The Joint Commission Update: 2018
Target Audience: Pharmacists
ACPE#: 0202-0000-18-007-L04-P
Activity Type: Knowledge-based
Disclosures

Melinda C. Joyce “declare(s) 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.”

The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Learning Objectives

1. Outline revisions to The Joint Commission (TJC) standards, focusing on those with a direct impact for health-system pharmacists.
2. Identify challenges for complying with TJC medication management standards.
3. Discuss the changes in the survey process.
1. Assessment Question

1. The risk matrix that is part of the new scoring guideline for The Joint Commission surveys, is based on
   A. How many total deficiencies are found during the survey
   B. Both the likelihood to cause harm and the scope of the frequency
   C. The number of times that the surveyor(s) consult with the Standards and Interpretation Group (SIG)
   D. The relationship between the deficiencies found and possible Sentinel events.
2. Assessment Question

2. Which of the following Medication Management (MM) standard was most cited in 2017?
A. MM.03.01.01 – Storage of medications
B. MM.04.01.01 – Clear and accurate medication orders
C. MM. 05.01.01 – Pharmacist review of medication orders
D. MM.08.01.01 – Evaluation of the medication management system
3. Assessment Question

3. Which of the following is true regarding pharmacist review of orders
A. Only applies to orders that are hand-written
B. Does not include review of therapeutic duplication since that is addressed through formulary management
C. Includes review of therapeutic appropriateness of the medication regimen
D. Includes drug-drug and drug-food interactions only
4. Assessment Question

4. Which of the following is true regarding the Medication Management (MM) standards for Antimicrobial Stewardship?

A. There must be leadership accountability for an antimicrobial stewardship program
B. Consultant medical staff cannot be members of the Antimicrobial Stewardship team
C. It is not the responsibility of the Antimicrobial Stewardship program to develop antibiotic-related protocols
D. Antimicrobial data should be collected and analyzed but does not need to be part of a formalized program
Survey Process
Survey Process

- Surveys are unannounced and the facility will know at 0730 that day if a survey is going to happen, the type of survey, the length of the survey, and the individual surveyors.

- Upon arrival, the team lead and other surveyors will spend some time coordinating the survey and setting their agenda.

- The number of surveyors will be dependent upon the services offered at your facility.

- Will most likely want to review certain documents first.
  - Document notebook

- Will also want a current patient census list and a surgery schedule.

- During the opening session, the surveyors will want to know what is new or different since the last survey.
TJC and CMS

- TJC surveyors are the “eyes and ears” of CMS
  - Hospitals are “deemed” to meet federal regulations when inspected by other organizations whose survey process and regulations are “deemed” by CMS to be equivalent to their federal survey process and regulations
  - This is one reason that hospitals use TJC for “deemed status” since CMS accepts the survey report from TJC

- Surveyors will have access to all previous TJC and CMS surveys

- Many TJC standards have been revised to more closely follow CMS conditions of participation (CoPs)
  - A CoP may have several different standards that roll-up to that particular CoP, which can impact the survey results
  - Surveyors may not have as much flexibility with whether or not a standard is met
Tracer Methodology

- Surveyors will continue to use the tracer methodology
  - Look for compliance with standards, adherence to policies, as well as consistency from location to location
  - Will want to talk with staff
  - May want to talk with patients
  - Will expect to see documentation
  - Policies are more important than ever
- Life Safety Surveyor will want to look EVERYWHERE!
- Will also be other types of “second generation tracers” that deal with a specific topic, such as Med Management tracer
- Patient safety is their focus!
New Scoring Methodology
SAFER Scoring Methodology

- **Survey Analysis for Evaluating Risk**
- Provides additional information related to risk of deficiencies cited during surveys
- This additional information helps to prioritize and focus corrective action
- Allows the facility to see areas of non-compliance at an aggregate level, showing significant components of risk analysis, likelihood of harm and scope of the deficiency
- The deficiencies that are found during the survey will be placed in the SAFER Matrix according to the likelihood of causing harm and how widespread the problem
- Any and all deficiencies found are placed in the matrix – “See It Cite It”
- The survey findings still correspond to the CMS Conditions of Participation
Changes to the Current Scoring Methodology

- A and C Elements of Performance have been eliminated as well as direct and indirect impacts
- All time frames for responses will be 60 days rather than the current 45 day response for direct findings or 60 days for indirect finishing
- Measures of Success (MOS) are no longer required
- Surveyors will no longer identify “opportunities for improvement”, which in the past were not be considered a finding
- Clarifications MUST be addressed during the survey – no longer a 10 day window for clarifications
- For deficiencies of a higher risk-level in the matrix, additional information will be required within the evidence of standards compliance (ESC) regarding sustainment of corrective actions
<table>
<thead>
<tr>
<th>Likelihood to Harm</th>
<th>Immediate Threat to Life</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High:</strong> Harm Could Happen at Any Time</td>
<td>![High Threat]</td>
</tr>
<tr>
<td><strong>Moderate:</strong> Harm Could Happen Occasionally</td>
<td>![Moderate Threat]</td>
</tr>
<tr>
<td><strong>Low:</strong> Harm Could Happen but would be Rare</td>
<td>![Low Threat]</td>
</tr>
</tbody>
</table>

