The Joint Commission Medication Management Update for 2010

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CPE Information and Disclosures

- Dr. Jorge D. Carrillo declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

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Learning Objectives

- Describe changes as a result of the Joint Commission's Standards Improvement Initiative (SII)
- Describe recent updates to the Joint Commission medication management (MM) standards for 2010
- List the most problematic MM standards in terms of noncompliance and provide best practice solutions
- Describe recent updates to the medication-related National Patient Safety Goals (NPSG) for 2010
- List the most problematic medication-related NPSG requirements in terms of noncompliance and provide best practice solutions
Self-Assessment Questions

• The Standards Improvement Initiative resulted in which of the following?
  a. Revision of all standards in the manual
  b. Reorganization of standards in logical fashion
  c. New numbering system
  d. All of the above

• What is the best approach to ensure compliance with the medication management standards?
  a. Let the nursing staff handle it
  b. Let physicians handle it
  c. Develop a multidisciplinary team
  d. Pharmacy can handle it by itself
Self-Assessment Questions

• When using multi dose vials, what is the best way to document the beyond use date?
  a. Follow the manufacturer’s expiration date
  b. Date vial with expiration date of 28 days from day it was first penetrated
  c. Date vial with day it was first penetrated, discard in 28 days
  d. Use only once and discard

• In 2009, the Medication Reconciliation process will:
  a. Be surveyed and scored with no changes
  b. Be eliminated for good
  c. Be surveyed, but not scored against the organization
  d. Be a more prescriptive process
Safety and Quality of Care

“Despite best efforts, serious quality and safety problems persist”

“Routine safety processes break down”

“Bad things still happen in good hospitals”

Dr. Mark R. Chassin, MD, MPP, MPH
President, The Joint Commission
Question

• The Standards Improvement Initiative resulted in which of the following?
  a. Revision of all standards in the manual
  b. Reorganization of standards in logical fashion
  c. New numbering system
  d. All of the above

Answer: d. All of the above
Standards Improvement Initiative (SII)

• Revised all standards and elements of performance (EPs)
• Categorized EPs based on their impact on care provided
• Standards and EPs are logically outlined
• New numbering system
• No new requirements were added, however . . .
Standards Improvement Initiative (SII)

Current Standard

SII Process (keep same requirement, revise structure, edit wording and grammar)

- Retain
  - No wording change
  - Change wording

- Split
  - Change wording

- Consolidate
  - Change wording

- Delete
  - Redundant
  - Non-essential
Standards Improvement Initiative (SII)

- All EPs are divided into two categories:
  - “A” EPs – either exist or do not exist
  - “C” EPs – based on the number of observations
  - Category “B” EPs were eliminated
  - No more Supplemental Findings

- Evidence of Standards Compliance (ESC)
  - Direct Impact – 45 days
  - Indirect Impact – 60 days
Standards Improvement Initiative (SII)

- **New Scoring Process**
  - Program-specific “Bands” for Direct Impact RFIs serve as screening thresholds
  - Summary of Survey Findings will not include accreditation decision
  - Final decision is made by TJC Central Office
2010 Medication Management Standards

- **Planning**
  - MM.01.01.01 - Plans medication management processes
  - MM.01.01.03 - Safely manage high-alert and hazardous medications
  - MM.01.02.01 - Safe use of Look-alike/Sound-alike medications

- **Selection & Procurement**
  - MM.02.01.01 - Select and procure medications

- **Storage**
  - MM.03.01.01 - Safely store medications
  - MM.03.01.03 - Safely manage emergency medications
  - MM.03.01.05 - Safely control medications brought in by patients, their families, or LIPs

- **Ordering & Transcribing**
  - MM.04.01.01 - Medication orders are clear and accurate

- **Preparing & Dispensing**
  - MM.05.01.01 - A pharmacist reviews the appropriateness of all orders for medications to be dispensed
  - MM.05.01.07 - Safely prepare medications
  - MM.05.01.09 - Medications are labeled
2010 Medication Management Standards

• Preparing & Dispensing (Cont.)
  – MM.05.01.11 - Safely dispense medications
  – MM.05.01.13 - Safely obtain medications when the pharmacy is closed
  – MM.05.01.17 - Follow a process to retrieve recalled or discontinued medications
  – MM.05.01.19 - Safely manage returned medications

