVEY WITHIN 1 YEAR	44% (22 HOSPITALS)	37% (15 HOSPITALS)
DENIALS	6% (3 HOSPITALS)	12% (5 HOSPITALS)

A REVIEW OF THIS YEAR'S STATISTICS IN COMPARISON WITH THOSE OF LAST APRIL REVEALS A SIGNIFICANT INCREASE IN THE NUMBER OF HOSPITALS THAT HAVE RECEIVED LONGER ACCREDITATION, PARTICULARLY, THREE YEARS. ALTHOUGH PROGRESS REPORTS ARE NOT MANDATORY, EXCEPT FOR THE LABORATORY, I WAS A BIT DISMAYED TO NOTE THAT A FEW ADMINISTRATORS FAILED TO SEND IN ANY DOCUMENTATION OF CORRECTIVE ACTION. AGAIN, I WOULD LIKE TO STRESS THE IMPORTANCE OF PROGRESS REPORTS. THAT IS ALWAYS THE FIRST REQUEST OF THE COMMITTEE...IS THERE A PROGRESS REPORT? AND, IF YOU'RE IN A QUANDRY AS TO WHAT TO INCLUDE IN THAT REPORT, DON'T HESITATE TO CONTACT ME FOR ASSISTANCE.

THERE WERE A NUMBER OF RECOMMENDATIONS THAT WILL BE PRESENTED TO THE BOARD OF TRUSTEES OF THE AOA AT THEIR MARCH MEETING.

OF PARTICULAR INTEREST WILL BE THE CHANGE IN THE PERSONNEL REQUIREMENT FOR THE INFECTION CONTROL OFFICER. THE REVISION WILL STATE A "PHYSICIAN, RN OR INDIVIDUAL QUALIFIED BY EDUCATION AND/OR EXPERIENCE". THE STANDARD FOR A PHYSICIAN AS THE COMMITTEE CHAIRMAN REMAINS UNCHANGED.

GUIDELINES FOR NURSE PRACTITIONERS WILL BE PRESENTED TO THE BOARD. THESE GUIDELINES WILL GOVERN THESE ALLIED HEALTH PERSONNEL THAT ARE EMPLOYED BY HOSPITALS. THE COHA IS ALSO IN THE PROCESS OF FORMULATING SPECIFIC STANDARDS FOR NURSE MIDWIVES.

ALTHOUGH DISCHARGE PLANNING WAS NOT AN AGENDA ITEM, THE SUBJECT WAS DISCUSSED AND ITS INTENT CLARIFIED. DISCHARGE PLANNING WILL CONTINUE TO BE MENTIONED IN THE ACCREDITATION REQUIREMENTS UNDER THE HEADING OF GOVERNING BODY. HOWEVER, IT WILL NOT BE A REQUIREMENT THAT THIS BE ADDRESSED IN THE BYLAWS. IT WAS THE CONSENSUS THAT SINCE DISCHARGE PLANNING IS FEDERALLY MANDATED, IT IS SUFFICIENT THAT IT JUST BE STATED FOR INFORMATIONAL PURPOSES IN THE MANUAL AND SURVEY REPORT BOOK. IT IS A REQUIREMENT THAT DISCHARGE PLANNING BE ACCOMPLISHED IN THE UTILIZATION REVIEW COMMITTEE. IT SHOULD BE NOTED THAT ANY HOSPITAL THAT WAS CITED FOR NOT HAVING THIS IN THEIR BYLAWS WAS NOT CONSIDERED TO BE OUT OF COMPLIANCE FOR THIS DURING THE REVIEW BY THE COHA.