**Scope**

- **Limited:** Unique occurrence that is not representative of routine/regular practice
- **Pattern:** Multiple occurrences with potential impact to few/some patients, visitors/staff and/or some settings
- **Widespread:** Multiple occurrences with potential to impact most/all patients, visitors, staff and/or settings
<table>
<thead>
<tr>
<th>Likelihood to Harm</th>
<th>Immediate Threat to Life</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td></td>
<td>Widespread</td>
</tr>
<tr>
<td>Moderate</td>
<td>MS.08.01.01. EP 1 RC.01.03.01. EP1 RC.03.05.15. EP 1</td>
<td>Pattern</td>
</tr>
<tr>
<td></td>
<td>IM.02.02.01. EP 3 PC.02.03.01. EP1</td>
<td>Limited</td>
</tr>
<tr>
<td>Low</td>
<td>EC.02.06.01. EP 1 MM.03.03.01. EP 2</td>
<td>Widespread</td>
</tr>
<tr>
<td></td>
<td>MS.12.01.01. EP 4</td>
<td>Limited</td>
</tr>
</tbody>
</table>
## What’s Next – Follow-Up Activity

<table>
<thead>
<tr>
<th>Standard</th>
<th>EP</th>
<th>Likelihood to Cause Harm</th>
<th>Scope</th>
<th>CoP</th>
<th>Tag</th>
<th>Included in the Medicare Deficiency Survey (Survey within 45 Calendar Days)</th>
<th>Included in the Evidence of Standard Compliance (within 45 Calendar Days)</th>
<th>Included in the Immediate Threat To Life Abatement Survey (within 23 Calendar Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR.09.04.01</td>
<td>1</td>
<td>ITL</td>
<td>ITL</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>EC.02.03.05</td>
<td>25</td>
<td>ITL</td>
<td>ITL</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>IC.02.01.01</td>
<td>1</td>
<td>High</td>
<td>Widespread</td>
<td>§482.51(b)</td>
<td>A-0951</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>IC.02.02.01</td>
<td>2</td>
<td>High</td>
<td>Limited</td>
<td>§482.51</td>
<td>A-0940</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MS.05.01.01</td>
<td>9</td>
<td>Low</td>
<td>Widespread</td>
<td>§482.22(d)</td>
<td>A-0364</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Moderate/Limited
Low Pattern
Low Widespread

- 60 day Evidence of Standards Compliance (ESC)
- ESC will include Who, What, When, and How sections
High Limited
High Pattern
High Widespread
Moderate Pattern
Moderate Widespread

- 60 day Evidence of Standards Compliance (ESC)
- ESC will include Who, What, When, and How sections
- Two additional sections
Follow-Up for Higher Risk Deficiencies

- 60 day Evidence of Standards Compliance (ESC)
  - Will include Who, What, When, and How sections
    - This is the same corrective action plan that has been in place for several years
  - ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis
  - Findings in the higher risk areas (dark orange and red areas) will be highlighted for potential review by surveyors on subsequent on-site surveys up to and including the next full survey
Leadership Involvement in ESC

- The measure of the success of change is in its sustainability within organizations.
- Success and sustainability are highly influenced by support from the top level of leadership.
- Examples of leadership involvement although TJC does not dictate what the leadership involvement should be:
  - Providing resources (e.g., staff, money, expertise)
  - Serving as a champion of the change
  - Direct participation on teams
  - Establishing intervals for communication and/or reporting
  - Direct oversight of change
Preventive Analysis in ESC

- Ensures the corrective action does not just simply fix the issue found during survey
- Focuses on identifying and addressing underlying reasons that caused the issue
- Efforts also focused on preventing future occurrences of the high risk issue
- Similar to the approach used for sentinel event corrective actions
  - What went wrong?
  - Why did this happen?
  - What process(es) failed?
  - What is the underlying reason why this went wrong?
- TJC has provided additional guidance as to what should be included in a preventive analysis
Immediate Threat to Life

- If an Immediate Threat to Life (ITL) is discovered during a survey, the organization immediately receives a preliminary denial of accreditation

- The organization has 72 hours to either entirely eliminate the ITL or implement emergency interventions to abate the risk to patients
  - If emergency interventions are put in place, there is a maximum of 23 days to totally eliminate the ITL
## Prioritized Follow-Up Actions

<table>
<thead>
<tr>
<th>Evidence of Standards Compliance (ESC) in 60 days</th>
<th>Low/Limited</th>
<th>Moderate/ Limited Low/ Pattern Low/ Widespread</th>
<th>Moderate/ Pattern Moderate/ Widespread</th>
<th>High/ Limited High/ Pattern High/ Widespread</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of Standards Compliance (ESC) plus additional fields for sustainment in 60 days</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Available for surveyors to see and review during subsequent surveys</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>
Example 1

<table>
<thead>
<tr>
<th></th>
<th>Immediate Threat to Life</th>
</tr>
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<tbody>
<tr>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>X</td>
</tr>
</tbody>
</table>

- It was observed that there was an entry in the record which had not been authenticated and/or dated and timed.
- The assessment had been signed by the author but the entry was not dated and timed.
Example 2

- It was observed during a tracer that the practices and processes associated with pre-cleaning of instruments/equipment prior to transporting to the decontamination areas was not consistent from location to location.
Example 3

- During the building tour of the Imaging/ Radiology/ and Emergency Department, it was observed that in all of the code carts inspected, the oral airways were stored in bulk and not individually wrapped, thereby creating the possibility for cross-contamination.