• Administration
  – MM.06.01.01 - Safely administer medications
  – MM.06.01.03 - Self-administered medications are administered safely and accurately
  – MM.06.01.05 - Safely manage investigational medications

• Monitoring
  – MM.07.01.01 - Monitor patients to determine the effects of their medications
  – MM.07.01.03 - Respond to actual or potential ADE, significant ADR, and medication errors

• Evaluation
  – MM.08.01.01 - Evaluate the effectiveness of its medication management system
Top MM Standards Scored Non-Compliant in 2009*

- MM.03.01.01 Medication Storage 33%
- MM.04.01.01 Medication Orders 33%
- MM.05.01.01 Pharmacist Review 13%
- MM.01.01.03 High Alert Medications 6%
- MM.05.01.07 Medication Preparation 6%
- MM.05.01.09 Medication Labeling 6%

*Based on 664 surveys Jan-Jun 2009
Question

• What is the best approach to ensure compliance with the medication management standards?
  a. Let the nursing staff handle it
  b. Let physicians handle it
  c. Develop a multidisciplinary team
  d. Pharmacy can handle it by itself

Answer: c. Develop a multidisciplinary team
MM.01.01.03
High-Alert Medications

• Issues
  – Not implementing effective actions
  – Not following own policy

• Best Practices:
  – Special precautions for High Alert Drugs
    • Store, Prescribe, Prepare, Administer and Monitor
  – Computer warnings and onscreen pop-up alerts
  – Independent double check required in pharmacy and patient care area
  – Warning labels

Hot Issue!

Medi-Dose/ EPS, Inc

Health Care Logistics, Inc
MM.01.02.01
Look-Alike/Sound-Alike (LASA)

• Issues
  – Not implementing effective actions
  – Not following own policy
  – Lack of annual review

• Best Practices:
  – Colored labels on shelves and bins
  – Physically separate in storage areas
  – Tall Man lettering (**cefTRIA\text{x}one, cefURO\text{x}ime**)
  – List both generic & brand names on label, MARs
  – Consider different formulations of the same drug
Select and Procure Medications

• Criteria for selecting medications:
  – Indication
  – Drug Interactions
  – Adverse Drug Events
  – Other Risks
  – Effectiveness
  – Potential Error & Abuse
  – Sentinel Event Advisory
  – Cost

• Standardize and limit the number of drug concentrations available
  – Summit on Preventing Patient Harm and Death from IV medication errors, AJHP Dec 2008

• Annual review of medications available
Medication Storage

• What is secure as defined by CMS?
  – An area in which staff are actively providing patient care or preparing to receive patients

• Best Practices:
  – Non-mobile carts must be locked
  – Place mobile carts in a locked room
  – Medications at bedside only if self-administered
  – “Fanny-pack” scenarios
MM.03.01.01 Medication Storage

• Store medications according to manufacturer’s recommendations

• Best Practices:
  – Temperature Monitoring
    • Centralized Monitoring System
    • Alarm Dialing Monitors

  – Actions taken when temperatures are out of range
MM.03.01.01 Medication Storage

• Written policy addressing the storage of medications between receipt by an individual healthcare provider and administration of medication, including:
  – Safe storage
  – Safe handling
  – Security
  – Disposition
  – Return to storage
MM.03.01.01
Medication Storage

• Excerpt of a Sample Policy
  – Any drug received from the pharmacy should be placed in an approved storage area as soon as possible, not to exceed 30 minutes from time of receipt. *(Handling, Storage)*
  – All drugs removed from a medication storage area must be removed just prior to administration and only for one patient at a time. *(Handling)*
  – Once removed, the drug must remain with the individual at all times and should not be left unattended. *(Security)*
  – The drug should not be left on or in any area exceeding 80 degrees, including in pockets. *(Storage)*
  – If not administered or used, the drug should be returned to the original storage area within 30 min. *(Disposition)*
Question

- When using multi dose vials, what is the best way to document the beyond use date?
  a. Follow the manufacturer’s expiration date
  b. Date vial with expiration date of 28 days from day it was first penetrated
  c. Date vial with day it was first penetrated, discard in 28 days
  d. Use only once and discard

Answer: b. Date vial with expiration date of 28 days from day it was first penetrated
MM.03.01.01 Medication Storage

• Multi-Dose Vials (MDV)
  – USP Chapter 797 - 28 days “beyond use date”
  – Date MDV with expiration date
  – Best Practices:
    • Minimize use of MDV
    • Document: date opened and expiration date (28 days from day MDV is penetrated)
  – Pre-printed labels available