IN-DEPTH DISCUSSIONS CENTERED AROUND THE LACK OF OSTEOPATHIC DOCUMENTATION, NOT ONLY OF TREATMENT GIVEN, BUT THE QUALITY AND SOMETIMES, COMPLETE ABSENCE OF PHYSICAL EXAMINATIONS IN THE NARRATIVE, DESCRIBING SPECIFIC OSTEOPATHIC FINDINGS. IT WAS WITH RARE EXCEPTION THAT A HOSPITAL WAS NOT CITED FOR DOCUMENTING EITHER OF THESE STANDARDS. IN FACT, A NUMBER OF THE INSTITUTIONS WERE CITED FOR NOT PROVIDING ANY FACILITIES FOR OSTEOPATHIC TREATMENTS. HOW CAN THE PROFESSION MAINTAIN ITS OSTEOPATHIC IDENTITY IF IT CONTINUES TO IGNORE THIS MODALITY? WE STATE THAT WE PROVIDE "MORE THAN..." AND PURSUE THE APPROACH OF SEPARATE AND DISTINCT. WE CONSTANTLY PETITION FOR RECOGNITION BY THE LEGISLATURE BUT FALL SHORT IN DOCUMENTING OUR DISTINCTIVENESS. WE CRY DISCRIMINATION WHEN OUTSIDE FORCES INHIBIT OUR GROWTH, SUCH A SEVERE BED CUTS OR UNFAVORABLE DECISIONS BY HEALTH PLANNING AGENCIES. WE MUST THEREFORE GO OUT OF OUR WAY AND NOT INADVERTENTLY SUPPORT THEIR DECISIONS.

*****

I HAD THE OPPORTUNITY OF ATTENDING A SEMINAR IN TEXAS THAT WAS DIRECTED TOWARD THE EXPANSION OR ADDITION OF TRAINING POSITIONS IN OUR HOSPITALS. IT WAS WELL ATTENDED BY MEMBERS OF THE PROFESSION, TRUSTEES AND HOSPITAL ADMINISTRATORS. A GREAT AMOUNT OF INTEREST WAS GENERATED AND LIVELY DISCUSSIONS FOLLOWED PRESENTATIONS.

THERE IS A REQUIREMENT THAT A TRAINING INSTITUTION HAVE A DIRECTOR OF MEDICAL EDUCATION. IN THE GROUP OF APPROXIMATELY 25 PARTICIPANTS (WITH AROUND NINE TO TEN FACILITIES REPRESENTED), A RATHER INTERESTING QUESTION CAME TO LIGHT WHICH MAY REFLECT THE THOUGHTS OF MANY.

TO ME, NOVA SEEMED A LOGICAL VEHICLE TO CONVEY THIS INFORMATION TO THE LARGEST NUMBER OF CONCERNED INDIVIDUALS. THE QUERY RAISED WAS, "WHAT IS MEANT BY A FULL-TIME OR WHOLE-TIME DME"? CONCERN WAS, IS IT PERMISSIBLE FOR A DIRECTOR OF MEDICAL EDUCATION TO MAINTAIN A PRIVATE PRACTICE OR MUST HE/SHE DEVOTE HIS TIME SOLELY TO THE ADMINISTRATIVE DUTIES OF THE OFFICE OF DME?

THE MANUAL OF POLICIES AND PROCEDURES FOR INTERN TRAINING, AMERICAN OSTEOPATHIC ASSOCIATION DEFINES THIS IN THE GLOSSARY, APPENDIX VI. IT STATES THE FOLLOWING:

FULL-TIME---AN INDIVIDUAL WHO HAS TOTAL RESPONSIBILITY FOR A DESIGNATED HOSPITAL ACTIVITY BUT WHO MAY ALSO ENGAGE IN OTHER ACTIVITIES IN OR OUT OF THE HOSPITAL, E.G., A DME WOULD BE CONSIDERED FULL-TIME IF HE/SHE WAS SOLELY RESPONSIBLE FOR CARRYING OUT THE DUTIES OF THE OFFICE BUT ALSO ACTED IN THE CAPACITY OF MEDICAL DIRECTOR AND/OR IS ENGAGED IN LIMITED PRACTICE.

WHOLE-TIME--AN INDIVIDUAL WHO DEVOTES HIS/HER ENTIRE WORKING TIME TO A SINGLE HOSPTIAL ENDEAVOR, E.G., A DME WOULD BE CONSIDERED WHOLE TIME IF HIS WORKING TIME WAS DEVOTED TO THE SINGLE RESPONSIBILITY OF CARRYING OUT THE FUNCTIONS OF THE DME'S OFFICE.