- Staff indicated that this type of storage was the policy of the facility.
Survey Findings

- **Standard Level**
  - Not considered systemic or severe as there are no significant negative outcomes from non-compliance
  - Does require an acceptable plan of correction (evidence of standards compliance)
  - Need to be cautious as several individual standard level deficiencies can be tied to a particular CMS tag number and roll up to a condition level

- **Condition Level**
  - One or more deficiencies considered systemic or severe
  - Requires an acceptable plan of correction but does trigger a follow-up survey (usually within 45 days) of those deficiencies that make up the condition level

- **Immediate Jeopardy (IJ)**
  - A situation in which the provider’s non-compliance with one or more requirements is likely to cause serious injury, harm, impairment, or death
  - Very serious and requires immediate, prompt attention, with 72 hours
# What’s Next – Follow-Up Activity

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<tr>
<td>APR.09.04.01</td>
<td>1</td>
<td>ITL</td>
<td>ITL</td>
<td></td>
<td></td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>EC.02.03.05</td>
<td>25</td>
<td>ITL</td>
<td>ITL</td>
<td></td>
<td></td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
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<td>1</td>
<td>High</td>
<td>Widespread</td>
<td>§482.51(b)</td>
<td>A-0951</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
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<td>Limited</td>
<td>§482.51</td>
<td>A-0940</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
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<tr>
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<td>9</td>
<td>Low</td>
<td>Widespread</td>
<td>§482.22(d)</td>
<td>A-0364</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>
CoP: §482.51  Tag: A-0940  Deficiency: Condition  
Corresponds to: HAP - IC.02.02.01/EP2, EP4  
Text: §482.51 Condition of Participation: Surgical Services  
If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

The Joint Commission  
Summary of CMS Findings

<table>
<thead>
<tr>
<th>CoP Standard</th>
<th>Tag</th>
<th>Corresponds to</th>
<th>Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>§482.51(b)(1)(ii)</td>
<td>A-0952</td>
<td>HAP - PC.01.02.03/EP5</td>
<td>Standard</td>
</tr>
<tr>
<td>§482.51(b)</td>
<td>A-0951</td>
<td>HAP - IC.02.02.01/EP2</td>
<td>Standard</td>
</tr>
<tr>
<td>§482.51(b)(6)</td>
<td>A-0959</td>
<td>HAP - RC.02.01.03/EP7</td>
<td>Standard</td>
</tr>
</tbody>
</table>
### What Are the Most Problematic Hospital Findings?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86%</td>
<td>LS.02.01.35</td>
<td>The hospital provides and maintains systems for extinguishing fires.</td>
</tr>
<tr>
<td>74%</td>
<td>LS.02.01.30</td>
<td>The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.</td>
</tr>
<tr>
<td>73%</td>
<td>EC.02.05.01</td>
<td>The hospital manages risks associated with its utility systems.</td>
</tr>
<tr>
<td>70%</td>
<td>IC.02.02.01</td>
<td>The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>68%</td>
<td>EC.02.06.01</td>
<td>The hospital establishes and maintains a safe, functional environment.</td>
</tr>
<tr>
<td>66%</td>
<td>LS.02.01.10</td>
<td>Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.</td>
</tr>
<tr>
<td>62%</td>
<td>EC.02.02.01</td>
<td>The hospital manages risks related to hazardous materials and waste.</td>
</tr>
<tr>
<td>60%</td>
<td>LS.02.01.20</td>
<td>The hospital maintains the integrity of the means of egress.</td>
</tr>
<tr>
<td>60%</td>
<td>EC.02.05.05</td>
<td>The hospital inspects, tests, and maintains utility systems.</td>
</tr>
<tr>
<td>57%</td>
<td>RC.01.01.01</td>
<td>The hospital maintains complete and accurate medical records for each individual patient.</td>
</tr>
</tbody>
</table>

From surveys in the first half of 2017 – TJC Perspectives
Medication Management Standards
Medication Management (MM) Standards

