Medical News

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JCAHO Deadline for Indicator Measurements

On February 18, 1997, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced a deadline for beginning the use of outcomes and other performance measures in the accreditation process. For the first time, accredited organizations will be required to collect performance-measurement data related to the outcomes of patient care and to submit those data to JCAHO on a continuous basis. This initiative, called ORYX: The Next Evolution in Accreditation, will include 60 acceptable performance-measurement systems that were reviewed and approved by JCAHO's Council on Performance Measurement last fall.

ORYX will establish the critical link between accreditation and the outcomes of patient care by requiring healthcare organizations to begin collecting and using performance data and to transmit these data to JCAHO. Initially, hospitals and long-term–care facilities will be required to participate. A parallel group of requirements is being developed for integrated delivery networks, health plans, and provider-sponsored organizations. In the future, ORYX will be expanded to include home care, ambulatory care, and laboratory accreditation programs.

Through ORYX, JCAHO will use measurement data to monitor the performance of accredited organizations on a continuous basis. In addition, JCAHO has said it will allow organizations to compare their performance with that of other peer organizations.

Many hospitals and long-term–care organizations already have engaged in performance-measurement activities. To assist organizations in preparing for the ORYX requirements, JCAHO is developing a special insert for the accreditation manual that will profile each of the 60 currently available performance-measurement systems and provide guidance on the selection of a system that best meets the individual organization's needs. A new accreditation manual chapter on the requirements have been prepared, and plans were made for distribution in March 1997. Performance-measurement systems include systems that measure performance in clinical, satisfaction, health status, administration, and financial categories.

By December 31, 1997, each accredited hospital and long-term–care organization *must* choose a performance-measurement system that best meets their needs. In addition, by this same date, each organization also must select two clinical performance indicators from its measurement system that relate to at least 20% of its patient population and inform JCAHO of its system and indicator selection. Hospitals and long-term–care organizations will be *required* to begin submitting data to JCAHO no later than the first quarter of 1999. Thereafter, data are expected to be submitted on a quarterly basis. It is expected that, over the next several years, JCAHO will expand the scope of measurement expected and will phase in incremental requirements. For example, current plans anticipate that accredited hospitals and long-term–care organizations will be required to select two additional measures, for a total of four, by the end of 1998. Together, the four clinical measures should address at least 40% of the patient population.

To accommodate hospitals engaged in performance-measurement activities at levels well beyond ORYX requirements, JCAHO will offer a voluntary accelerated option. ORYX Plus, initially offered only to hospitals, will involve use of a common set of acute-care measures, with data being part of a national comparative database. Participating hospitals also will be required to commit to future public disclosure of performance data and information. To participate, hospitals must choose at least 10 of 25 identified measures, and special recognition will be given to all participating hospitals.

Tom Granatir, Director of Quality Initiatives at the American Hospital Association, said, "This is a small but important first step towards the creation of an accreditation process that will be based on results."

The CDC National Nosocomial Infections Surveillance (NNIS) System is not currently on the list of indicators. Dr Robert Gaynes, Chief of Nosocomial Infections Surveillance Activities in the CDC's Hospital Infections Program said, "The CDC's NNIS System is among the 71 systems initially reviewed and approved by the JCAHO's Council on Performance Measurement. However, the NNIS System presently is not one of the 60 systems that are under contract with the JCAHO. For participation by the NNIS System in the JCAHO's Performance Measurement System, the CDC would need to revise the contract sent by the JCAHO, in order to be consistent with federal law, Section 308(d) of the Public Health Service Act and CDC policy." Dr. Gaynes explained that Section 308(d) of the Public Health Service Act states that "the identity of NNIS hospitals remains confidential." The CDC's Office of General Counsel currently is reviewing the contract.

For more information on JCAHO's new performance-measurement requirements, please telephone 630-792-5085, or visit their home page at http//www.jcaho.org.

FROM: Joint Commission on Accreditation of Healthcare Organizations. Press release: ORYX: The Next Evolution in Accreditation. Oakbrook, IL: JCAHO; February 18, 1977.

OSHA Mandates Reporting of Illness and Injury Data

The Occupational Safety and Health Administration (OSHA) issued a final rule in the February 11, 1997, *Federal Register,* that amends the Occupational Injury and Illness

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Reporting Regulation (29 CFR Part 1904), established in 1971. Under the original reporting regulation, employers were required to collect and maintain injury and illness data and to have them available for OSHA to examine. It was determined that OSHA needed a separate provision for collection of data by mail. As such, this final rule requires employers, upon request, to report to OSHA their illness and injury data, in addition to the number of workers and the number of days worked in a designated period.