THE OFFICE OF EDUCATION WILL BE MORE THAT HAPPY TO PROVIDE YOU WITH ADDITIONAL INFORMATION IN INITIATING A TRAINING PROGRAM OR INCREASING YOUR EXISTING PROGRAMS.

*****

DID YOU KNOW

.....THAT FROM TIME TO TIME, THERE IS SOME DISCUSSION ABOUT "PHYSICIAN RESPONSIBILITY" AS IT IS STATED IN BOTH THE MANUAL AND THE SURVEY REPORT BOOK. WITH REFERENCE TO THIS DEFICIENCY, AT THE TIME OF SURVEY, A NOTATION MAY BE STATED THAT PATIENTS ARE REFERRED TO "CARDIOLOGY", "INTERNAL MEDICINE TO CONSULT" OR "W/L/G TO PARTICIPATE".

A DETERMINATION BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IS THAT PATIENTS ARE TO BE UNDER THE CARE OF A PHYSICIAN AND THAT PRIVILEGES ARE GRANTED TO INDIVIDUALS AND NOT TO A GROUP OR TYPE OF PRACTICE.

.....THAT IF YOUR HOSPITAL SURVEY DATE FALLS BETWEEN SEPTEMBER 14, 1981 AND MARCH 5, 1982, YOU WILL BE REVIEWED BY THE APRIL 1-2 COMMITTEE ON HOSPITAL ACCREDITATION. AND, MARCH 12, 1982 IS THE LAST DAY FOR SENDING IN PROGRESS REPORTS. IF YOU THINK THAT YOUR HOSPITAL SURVEY FALLS WITHIN THIS TIME-FRAME, TAKE A MOMENT AND MARK THOSE DATES ON YOUR CALENDAR.

.....THAT YOU WILL NOT RECEIVE ANY REVISIONS TO THE MANUAL UNTIL MAY OF 1982. REQUESTS FOR MANUALS OR THE SURVEY REPORT BOOKS ARE ONLY HANDLED THROUGH THE ORDER DEPARTMENT. THAT DEPARTMENT IS EXTENSION # 5861.

.....THAT THIS IS THE LAST ISSUE OF NOVA FOR THE YEAR 1981, ENDING ITS (ALMOST) FOURTH YEAR OF PUBLICATION. NOVA HAS GROWN FROM ITS TWO PAGE PUNY START TO A FOUR PAGE NEWSLETTER FOR HOSPITALS AND FOUR PAGE ISSUE DIRECTED TO THE LABORATORY WITH QUARTERLY MAILINGS OF OVER 825 COPIES.

.....THAT I EXTEND MY VERY BEST WISHES FOR A HAPPY HOLIDAY SEASON AND HAPPY NEW YEAR. MY SPECIAL THANKS TO THOSE OF YOU WHO HAVE WILLINGLY AND GENEROUSLY VOLUNTEERED YOUR SERVICES TO ENHANCE THE SURVEY PROGRAM OF THE AMERICAN OSTEOPATHIC ASSOCIATION.

SINCERELY,

JOAN GROSS, SECRETARY
COMMITTEE ON HOSPITAL ACCREDITATION

November 1981
Volume V, No. 4

NOVA

Office of
Hospital Accreditation

February 1982
Hospital Vol. VI, No. 1

And so to Bed.....

THE LABORATORY NOVA CEASES TO EXIST AS THIS ADDITIONAL NEWSLETTER HAS OUTLIVED ITS USEFULNESS. IN AN EFFORT TO CONTAIN COSTS, IT WILL BE DELETED FROM FURTHER PUBLICATION.

WAY BACK, IN 1979-80 WHEN NEW FEDERAL REGULATIONS BECAME EFFECTIVE FOR LABORATORIES, A DAY HARDLY PASSED THAT THERE WASN'T A CRISIS OR ANOTHER NEW AND DIFFERENT LABORATORY STANDARD. AS A MEANS OF TRYING TO KEEP CURRENT WITH ALL OF THE CHANGES AND REQUIREMENTS, THE SECOND NOVA FOR THE LABORATORY WAS CREATED AS A SEPARATE ISSUE. IT WAS USED AS A MEANS OF EXPEDITING THE EVERCHANGING INFORMATION TO YOU.