- Several changes in the MM standards
- Still is considered to be one of the highest risk chapters and is a very hot topic chapter
- Surveyors will continue to focus on problematic standards during the tracer process
- Pharmacy visit is usually fairly short but the dedicated Life Safety surveyor may also spend time in the pharmacy
  - Will want to look at the automated dispensing cabinets (ADCs)
- Most of the medication management standards are surveyed on the nursing units
- Close attention to policies
  - Will survey not only to the standard but also to whether or not the policy is being followed
<table>
<thead>
<tr>
<th>Standard</th>
<th>% Non-Compliant 2017</th>
<th>% Non-Compliant 2016</th>
<th>% Non-Compliant 2015</th>
<th>% Non-Compliant 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM.04.01.01 Medication Orders</td>
<td>49.3%</td>
<td>33.5%</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td>MM.03.01.01 Storage and Security of Meds</td>
<td>47.8%</td>
<td>31.4%</td>
<td>32%</td>
<td>32.2%</td>
</tr>
<tr>
<td>MM.05.01.01 Medication Order Review</td>
<td>14.9%</td>
<td>11%</td>
<td>18%</td>
<td>20.3%</td>
</tr>
<tr>
<td>MM.05.01.07 Preparing Medications</td>
<td>14.2%</td>
<td>6.4%</td>
<td>5.4%</td>
<td>5.3%</td>
</tr>
<tr>
<td>NPSG.03.04.01 Labeling in OR/Procedures</td>
<td>8.8%</td>
<td>11%</td>
<td>9.9%</td>
<td>12.3%</td>
</tr>
<tr>
<td>MM.03.01.03 Emergency Medication</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPSG.03.06.01 Reconciling Medications</td>
<td>6.7%</td>
<td>4%</td>
<td>4.3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>MM.09.01.01 Antimicrobial Stewardship</td>
<td>4.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MM.05.01.11 Safe Dispensing of Medications</td>
<td>4.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
About This Chapter:
Safe and Effective Medication Use

- Managing high-alert and hazardous medications
- Selecting and procuring medications
- Storing medications
- Managing emergency medications
- Managing medication orders
- Managing medications brought in by patients/families
- Preparing medications
- Labeling medications
- Dispensing medications
- Administering medications
- Retrieving recalled or discontinued medications
- Managing investigational medications
- Monitoring patients’ reactions to medications
- Responding to adverse drug events and medication errors
M.M. 01.01.01:
The Hospital Plans its Medication Management Processes

- Hospital plans each part of the medication management process with care so safety and quality are maintained

- Written policy and procedures that indicate the following information about the patient is accessible to licensed independent practitioners (LIPs) and staff who participate in the management of medications
  - Age
  - Sex
  - Diagnoses
  - Allergies
  - Sensitivities
  - Current medications
  - Height and weight
    - Accurate!
  - Pregnancy and lactation
  - Laboratory results
  - Any additional information required by facility
MM.01.01.03
High-Alert and Hazardous Medications

- *The hospital safely manages high-alert and hazardous medications*

- **Issues**
  - Because of the concerns associated with compounding, both TJC and CMS have an intense review on medication safety, especially medication preparation and administration
  - Not implementing effective actions
  - Not following own policy
  - Nursing staff not able to talk about high-alert or hazardous medications
  - Certain topics, such as pharmaceutical waste may also come up during the Environment of Care or Life Safety survey
MM.01.01.03

- **High-Alert Medications**
  - Those medications involved in a high percentage of errors and/or sentinel events, as well as those that carry a high risk for abuse or other adverse outcomes
  - Must have a list that is developed by the facility
  - Must outline specific strategies
  - If there are special policies dealing with high-alert medications, must be followed at all times
  - Hospital reports abuses and losses of controlled substances to the Director of Pharmacy and to the CEO (as appropriate)
The hospital selects and procures medications

- MANY elements of performance!
- Must have medical staff and other appropriate professionals involved in formulary decisions
- Criteria on why medications are available
  - Formulary should be reviewed annually based on safety and efficacy information
- Standardization and limitations on the number of drug concentrations available
  - Must be appropriate for patient care needs
- Plan for how a new medication will be monitored
- Plan should include anything specific about pediatric or geriatric monitoring
  - Beer’s List
  - Weight-based dosing
- Process for obtaining non-formulary drugs
- Shortages/ outages
MM. 02.01.01
Medication Procurement

Questions:

- How can you demonstrate that there is a process for medication procurement and formulary management?
- What is the process for handling drug shortages?
- How is information about drug shortages or outages communicated to the medical staff? Nursing staff?
- Are substitution protocols in place?
- How are medications monitored?
- How is information about that monitoring disseminated?
MM.03.01.01
Medication Storage

- The hospital safely stores medications
- Number two medication management standard for non-compliance!
- 47.8% of acute care hospitals had this as a finding in 2017
- Focus should be on all medications, but especially controlled substances
MM.03.01.01

- MANY Elements of Performance (EPs):
  - EP 2: Medications are stored according to manufacturer’s recommendations
  - EP 3: All medications and biologicals are stored in secure areas to prevent diversion and locked when necessary, in accordance with law and regulation
  - EP 4: Written policy addressing the control of medication between receipt by an individual and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage
  - EP 6: The hospital prevents unauthorized individuals from obtaining medications in accordance with law and regulation
  - EP 7: Medications and chemicals are properly labeled
  - EP 8: Removes expired, damaged, and/or contaminated medications and stores them separately
  - EP 24: Hospital maintains records of the receipt and disposition of radiopharmaceuticals
Medication Storage