Health Care Logistics, Inc
Medi-Dose/ EPS, Inc
PHARMEX/ TimeMed
**MM.03.01.01**

**Medication Storage**

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**MULTIDOSE INJECTABLE VIALS (MDV)**

**MULTI-DOSE VIALS (MDV)** (lidocaine, insulins, injectables with preservative etc.)

Expiration: 28 days from initial use or sooner if specified by manufacturer; also called Beyond-Use-Date; **must be labeled**

**Label:**

Date Opened: 21 Mar 08
28 Day EXP: 18 Apr 08

**Examples:**

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**ALL OTHER MULTI-DOSE CONTAINERS (MDC)**

**MULTI-DOSE CONTAINERS (MDC)** (eye drops, Tylenol, Motrin, etc)

Expiration: Manufacture’s Expiration date or discard sooner if the product has been contaminated.

**Examples:**
MM.03.01.01 Medication Storage

- **Beyond Use Date**
  - Contrast media and warmers
  - Solution bags/bottles and warmers
  - Glucometer strips

- **Most ready-to-administer forms available from manufactures**
  - Contrast media, heparin, saline flush, others
  - Insulin pens

- **Unit-doses repackaged by the pharmacy or a licensed repackager**
MM.03.01.01  
Medication Storage

• Ready-to-administer forms  
  – Contrast media, heparin, saline flush, others  
  – Unit-doses

• Concentrated Electrolytes  
  – Best Practices:  
    • Remove from patient care units  
    • If required for emergencies (OR, ER, etc.):  
      – Segregate and/or Lock up  
      – Label (“MUST BE DILUTED” or “HIGH RISK MEDICATION”)  
    • High-alert medication procedures
• Unauthorized persons, in accordance with the hospital’s policy and law or regulation, cannot obtain access to medications
• Remove expired, damaged and/or contaminated medications
• Periodic inspection of storage areas
MM.03.01.03
Emergency Medications

• Issue
  – Emergency medications selection

• Best Practices:
  – Maximize use of unit-dose, age-specific, ready-to-administer
  – Pediatric dosing guidelines
  • Broselow™ Pediatric Emergency Tape
  – Emergency medications are secure
  – Process in place to replace emergency medications & supplies when needed
Ordering and Transcribing

• Issues
  – Lack of implementation of existing policies
  – Lack of policy on acceptable orders
  – Interpretation of range

• Best Practices:
  – Minimize verbal or telephone orders
  – Range Orders
    • Use only one variable (i.e. dose or dosing interval)
  – PRN Orders
    • Indication – Acetaminophen pain or fever?
    • Therapeutic duplication – which one 1st? 2nd?
Best Practices (cont.):

- Define required elements of a complete medication orders
  - Must include route of administration
- Pre-printed Orders
  - Check electronic and paper pre-printed orders
  - Forms Committee, P&T Committee, etc.
- No Blanket Orders
- Look-Alike/Sound-Alike Medications
  - Tallman lettering in pharmacy computer
 Exceptions allowed:
- Licensed Independent Practitioner (LIP) controls ordering, preparing and administration of drug
  - LIP must be physically present with the patient
- Urgent Situations

 Emergency Department – Review Exception
- LIP in the immediate area
- Pharmacy retrospective review of sample of orders
• Radiology – Review Exception
  – Protocol Based Approach (Screening Tool)
    • Oral and Rectal Contrast
    • IV and Other Contrast – only if:
      – Define role of LIP before/during IV contrast administration in protocol
      – Must be approved by medical staff
      – Appropriateness is reviewed by a qualified health care professional
      – Implement quality control procedures
      – Pharmacist is available on-call, if needed
      – Retrospective chart audits of sample
    • Does not apply to non-contrast meds

MM.05.01.01
Pharmacist Review of Orders

• Best Practices:
  – Automated Dispensing Cabinets (ADC)
    • Maximize ADC safety features
    • Minimize and monitor “Overrides”
  – No 24hr Inpatient Pharmacy Service
    • Qualified health care professional reviews order in the pharmacist’s absence
    • Measure competency
    • Retrospective review by a pharmacist
    • Consider telepharmacy and remote order entry services
  – Check with Surgery, L&D, and PACU
MM.05.01.01
Pharmacist Review of Orders

• Appropriate Review of Medication Order
  – Patient allergies/potential sensitivities
  – Existing/potential food & drug interactions
  – Appropriateness of drug, dose, frequency & route of administration
  – Current/potential impact of laboratory values
  – Therapeutic duplication
  – Other contraindications
  – Variation from approved indications for use
  – Clarification with individual prescriber prior to dispensing
MM.05.01.07
Safely Prepare Medications

• Issue
  – Non-pharmacy staff preparing IV medications

• Best Practices:
  – Only Pharmacy admixes sterile IV products
    • Except in emergencies or when not feasible
    • Be aware of elastomeric pump systems
    • Remove non-emergent medications from patient care units
  – Functionally separate area on nursing unit
  – Technical competency must be documented
MM.05.01.09
Medications are Labeled

• Issue
  – Drugs not labeled when should
  – No expiration date

• Applies to labeling medications in general

• It is also a National Patient Safety Goal
  – NPSG focuses on perioperative and procedural areas

• Best Practices:
  – Label all medication if prepared but not immediately administered
  – Educate staff on importance of requirement
  – Pre-printed labels
Dispense Medication

• Issues
  – Dispense medication and maintain records
  – Dispense within defined time-frame to meet patient needs

• Best Practices:
  – Develop anti-diversion strategies
    • ADC reports, Pandora Data System, etc.
  – Maximize use of most ready-to-administer forms and unit doses
    • Minimize use of MDV
MM.05.01.13
Pharmacy Access After Hours

• Process for providing medications to meet patient needs
• When non-pharmacist health care professionals are allowed to obtain medications:
  – Store/secure approved medications outside pharmacy (Medication Cabinet vs. ADC)
  – Only trained individuals are permitted access
  – Implement quality control measures
  – On call pharmacist available
MM.06.01.01
Administer Medication

- Define individuals authorized to administer medications
- Before administration, individual must:
  - Verify medication matches the order
  - Visually inspect medication
  - Verify expiration date
  - Verify contraindications
  - Ensure proper time, dose and route
  - Discuss unresolved concerns
  - Educate patient/family on new medication
Monitor Patient

- Monitor patient’s perceptions of side effects and effectiveness
- Monitor patient response to medication
  - Medical record
  - Relevant laboratory values
  - Clinical response
  - Medication profile
Adverse Drug Events

• Process to respond to actual and potential events
• Best Practices:
  – Assess Patient Safety Culture
  – Develop a Systems Approach
  – Limitations of Voluntary Reporting and Retrospective Reporting
  – Reporting tools
    • Paper vs. Electronic Form
    • Standardized vs. Free-Text Form
  – Identify Triggers
    • For Example: Benadryl, Dex 50%, Naloxone, Vit K, INR >6
  – Develop prospective process to identify and assess risks
Evaluation

• Issue
  – Lack of evaluation of risk points and internal review

• Best Practices:
  – Establish Process Improvement Program
  – Identify opportunities for improvement
  – Takes action and document improvements
  – Review literature/external sources
    • ASHP, APhA, ISMP, TJC, IHI, AHRQ, USP & others
  – Evaluate changes
USP Chapter 797

• TJC Does NOT survey against USP 797
• Organizations are required to
  – Evaluate own system against most current USP 797 requirements
  – Develop action plan for implementation of any changes you feel are necessary to improve process (MM.08.01.01)
• Can choose to do something different – unless required by state law or regulation
• No maximum timeline – you specify
• Only surveyed if evaluation done & plan present
Medication-Related National Patient Safety Goals

Top Non-Compliant Med-Related NPSG in 2009

- 03.04.01 Med Labeling in Procedures 29%
- 02.02.01 Unapproved Abbreviations 25%
- 01.01.01 Two patient identifiers 6%
- 03.05.01 Anticoagulation Management 5%
- 03.03.01 Look-Alike, Sound-Alike Drugs 5%

*Based on 664 surveys Jan-Jun 2009*
NPSG Changes for 2010

• Moved from NPSG to Standards:
  – Read Back of Verbal Orders 02.01.01  PC.02.01.03, EP 20
  – Do Not Use Abbreviations 02.02.01  IM.02.02.01, EP 2
  – Hand off Communications 02.05.01  PC.02.02.01, EP 2
  – Look-Alike Sound-Alike 03.03.01  MM.01.02.01
  – Fall Prevention 09.02.01  PC.01.02.17 *
  – Patient Involvement 13.01.01  PC.02.03.01, EP 27*
  – Early Response 16.01.01  PC.02.01.19 *

* and other miscellaneous standards
NPSG 1
Patient Identification

• NPSG 01.01.01: Two Patient Identifiers
  – EP1: Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier.
NPSG 2
Effective Communication

• Old - NPSG.02.02.01: Do Not Use Abbreviations
• Now IM.02.02.01, EP2
  – Best Practices:
    • Delete prohibited abbreviations from preprinted and/or automated order sheets
    • Educate and monitor staff who document in the medical record
    • Pharmacy does not accept any prohibited abbreviations
    • At medical staff meeting, give patient safety updates, including information about the prohibited abbreviations
    • Identify and promote "Physician Champions"
    • Ask every staff person to sign a statement that he/she has received the list and agrees not to use the abbreviations

http://www.jointcommission.orgPatientSafety/NationalPatientSafetyGoals

New Standard in 2010
NPSG 3
Safety of Using Medications

• NPSG.03.04.01: Labeling Medications
  – Issues
    • Not consistent in all procedural areas
    • Not all solutions labeled
    • No strength on label
    • Actual containers not labeled
    • Attaching vial to syringe as a label
    • Use of pre-labeled containers
    • Throwing out original containers before end of procedure
    • More than one medication labeled at a time
NPSG 3
Safety of Using Medications

• NPSG.03.04.01: Labeling Medications
  – Best Practices:
    • Pre-printed labels for OR/Anesthesia
      ![VClonidine mg/ml](Health Care Logistics, Inc)
      ![Midazolam mg/ml](Health Care Logistics, Inc)
    • Pre-printed labels for treatment rooms
      ![Medication cups](Medi-Dose/ EPS, Inc)
    • Process to label medications on & off sterile field
      – Surgical and procedural settings
      – Medication is aseptically delivered to sterile field
        » TJC Perspective on Patient Safety, July 2008
NPSG 3
Safety of Using Medications

• NPSG.03.05.01: Anticoagulation Therapy
  – Applies only to patients on anticoagulants when the drug is dispensed or administered by the organization
  – Applies to outpatient retail pharmacies owned by the hospital
  – Currently applies only to:
    • Warfarin
    • Heparin
    • LMW heparin
    • Not to antiplatelets and thrombolytics
  – Does not apply to flushes and prophylactic SQ heparin and prophylactic SQ LMW heparin
    • Prophylaxis vs. Therapeutic
NPSG 3
Safety of Using Medications

• NPSG.03.05.01: Anticoagulation Therapy
  – Elements of Performance
    1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
    2. Use written approved protocols for the initiation and maintenance of anticoagulant therapy.
    3. Before starting a patient on warfarin, assess the patient’s baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.
    4. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.
    5. When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.
NPSG 3
Safety of Using Medications

• NPSG.03.05.01: Anticoagulation Therapy
  – Elements of Performance
    6. A written policy addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies.
    7. Provide education regarding anticoagulant therapy to staff, patients, and families. Patient/family education includes the following:
       – The importance of follow-up monitoring
       – Compliance
       – Drug-food interactions
       – The potential for adverse drug reactions and interactions
    8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.
NPSG 7
Health Care-Associated Infections

• NPSG.07.05.01 Surgical Site Infections
  • Antimicrobial agents for prophylaxis used for a particular procedure or disease are administered according to evidence-based standards and guidelines for best practices
    – Administer within 1 hr before incision (two hours are allowed for the administration of vancomycin and fluoroquinolones)
    – Discontinue within 24 hours after surgery (within 48 hours is allowable for cardiothoracic procedures)
In 2009, the Medication Reconciliation process will:

a. Be surveyed and scored with no changes
b. Be eliminated for good
c. Be surveyed, but not scored against the organization
d. Be a more prescriptive process

Answer: c. Be surveyed, but not scored against the organization
NPSG 8
Medication Reconciliation

• Intent: To prevent errors of omission or duplication of medication therapy when a patient transitions from one setting or level of care to another
• As of January 1, 2009:
  – Will not factor into the accreditation decision
  – TJC will evaluate and refine the expectations
• New goal recommendations expected to be in effect on January 1, 2011
The Joint Commission’s Mission

• To continuously **improve health care for the public**, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in **providing safe and effective care of the highest quality and value**
Closing Remarks

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