THE STORM APPEARS TO HAVE SUBSIDED TO A DULL ROAR, THE LABORATORIES ARE NOW USED TO THE NEW REGULATIONS AND THE LABORATORY SURVEY PROGRAM IS SETTLED DOWN TO SOMEWHAT OF A ROUTINE OCCURENCE. THEREFORE, AT THIS POINT IN TIME, WE'LL ADD A FEW HUNDRED DOLLARDS BACK INTO OUR BUDGET. IF, AT A LATER DATE, CIRCUMSTANCES CHANGE AND LABORATORIES OR ANOTHER FACET OF HOSPITAL CARE BECOMES A CRITICAL ISSUE, ANOTHER SPECIAL NOVA MAY BE CREATED.

SPEAKING OF THE FEDERAL GOVERNMENT AND REGS, THE NOTICE OF PROPOSED RULE MAKING, NPRM FOR THE CONDITIONS OF PARTICIPATION THAT WERE PRINTED IN THE FEDERAL REGISTER WAY BACK IN 1980 RECEIVED SHARP CRITICISM. COMMENTS TOTALED MORE THAN 20,000. WITH THAT AMOUNT OF CONTROVERSY, THE FEDS DECIDED NOT TO REVISE AND REPUBLISH THE CONDITIONS.

AT THE PRESENT TIME, A TASK FORCE HAS BEEN ESTABLISHED AT THE HEALTH CARE FINANCING ADMINISTRATION, (HCFA), TO FORMULATE NEW CONDITIONS. THE PROJECTED TIME-FRAME BY HCFA IS FOR THE TASK FORCE TO COMPLETE THEIR PART IN ABOUT SIX WEEKS, SEND IT TO ANOTHER AGENCY TO BE REWRITTEN IN ACCORDANCE WITH FEDERAL FORMAT AND COMPLETED AS A NPRM ABOUT MAY/JUNE, 1982. AGAIN, AT THAT POINT, THE RULE WILL BE SUBJECT TO COMMENT.

BARRING CHAOS, THESE NEW REGULATIONS WILL MODIFIED AFTER EVALUATING THE COMMENTS AND PUBLISHED IN THE FEDERAL REGISTER AS A FINAL RULE. IT SHOULD BE NOTED, HOWEVER, THAT THE MAY/JUNE NOTICE OF PROPOSED RULES MAKING IS PURELY A (FEDERAL) PROJECTION AND IF THESE CONDITIONS FOLLOW THE SAME TIMING AS OTHER FEDERAL PUBLICATIONS, NEW REGULATIONS COULD HARDLY BE EXPECTED TO BE IN EFFECT PRIOR TO 1983.

THE ACCREDITATION REQUIREMENTS OF THE AMERICAN OSTEOPATHIC ASSOCIATION ARE SUBJECT TO REVIEW EVERY SIX MONTHS, AT THE TIME OF THE COMMITTEE ON HOSPITAL ACCREDITATION MEETINGS. THESE REVISIONS ARE MAILED TO YOU FOLLOWING ADOPTION BY THE BOARD OF TRUSTEES OF THE AOA, UPON RECOMMENDATION OF THE COMMITTEE ON HOSPITAL ACCREDITATION.

*****

ALTHOUGH THIS NEWSLETTER IS SCANT IN ITS WRITTEN WORD, THE LAST TWO PAGES ARE IMPORTANT. THESE ARE THE WORKSHEETS A SURVEYOR USES AT THE TIME OF THE HOSPITAL ACCREDITATION SURVEY. THEY ARE BEING REPRINTED FOR THIS ISSUE AS PAGES THREE AND FOUR. SINCE IT IS ALWAYS RECOMMENDED THAT YOU PERFORM A MOCK SURVEY PRIOR TO THE ACTUAL SURVEY, THESE WORKSHEETS WILL ALLOW YOU TO REVIEW DEPARTMENT AND STAFF MEETINGS FOR COMPLIANCE WITH ATTENDANCE AND CLINICAL REVIEW REQUIREMENTS AS WELL AS CHART REVIEW. AGAIN A SUGGESTION, MAKE COPIES OF THESE FOR FUTURE USE. PULL 40 RANDOM CHARTS AS THE SURVEYOR DOES, E.G., SIX MI'S, SIX SURGICALS, SIX NEWBORNS, ETC. AND SEE IF YOUR DOCUMENTATION IS ADEQUATE.