- **EP 2:**
  - Refrigerator temperatures!
  - What actions are taken if the refrigerator temperature is out of range?
  - What happens when the medication refrigerator is located in an area that is closed on weekend?
  - Can also be a finding in IC.01.01.04 or IC.02.02.01

- **EP 4:**
  - Written policy addressing the control of medication between receipt by an individual and administration
  - Think about the tube or dumb-waiter systems

- **EP 6:**
  - How do you provide and remove access to automated dispensing cabinets (ADCs)?
Medication Storage

**EP 7:**
- Beyond use dating
  - Cannot use “date opened” labels
  - Revised expiration date of 28 days from the date of opening or puncture
  - Vaccines are exempt from 28 day rule and should be stored in the middle of the refrigerator
  - Can also be a finding in IC.01.01.04 or IC.02.02.01
- Use of syringes on multiple patients

**EP 8:**
- Expired medications
  - Will look for these!
  - How are the expired medications segregated in the pharmacy from other medications and what is the process for return
Medication Storage Issues

Questions:

- Where are medications stored?
- Are medications being stored in places other than those addressed in manufacturer guidelines?
- Are carts kept locked?
- If the cart is in a room is the room locked?
- What is the process if the medication refrigerator is found to be out of range?
- Are fanny-packs in use?
- What is the beyond use date for a single use vial? For a multi-use vial?
- Can an insulin pen be used on more than one patient provided the needle is changed?
- What is the policy for samples?
- How is the pharmacy notified when a nurse with ADC access leaves the organization?
MM.03.01.03
Emergency Medications

- *Hospital needs to safely manage emergency medications*
  - Code cart contents should reflect the latest ACLS guidelines
  - Code cart contents should be in the most ready-to-use formulation
  - Remember to ensure pediatric doses are available, especially in a code situation
  - Make sure that any Broselow tapes are current!
  - Always check expiration dates carefully
  - Make sure that crash carts are restocked in a timely and secure manner
  - All surveyors may check but generally falls under the life safety surveyor to check to see if crash carts are being checked
    - If they find one instance of a crash cart not being checked, then will start looking intently at all carts
HM.03.01.05

- Hospital safely controls medications brought into the hospital by patients, families, and licensed independent practitioners
  - Defines when medications brought into the hospital can be administered
    - Applies to samples
  - Before use or administration, the medication is identified and visually evaluated for integrity
    - Standard does not state that it has to be a pharmacist but practice and policy must agree
MM.04.01.01
Medication Orders

- *Medication orders are clear and accurate*
- This standard is the crux of safety regarding communication about medications
- Contains many elements of performance that can be problematic
  - Electronic prescribing has helped but has also caused different problems

**Number 1 Med Management Finding!**
MM.04.01.01

- **EP 1:** The hospital identifies the specific type of medication orders that is deemed acceptable for use
  - All “PRN” orders must include indication unless the medication is used for only one indication
  - Titration orders
  - Range orders
  - Standing orders
  - Orders with compounded medications
  - Herbal products
  - Medication-related devices
Range Orders

- Orders must comply with organizational policy on required elements
  - Dose range
  - Interval range
- How is that range order interpreted?
  - Is the interpretation consistent throughout the hospital
- Does therapeutic duplication also exist?
- What is the nursing education for range orders?
Titration Orders

- Policy needs to spell out what needs to be included in the order
  - Starting dose
  - Assessment parameters
  - Final endpoint
  - Maximum dose

- Watch orders that state “Titrate drug X according to guidelines”
  - Where are the guidelines? Are they readily available? Are they part of the medical record?
  - What is the nursing education for titration orders/

- Watch sedation and oxytocin titration orders carefully
MM.04.01.01

- **EP 3:** Policy for which orders require an indication
- **EP 4:** Precautions for ordering medications that are look-a-like/sound-a-like
- **EP 6:** Verbal orders and telephone orders are minimized
- **EP 7:** The hospital reviews and updates pre-printed order sheets, within the time frame it identifies or sooner if necessary based on current evidence and practice
  - Policy and practice must agree!
  - Pharmacist must be part of a review of pre-printed orders
  - How often are pre-printed orders reviewed
- **EP 8:** Prohibits blanket orders to resume previous medications
- **EP 10:** Hospital defines, in writing, when weight-based dosing is required for pediatric patients
MM.04.01.01

- **EP 13:** Hospital implements its policies for medication orders (ties to EP 1)
  - Policy and practice must agree!
  - Nursing staff must be able to speak to the policy
  - Policy must include:
    - The elements of a complete order
    - Indications for PRN orders unless the medication is used for only one indication
    - Range Orders
    - Look-alike-sound-alike medications
    - When should weigh-based dosing be used
    - Titration Orders with initial rate and/or clear parameters for titration
    - Blanket Orders are not acceptable
    - Watch for multiple orders for similar medications
      - Which orders take precedence?
MM.04.01.01

- **EP 15**: Processes for the use of pre-printed and electronic standing orders, order sets, and protocols for medication orders
  
- Requirements are clearly specified
  - Must have approval from medical staff, pharmacy leadership, and nursing leadership
  - Developed using nationally recognized and evidence-based guidelines
  - Must undergo a regular review to determine if the standing order is still relevant
  - Dating, timing, and authentication per hospital policy and medical staff by-laws

- Order Set – list of individually selectable interventions or orders that the practitioner may choose from

- Protocol – requires the patient to meet certain clinical criteria, but there must be an order to initiate the protocol

- Standing order – an order that may be initiated without an initial order by the LIP if the patient meets certain criteria
MM.04.01.01

Questions:

- What is the policy for range orders?
- Is it acceptable to have an order that states “Resume all medications after surgery”?
- Are titration orders handled consistently from area to area?
- How often are standing orders reviewed?
- What is the process for a new standing order to be placed into use?
- What is done differently for a look-a-like or sound-a-like medication order?
- What is the process for standing order reviews now that most all of the orders are entered electronically?
- If a patient has an order for three different pain medications, how do the nursing staff know which one to administer?
- Does the policy and practice agree?
MM.05.01.01

- A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital

- **EP 1:** Before dispensing or removing medications from floor stock or from an automated dispensing cabinet (ADC), a pharmacist reviews all medication orders unless:
  - A Licensed Independent Practitioner (LIP) controls ordering, preparing, and administering of drug
  - Delay would harm the patient in urgent situations
  - Two exceptions noted

- Nursing staff need to be able to speak to this standard

- Ties to MM 08.01.01
Exceptions

- Emergency Department
  - A licensed independent practitioner (LIP) is not required to remain at the bedside when the medication is administered. However, a LIP must be available to provide immediate intervention should a patient experience an adverse drug event.

- Radiology
  - Pharmacist review of contrast orders (including radiopharmaceuticals) is exempted. However, the hospital is expected to define, through protocol or policy, the role of the LIP in the direct supervision of a patient during and after IV contrast is administered, including the LIP’s timely intervention in the event of a patient emergency.
  - Includes any ambulatory radiology areas.
MM 05.01.01

- EP4: Allergies/ sensitivities
- EP 5: Potential interactions
- EP 6: Appropriateness of the medication, dose, frequency, and route of administration
- EP 7: Current or potential impact as indicated by laboratory values
- EP 8: Therapeutic duplication
  - Very much an issue, especially if providers are allowed to create their own order sets without pharmacist involvement
- Remember: Policy and practice must agree!!!
MM.05.01.01
Pharmacist Review of Orders

- For those facilities that do not have a 24/7 on-site pharmacy

- **EP2:** When on-site pharmacy is not open 24/7, qualified healthcare professional reviews the medication order in the pharmacist absence
  - Must be followed by a pharmacist review when the pharmacy is open
  - Must outline the “qualified healthcare professional” in policy

- **EP 3:** A pharmacist conducts a retrospective review of all medication orders as soon as a pharmacist is available
Safely Prepare Medications

- The hospital safely prepares medications

- EP 1: When an on-site licensed pharmacy is available, pharmacy compounds or admixes all compounded sterile preparations except in urgent situations in which a delay could harm the patient
  - Non-pharmacy staff preparing IV medications

- Questions:
  - Are pre-mixed IV solutions used whenever possible?
  - When does the Pharmacy staff not prepare IV solutions?
  - If nursing staff is preparing IV solutions, is it done in a functionally separate area?
  - Is technical competency assessed by a pharmacist?
  - Is the fact that the pharmacy is not open 24/7 an exception?
The hospital safely prepares medications

EP 6: In-house preparation of radiopharmaceuticals is done by, or under the supervision of, an appropriately trained registered pharmacist or doctor of medicine or osteopathy

Questions:
- Where do radiopharmaceuticals come from?
- Are they unit-dose, patient-specific?
- Is there an on-site generator?
- What is mixed in the hot lab?
- Is the Radiation Safety Officer involved in the process?
MM.05.01.09

- **Medications are labeled**
  - Many Elements of Performance and this ties back to the NPSG
  - **EP 1:** Medication containers are labeled whenever medications are prepared but not immediately administered
  - **EP 2:** Information on medication labels is displayed in a standardized format
  - **EP 3:** Labeled with medication name, strength, and amount
  - **EP 4:** Expiration date when not used within 24 hours
  - **EP 5:** Expiration time when expiration occurs in less than 24 hours
  - **EP 10, 11, 12:** If prepared by other person than who will administer, patient’s name, location, directions, and cautions
MM.05.01.09

- Know what needs to be on the label and make sure that all elements are there
  - Name
  - Strength
  - Amount if not apparent from container
  - Expiration date/time
  - Date prepared
  - Diluent for compounded IVs (additional if preparing individualized doses for multiple patients)
  - Cautionary labels if applicable

- Know where medications may be prepared and how they are labeled
MM.05.01.09

- Remember **NPSG.03.04.01 – Labeling in Procedures**

- In the peri-operative and other procedural settings both on and off the sterile field, medication or solution labels include:
  - Medication or solution name
  - Strength
  - Amount of medication or solution containing medication (if not apparent from the container)
  - Diluent name and volume (if not apparent from the container)
  - Expiration date and time
The hospital safely obtains medications when the pharmacy is closed

EP 1: Process for provision of medications when the pharmacy is closed

EP 4: Only trained health care professionals are allowed by law or regulation to obtain medication
  - Types of medications available should be limited

EP 5: Quality control procedures for what has been retrieved from the pharmacy

Questions:
  - What medications are available when the pharmacy is closed?
  - Is there some kind of double check system after the medication has been retrieved? Drug security?
  - Is there a pharmacist on-call for questions?
MM.05.01.17 and MM.05.01.19

- **MM.05.01.17**
  - *Hospital follows a process to retrieve recalled or discontinued medications*
    - Policy for how to handle a recalled medication
    - Notification to the prescriber that a medication has been recalled
    - Notification to the patient IF part of the policy
    - Segregation from unaffected pharmacy stock

- **MM.05.01.19**
  - *Hospital safely manages returned medications*
    - Policy for what circumstances unused, expired, or returned medication will be managed by the pharmacy
    - Process for control of returned medications to prevent diversion
MM.06.01.01

- **The hospital safely administers medications**
- **EP 1:** Who can administer medications
- **EP 3, 4, 5, 6, 7, and 8:** Activities before a medication is administered
- **EP 9:** Before administering a new medication, the patient or family is informed about any potentially clinically significant adverse reactions (ties to MM.0.01.03 and PC.02.03.01)
- **EP 13:** Before administering a radioactive pharmaceutical for diagnostic purposes, staff verify that the dose to be administered is within 20% of the prescribed dose, or, if the dose is prescribed as a range, staff verify that the dose to administered is within the prescribed range
MM.06.01.01

- **Questions:**
  - What will the surveyor see during med pass?
  - Do staff follow isolation precautions or hand hygiene before administering medications?
  - Do staff educate the patient/family about potential adverse reactions?
  - How do staff discuss any unresolved medication issues with the prescriber?
  - Nursing staff needs to be able to talk about what they do
**MM.06.01.03**

- **Self-administered medications are administered safety and accurately**
  - Family members are included in the definition of self-administered

- **EP 1:** Written process
  - Training
  - Supervision
  - Documentation
  - Monitoring

- **EP 3, 4, 5, and 6:** Education of patient/family involved in self-administration of medications

- **EP 7:** The patient (or family member) is competent to administer the medication
Questions:

- Does hospital policy allow for self administration?
- How is the patient trained and educated? How and where is that education documented?
- Does patient know potential side effects or effects to monitor?
- How does staff know if the patient/ family is competent to perform the self-administration?
The hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors

EP 1: Policy on how to respond
EP 2: Prescriber notification
EP 3: Internal and/or external reporting requirements
EP 5: Implements its process

CMS expects that the hospital’s PI program include indicators to identify and reduce medical errors, which would include medication errors and adverse drug events

- Expectation that opioid monitoring be included in the QAPI (Quality Assurance Performance Improvement) Worksheet – ties to new pain standards
- Expectation that medication errors are reviewed with a multi-disciplinary team
MM.08.01.01
Evaluates the Effectiveness

- The organization evaluates the effectiveness of its medication management system
- Analyzes data
- Compares data over time to identify risk points, levels of performance, patterns, trends, and variations
  - What action items are implemented when satisfactory data is not achieved or sustained
- If the facility has a disease-specific TJC certification, such as a primary stroke center, need to make sure that any pharmacy-specific performance improvement data is monitored
- Evaluates the literature and implements best practices
- Data is incorporated into the facility’s overall QAPI Worksheet
- NEW! EP 16: When automated dispensing cabinets (ADCs) are used, the hospital has a policy that describes the types of medication overrides that will be review for appropriateness and the frequency of the reviews
The hospital has an antimicrobial stewardship program based on current scientific literature

- **EP 1:** Leaders establish antimicrobial stewardship as an organizational priority (ties to the LD chapter)

- **EP 2:** Education is provided to staff and licensed independent practitioners involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial resistance and antimicrobial stewardship practice
  - Occurs upon hire or granting of initial privileges and periodically based on organizational need
MM.09.01.01

- **EP 4:** Antimicrobial stewardship multidisciplinary team
  - Infectious disease physician
  - Infection preventionist(s)
  - Pharmacist(s)
  - Practitioner
  - Part-time, consultant staff, or telehealth staff are acceptable as members of the team

- **EP 5:** Antimicrobial stewardship program has the following components
  - Accountability – single leader responsible for program outcomes
  - Drug expertise – single pharmacist leader
  - Action – implementing action plans based on evaluation of data
  - Tracking – monitoring the antimicrobial stewardship, including prescribing information and resistance patterns
  - Reporting – regular reports to providers, staff, and administration
  - Education – regular education as needed
MM.09.01.01

- **EP 6:** Antimicrobial stewardship program uses organization-approved multidisciplinary protocols
- **EP 7:** Collects, analyzes, and reports data on its antimicrobial stewardship program
- **EP 8:** Takes action on improvement opportunities identified in its antimicrobial stewardship program
Questions:

- Is there an Antimicrobial Stewardship Team?
- What is the evidence of the Team in leadership minutes, such as governing board meeting minutes?
- Who are the members of the Team?
- What is the Antimicrobial Stewardship policy?
- What kinds of protocols are in place for antimicrobial stewardship?
- What data is available to show the effectiveness of an antimicrobial stewardship program?
Other Pertinent Standards and Issues
IC.02.02.01
Medical Equipment, Devices, and Supplies

- **Infection Control Standard**
  - **EP 4:** Storage of medical equipment, devices, and supplies
  - Implementation of the infection prevention plan
  - Although this standard is usually thought to address disinfecting and sterilization, it is a “catch-all” standard that can have many potential findings
  - 70% of all acute care hospitals had this as a finding in 2017
    - Wire shelves
    - Open containers of antiseptic or bleach wipes
    - Storage in clean versus soiled utility rooms
    - High-level disinfection processes
    - Expiration dates
    - Cardboard!!
EC.02.05.03

- Hospital has a reliable emergency electrical power source
- EP 14: Implement a policy to provide emergency backup for essential medication dispensing equipment
- EP 15: Implement a policy to provide backup for essential refrigeration for medications
Pain Management Standards

- Identification of a leader or a leadership team that is responsible for pain management and safe opioid prescribing

- Involvement of patients in developing their treatment plans and setting realistic expectations and measurable goals

- Promotion of safe opioid use through identification of high-risk patients

- Monitoring of high-risk patients

- Facilitation of clinician access to prescription drug monitoring program databases

- Conduct performance improvement activities focusing on pain assessment and management to increase safety and quality for patients
Pain Management Standards

- Many chapters are involved
- Leadership chapter (LD.04.03.13)
- Medical staff chapter (MS.05.01.01)
- Provision of care chapter (PC.01.02.07)
- Performance improvement chapter (PI.01.01.01 and PI.02.01.01)
- Pharmacists must be involved in with these pain management standards!
Resources/ References

- There are MANY resources and references available for all of these topics
- Joint Commission
  - www.jointcommission.org
  - Perspectives
  - Sentinel Event Alerts
- Institute of Safe Medication Practices
  - www.ismp.org
- Centers for Disease Control
  - www.cdc.gov
- CMS – Conditions of Participation
Key Points

- **Must be prepared as if we know the surveyors will be here tomorrow!**
- **Be survey ready at all times**
  - Keep policies up-to-date
  - Keep competencies and any license requirements current
  - Participate in mock tracers
  - Know where medications are being stored and don’t depend on others to be checking those meds
- **Clean and De-Clutter**
  - That first impression when the surveyors walk into the Pharmacy Department is huge
  - Be ready to show off your area
Key Points

- **Education**
  - Talk to your staff/ask questions like a surveyor
  - Continually provide information about changes in standards
  - Participate in mock tracers and give feedback on what is found during tracers

- **Read and know the standards**
  - Don’t forget the Medicare Conditions of Participation
  - You are the expert on the medication management standards!

- **Stay positive! The goal is an outstanding survey but more importantly, following the standards helps to provide safe and outstanding quality patient care.**
1. The risk matrix that is part of the new scoring guideline for The Joint Commission surveys, is based on
A. How many total deficiencies are found during the survey
B. Both the likelihood to cause harm and the scope of the frequency
C. The number of times that the surveyor(s) consult with the Standards and Interpretation Group (SIG)
D. The relationship between the deficiencies found and possible Sentinel events.
2. Assessment Question

2. Which of the following Medication Management (MM) standard was most cited in 2017?
A. MM.03.01.01 – Storage of medications
B. MM.04.01.01 – Clear and accurate medication orders
C. MM. 05.01.01 – Pharmacist review of medication orders
D. MM.08.01.01 – Evaluation of the medication management system
3. Assessment Question

3. Which of the following is true regarding pharmacist review of orders
   A. Only applies to orders that are hand-written
   B. Does not include review of therapeutic duplication since that is addressed through formulary management
   C. Includes review of therapeutic appropriateness of the medication regimen
   D. Includes drug-drug and drug-food interactions only
4. Assessment Question

4. Which of the following is true regarding the Medication Management (MM) standards for Antimicrobial Stewardship?

A. There must be leadership accountability for an antimicrobial stewardship program
B. Consultant medical staff cannot be members of the Antimicrobial Stewardship team
C. It is not the responsibility of the Antimicrobial Stewardship program to develop antibiotic-related protocols
D. Antimicrobial data should be collected and analyzed but does not need to be part of a formalized program
Questions?

Thank You!

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