The new rule establishes a procedural mechanism for OSHA to conduct an annual survey of 10 or more employers by mail or other remote transmittal. The specific request may come directly from OSHA or its designee (eg, The National Institute of Occupational Safety and Health). The data will be used for injury and illness surveillance, to evaluate OSHA standards, and to evaluate the effectiveness of enforcement training. In addition, they will be used to direct OSHA's programs for scheduled inspections.

Concerns were expressed throughout the rule-making process that reporting this information was burdensome and duplicative and that the data could be obtained from other sources, such as the workers' compensation files. OSHA argued that this new system would provide more reliable data better suited to OSHA's needs than any available alternative. Considering that OSHA cannot directly visit the over 5 million worksites, this provides information to target their activities, including workplace inspections. OSHA reported that 80,000 workplaces were inspected in 1996.

Employers will have 30 days to submit their data after the request is received. Employers will be notified in an upcoming *Federal Register* notice of the type of information that needs to be collected. Much of the injury and illness information to be reported will be taken from records that employers already are required to create, maintain, and post. The employment figures to be collected are critical to OSHA's ability to evaluate the injury and illness data. This regulation was scheduled to become effective on March 13, 1997.

Occupational health and safety experts have said that this rule will benefit those employers with good health and safety programs.

FROM: Department of Labor, Occupational Safety and Health Administration. Reporting occupational injury and illness data to OSHA. Final Rule. *Federal Register* 62 (28) February 11, 1997:6434-6442.

Safety Devices Prevent Percutaneous Injuries During Phlebotomy

Phlebotomy, one of the most commonly performed medical procedures, has been associated with 13% to 62% of injuries reported to hospital occupational health services and with 20 of 51 documented episodes of occupationally acquired HIV infection in the United States. A collaborative study recently was conducted by the CDC and six university-affiliated hospitals located in Minneapolis, New York City, and San Francisco to evaluate safety devices used for phlebotomy. The assessment was restricted to a comparison of safety devices with conventional devices. Each hospital selected the products to be evaluated (vacuum-tube collection devices or winged steel needles with safety features). Three products were evaluated and included a resheathable winged steel needle (device 1; Safety-Lok, Becton Dickinson, Franklin Lakes, NJ); a blunt vacuum-tube blood-collection needle activated while in the patient's vein (device 2; Puncture-Guard, Bio-Plexus Inc, Tolland, CT), and a vacuum-tube blood collection needle with a hinged recapping sheath (device 3; Venipuncture Needle-Pro, Smith Industries-Concord Portex, Keene, NH). Each product required the healthcare worker to activate the safety feature during or after phlebotomy. During phase I of the study, hospitals used conventional phlebotomy devices and conducted enhanced surveillance for injuries (encourage reporting, newsletters and published notices, inservice training). Underreporting and estimates of number of phlebotomies performed daily was assessed with an anonymous survey. During phase II of the study, investigators replaced conventional devices with safety devices. A second survey was done and also included an assessment of satisfaction with safety devices and any adverse effects in patients.

Overall, respondents acknowledged reporting only 54% of the 564 needlestick injuries that were sustained during the previous year. The findings indicated that, for each of the safety devices evaluated, the number of phlebotomy-related percutaneous injuries was significantly less for the safety devices compared to the conventional devices (both adjusted and unadjusted for underreporting). The percentage reduction in percutaneous injury rate with safety devices was 23% for device 1; 76% for device 2; and 66% for device 3.

The results of this study suggest that safety devices for phlebotomy may be generally acceptable to users. Activation rates of safety features and user acceptability may be influenced by factors such as the perceived risk for occupational infection by the HCW, design of the device, training provided before and after introduction of the device, length of time needed to become adept at using the device, ease of use, necessary changes in technique, and previous experience with a safety device.

FROM: Centers for Disease Control and Prevention. Evaluation of safety devices for preventing percutaneous injuries among health care workers during phlebotomy procedures—Minneapolis-St Paul, New York City, and San Francisco, 1993-1995. *MMWR* 1997;46:21-25.

Blunt Suture Needles Reduce Risk of Percutaneous Injuries

Percutaneous injuries (PIs) have been reported during 1% to 15% of surgical procedures, mostly associated with suturing. Most suturing is done using curved needles, although straight needles are used by some surgeons for suturing skin. Blunt suture needles (curved suture needles that have a relatively blunt tip) may be less likely to cause PIs, because they do not penetrate the skin easily. Based on a few small studies, these blunt suture needles are able to replace conventional curved suture needles for suturing many tissues, although they may require more pressure to penetrate the tissues. During March 1993 to June 1994, the CDC collaborated with three teaching hospitals in New York City to evaluate a blunt suture needle (Ethiguard, Ethicon Inc, Somerville, NJ) in gynecologic surgery. A total of 1,464