BEST WISHES,

Joan

JOAN GROSS, SECRETARY
COMMITTEE ON HOSPITAL ACCREDITATION

February, 1982
Volume VI, No. 1

CLINICAL REVIEW

DEPT.	JAN.	FEB.	MAR.	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
GEN.PRACT.												
SURGERY												
MEDICINE												
OB/GYN												
STAFF												

B = Business Meeting
E = Educational Meeting
C = Clinical Review Meeting
O = No Meeting

CLINICAL REVIEW LEGEND

Gen.Pract. _____ of _____ Meetings

Surgery _____ of _____ Meetings

Medicine _____ of _____ Meetings

OB/GYN _____ of _____ Meetings

_____ _____ of _____ Meetings

_____ _____ of _____ Meetings

Staff _____ of _____ Meetings

DEPARTMENTAL MEETINGS
Attendance

DEPT.	JAN.	FEB.	MAR.	APRIL	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
GEN.PRACT.	*											
SURGERY												
MEDICINE												
OB/GYN												
STAFF												

*No. in Dept.

CHART AUDIT WORK SHEET
Med. Surg. OB. Mort.
(circle one)

Chart #_____
Patient Age_____
Diagnosis_____

Rating:
(Ex., Gd., Fair, Poor)
Professional Mgmt._____
Chart Mechanics_____

HISTORY & PHYSICAL

PAST HIST'Y		FAMILY HIST'Y		CHIEF COMPL'T		SYSTEMS REVIEW		COMPLETE		PHYS'CL EXAM		COMPLETE		NARRATIVE		COMPLETE		OMT GIVEN	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	YES	NO

OSTEOPATHIC FINDINGS

ANESTHESIOLOGIST

PRE-OPERATIVE		POST-OPERATIVE		POST-OP TIMED	
Yes	No	Yes	No	Yes	No

SURGEON

PRE-OPERATIVE		POST-OPERATIVE		POST-OP TIMED	
Yes	No	Yes	No	Yes	No

TISSUE TO PATHOLOGIST

ALL		FOREIGN BODIES	
Yes	No	Yes	No

CONSULTATIONS

ORDERED		DONE		CHART REVIEW		PHYS'CL EXAM		TIMED	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

SUMMARY

COND-ITION		DISPO-SITION		REVIEW		COMPLI-CATIONS		AUTOPSY DISC'D	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

COMMENT:

CHART AUDIT WORK SHEET
Med. Surg. OB Mort.
(circle one)

Chart #_____
Patient Age_____
Diagnosis_____

Rating:
(Ex., Gd., Fair, Poor)
Professional Mgmt._____
Chart Mechanics_____

HISTORY & PHYSICAL

PAST HIST'Y		FAMILY HIST'Y		CHIEF COMPL'T		SYSTEMS REVIEW		COMPLETE		PHYS'CL EXAM		COMPLETE		NARRATIVE		COMPLETE		OMT GIVEN	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	YES	NO

* OSTEOPATHIC FINDINGS *

ANESTHESIOLOGIST

PRE-OPERATIVE		POST-OPERATIVE		POST-OP TIMED	
Yes	No	Yes	No	Yes	No

SURGEON

PRE-OPERATIVE		POST-OPERATIVE		POST-OP TIMED	
Yes	No	Yes	No	Yes	No

TISSUE TO PATHOLOGIST

ALL		FOREIGN BODIES	
Yes	No	Yes	No

CONSULTATIONS

ORDERED		DONE		CHART REVIEW		PHYS'CL EXAM		TIMED	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

SUMMARY

COND-ITION		DISPO-SITION		REVIEW		COMPLI-CATIONS		AUTOPSY DISC'D	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

COMMENT: