Your Annual Joint Commission Update

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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.”
CPE Information

- Target Audience: Pharmacists and Pharmacy Technicians
- ACPE#: 0202-0000-19-032-L04-P/T
- Activity Type: Knowledge-based
Learning Objectives

At the completion of this knowledge-based activity, participants will be able to:

• Outline revisions to The Joint Commission standards, focusing on those with a direct impact for health-system pharmacists.

• Identify challenges for complying with medication management standards.

• Discuss how the Survey Analysis for Evaluating Risk Matrix scoring guidelines can be used to direct survey readiness.
Assessment Questions

1. Which of the following Medication Management (MM) standards was most cited in 2018?
   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
2. Why are range orders often found as a problem during a survey by The Joint Commission?

A. The hospital has a written policy that identifies specific types of range orders that it deems acceptable for use.

B. The hospital policy on range orders have required elements, such as dose range and interval range.

C. There is inconsistent interpretation of how to carry out the range order.

D. The hospital process for range orders must also include review for therapeutic duplication.
Assessment Questions

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 drug-drug and drug-food interactions only.
   D. Includes review of therapeutic appropriateness of the medication regimen.
4. When a particular element of performance from a medication management standard is found to be in non-compliance and cited on the Survey Analysis for Evaluating Risk Matrix as a High Risk/ Widespread finding, the following will be required as part of the evidence of standards compliance.

A. Four months of tracking improvement activities that will be submitted to The Joint Commission.

B. Any policy updates resulting from the findings will be submitted to The Joint Commission.

C. A preventive analysis is done to ensure that the corrective action identifies and addresses any underlying reasons that might have lead to the non-compliance.

D. A signed attestation by the Chief Executive Officer.
Survey Process
Comprehensive Accreditation Manuals

• All of the standards for a particular healthcare entity that is accredited by The Joint Commission (TJC), such as a hospital, critical access hospital, or nursing care center has a comprehensive accreditation manual

• Each manual is divided into chapters that correspond to areas within the facility
  • Examples include:
    • Environment of Care (EC) chapter
    • Infection Prevention and Control (IC) chapter
    • Life Safety (LS) chapter
    • Medication Management (MM) chapter
Comprehensive Accreditation Manuals

• Each chapter lists each of the standards and elements of performance (EPs)
  • The EPs are more specific requirements to show compliance with the standard
  • Each standard may have multiple EPs
• For this presentation, the 2019 Comprehensive Accreditation Manual for Hospitals, e-Edition has been used
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.
The Joint Commission (TJC) and the Center for Medicare and Medicaid (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, including previous scoring matrix grids
- 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 Medication Management tracer

- Patient safety is their focus!
Scoring Methodology

- **Survey Analysis for Evaluating Risk (SAFER)**
  - 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 with 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 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>Red</td>
</tr>
<tr>
<td><strong>Moderate:</strong> Harm Could Happen Occasionally</td>
<td>Yellow</td>
</tr>
<tr>
<td><strong>Low:</strong> Harm Could Happen but would be Rare</td>
<td>Green</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
## 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>$482.51(b)</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>A-0951</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</td>
<td>A-0940</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>
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<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>
Evidence of Standards Compliance (ESC)

• Also referred to as corrective action for each finding identified during the survey
• Each ESC should indicate the one individual responsible for all corrective actions and ongoing compliance associated with the element of performance
• The ESC should also include a specific date when all actions were completed as well as a description of actions taken to ensure ongoing compliance
• Corrective actions may include:
  • Review, revision, and approval of existing policies and procedures
  • Implementation of a new policy or procedure
  • Modifications to building infrastructure
  • Re-education or reassignment of job responsibilities to qualified individuals assigned to specific tasks
  • Education of those individuals responsible for the delivery of care, treatment, and services
Follow-Up for Higher Risk Deficiencies

- Findings that are considered to be High Risk/ Limited, Pattern or Widespread and Moderate Risk/ Pattern or Widespread will have two additional ESC sections.
- 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 and Preventive Analysis

• Leadership Involvement
  • ESC must outline the leader involved but TJC does not dictate what the leadership involvement needs to be

• Preventive Analysis
  • 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
  • Also should focus on preventing future occurrences of the high risk issue
## What Are the Most Problematic Hospital Findings?

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Requirements</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>LS.02.01.35</td>
<td>The hospital provides and maintains systems for extinguishing fires</td>
<td>88%</td>
</tr>
<tr>
<td>EC.02.05.01</td>
<td>The hospital manages risks associated with its utility systems</td>
<td>80%</td>
</tr>
<tr>
<td>IC.02.02.01</td>
<td>The hospital reduces the risk of infections associated with medical equipment, devices, and supplies</td>
<td>74%</td>
</tr>
<tr>
<td>EC.02.06.01</td>
<td>The hospital establishes and maintains a safe, functional environment</td>
<td>73%</td>
</tr>
<tr>
<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>
<td>72%</td>
</tr>
<tr>
<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>
<td>69%</td>
</tr>
<tr>
<td>LS.02.01.20</td>
<td>The hospital maintains the integrity of the means of egress</td>
<td>66%</td>
</tr>
<tr>
<td>EC.02.05.05</td>
<td>The hospital inspects, tests, and maintains utility systems</td>
<td>64%</td>
</tr>
<tr>
<td>IC.02.01.01</td>
<td>The hospital implements its infection prevention and control plan</td>
<td>61%</td>
</tr>
<tr>
<td>EC.02.02.01</td>
<td>The hospital manages risks related to hazardous materials and wastes</td>
<td>61%</td>
</tr>
</tbody>
</table>

January 1 – June 30, 2018: TJC Perspectives
Medication Management Standards
## Medication Management Top Findings

<table>
<thead>
<tr>
<th>Standard</th>
<th>Standard Requirement</th>
<th>Scoring</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM.03.01.01</td>
<td>Medication Storage</td>
<td>49.96%</td>
<td>17.10% (EP 2) 14.5% (EP 3)</td>
</tr>
<tr>
<td>MM.04.01.01</td>
<td>Medication Ordering</td>
<td>47.36%</td>
<td>30.11% (EP 1)</td>
</tr>
<tr>
<td>MM.05.01.01</td>
<td>Pharmacist Review of Orders</td>
<td>15.88%</td>
<td></td>
</tr>
<tr>
<td>MM.05.01.07</td>
<td>Medication Preparation</td>
<td>13.72%</td>
<td>15.61% (EP 2)</td>
</tr>
<tr>
<td>NPSG.03.04.01</td>
<td>Medication Labeling Procedural Area</td>
<td>9.41%</td>
<td></td>
</tr>
<tr>
<td>MM.01.01.03</td>
<td>High-Alert/ Hazardous Medication Management</td>
<td>5.49%</td>
<td></td>
</tr>
<tr>
<td>MM.03.01.03</td>
<td>Emergency Medication Management</td>
<td>4.98%</td>
<td>22.68% (EP 2)</td>
</tr>
<tr>
<td>MM.05.01.11</td>
<td>Safely Dispensing Medication</td>
<td>4.19%</td>
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<tr>
<td>MM.09.01.01</td>
<td>Antimicrobial Stewardship</td>
<td>3.68%</td>
<td></td>
</tr>
<tr>
<td>MM.01.02.01</td>
<td>Look-A-Like/ Sound-A-Like Medication</td>
<td>3.10%</td>
<td></td>
</tr>
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</table>

June 1, 2017 – May 31, 2018: TJC Perspectives
Medication Management (MM) Standards

- Most of the changes for 2019 involved combining and renumbering some of the elements of performance (EPs)
- Still considered to be one of the highest risk chapters with several areas of focus
- Important to remember if your organization has already been surveyed using the SAFER scoring matrix, any finding in the Moderate/Pattern or Widespread; or any area in the High category will be available for surveyors to see and review during subsequent surveys
- The Pharmacy visit is usually short but the dedicated Life Safety Surveyor will most likely spend time in the department
- 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
The Goal of Medication Management Standards is Safe and Effective Medication Use

- Managing high-alert and hazardous medications
- Selecting and procuring medication
- 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
• Hospital plans each part of the medication management process with care so safety and quality are maintained
• Written policy that describes the following information about the patient is accessible to licensed independent practitioners (LIPs) and staff
  • Age
  • Sex
  • Diagnoses
  • Allergies
  • Sensitivities
  • Current medications
  • Height and weight
    • Accurate!
  • Pregnancy and lactation
  • Laboratory results
  • Any additional information required by facility
• The hospital safely manages high-alert and hazardous medications

• High-Alert Medications
  • Those medications that have a heightened risk of causing significant harm when used in error
  • The list is defined by the organization as well as the strategies to mitigate harm
    • This list should be reflective of medications used routinely in the facility
  • List should be reviewed at least annually
• Hazardous Medications
  • Any drug identified as hazardous or potentially hazardous by the National Institute of Occupational Safety and Health (NIOSH) on the basis of at least one of six criteria:
    • Carcinogenicity
    • Teratogenicity or development toxicity
    • Reproductive toxicity in humans
    • Organ toxicity at low doses in humans or animals
    • Genotoxicity
    • New drugs that mimic hazardous drugs in structure or process
  • Organization should have a list of hazardous medications and strategies to maintain safety
    • The list should be based on hazardous medications used at the facility
MM.01.01.03

• 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 developing a list of high-alert and hazardous medications
  • 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
  • Hospital reports abuses and losses of controlled substances to the Director of Pharmacy and to the Chief Executive Officer (CEO) as appropriate

• Questions
  • Quiz staff about high-alert and hazardous medications and their processes
• The hospital addresses the safe use of look-alike/sound-alike medications (LASA)
• Develop a list of LASA medications
• Take action to prevent errors
• Hospital annually reviews and revises the list
• Written policy on the precautions for ordered LASA medications
• **Issues**
  • Pharmacy is compliant with storage policies but not other places within the hospital
    • Automated dispensing cabinets
  • Non-pharmacy staff not familiar with LASA policies
  • List is not updated and approved annually

• **Questions**
  • Quiz staff about LASA policies
• 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
• **Questions**
  
  • How can you demonstrate 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?
  • How is a medication not on formulary obtained?
The hospital safely stores medications

Number one medication management standard for non-compliance!
  • 49.96% of hospitals in the first half of 2018 had this as a finding

Also found as a high-risk issues for EP 2 and EP 3
• 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
• MANY Elements of Performance (EPs):
  • EP 7: Medications and chemicals are properly labeled
  • EP 8: Removes expired, damaged, and/or contaminated medications and stores them separately
  • EP 18: Periodically inspects all medication storage areas
  • 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
  • Contrast and IV solution warmers
    • Is the temperature being monitored?

• **EP 3:**
  • Medications are stored to prevent diversion and locked
    • What happens after-hours in areas that are not staffed 24 hours per day?
Medication Storage

• **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

• 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?
  • Who monitors the refrigerator on the weekend when the area is closed?
  • 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?
The hospital safely manages emergency medications

- Likely to be a high-risk issue – availability and accessibility of 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
• **Issues**
  
  • 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
  
  • Not just crash carts – CMS standard states that the hospital must meet the emergency needs of patients in accordance with acceptable standards of practice
    • Think about malignant hyperthermia
    • Think about OB emergencies, such as maternal hemorrhage
  
  • Want to consider mock drills for emergencies other than just code cart usage
• *Medication orders are clear and accurate*
• Number 2 most common medication management standard in the first half of 2018
• Also, EP 1 most likely to be a high risk issue
• 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
  • Consistent implementation and following hospital policy is the biggest challenge
• **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
  - Signed but held orders
  - Orders with compounded medications
  - Herbal products
  - Medication-related devices
  - Investigational medications
  - Orders for medications at discharge or transfer
Titration Orders

• Policy needs to spell out what needs to be included in the order
  • Medication name/ route of administration
  • Starting dose
  • Incremental dose change (both increase and decrease) and frequency of dose change
  • 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
Range Orders

• Orders must comply with organizational policy on required elements
  • Dose range
  • Interval range

• Important to know how range orders interpreted
  • Is the interpretation consistent throughout the hospital?

• Does therapeutic duplication also exist?

• How is the nursing staff educated regarding range orders?

• Is there ambiguity with range orders?
• **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
• **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
• **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?
  • Are parameters in titration orders defined?
  • 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?
• 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
• Policy and practice must agree
• 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.
• **EP 2:** 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 4:** All medication orders are reviewed for the following
  - Allergies/ sensitivities
  - Potential interactions (drug-drug and drug-food)
  - Appropriateness of the medication, dose, frequency, and route of administration
  - Current or potential impact as indicated by laboratory values
  - Therapeutic duplication
  - Other contraindications
• **EP 11:** All concerns, issues, or questions are clarified before dispensing
Hot Topics

• The hospital safely prepare medications

• Can be a high-risk issue

• EP 1: A pharmacist or pharmacy staff, under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product’s stability is short

• EP 2: Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation

• EP 6: In-house preparation of radiopharmaceuticals is done, or under the supervision of, an appropriately trained registered pharmacist or doctor of medicine or osteopathy
• **Issues**
  • Preparing IV solutions for “convenience” rather than need
  • Nursing staff at off-site clinics, such as chemotherapy or infusion clinics preparing their own IV medications
  • Inconsistent practices
  • Not having a dedicated space for preparation of an IV that meets criteria
  • No training of individuals that prepare IV medications
Sterile Compounding USP 797/800

• USP 797/800 likely to go into effect by December 1, 2019
• Very involved!!!
• Certification/ testing report evaluation
• Compounding evaluation
• Secondary engineering control
• Differences between buffer and ante
• Room structure
• Staff activities before and during compounding
• Compounding room competencies
• **Questions**
  
  • How prepared is your pharmacy for USP 797/800?
  • 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?
  • 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 with radiopharmaceuticals?
• 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 the following:
    • Medication name, strength, and amount
    • Expiration date when not used within 24 hours
    • Expiration date and time when expiration occurs in less than 24 hours
    • The date prepared and the diluent
• **EP 7:** When preparing individualized medications for multiple patients, the label also includes:
  • Patient’s name
  • Location where the medication should be delivered
  • Directions for use and applicable accessory and cautionary instructions

• **EP 10:** If prepared by other person than who will administer, the label includes
  • Patient’s name
  • Location
  • Directions and applicable accessory and cautionary instructions
• 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

• Includes ALL medications – even if there is only one

• Label must be applied immediately before or after the container is filled

• Applies to the OR and other procedural settings, not just invasive procedures
• The hospital safely obtains medications when the pharmacy is closed

• EP 1: A process is followed for providing medications when the pharmacy is closed

• EP 2: When non-pharmacist healthcare providers are able to obtain medications
  • Types of medications available are limited by the facility
  • Only trained, designated prescribers and nurses are permitted to access the approved medications
  • Quality control procedures are in place to prevent medication errors
  • A pharmacist is available on-call or at another hospital to answer questions or to provide medications not available
• **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?
  • How quickly are the medication orders reviewed by a pharmacist?
  • Is there a pharmacist on-call for questions?
• **The hospital safely administers medications**

• **EP 1**: Policy to state who can administer medications

• **EP 3**: Outlines the activities that should occur before a medication is administered

• **EP 9**: Patient or family informed about adverse drug reactions or other information (ties to MM.06.01.03 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
• 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?
  • How do radiology staff document the verification of the prescribed dose of a radioactive pharmaceutical?
  • Nursing staff needs to be able to talk about what they do
• **Self-administered medications are administered safely and accurately**
  • Family members are included in the definition of self-administered

• **EP 1: Written process**
  • Training
  • Supervision
  • Documentation

• **EP 3: Education of patient/family involved in self-administration of medication**
  • Medication name, type, and reason for use
  • How to administer, including process, time, frequency, route, and dose
  • Anticipated actions and adverse effects
  • Monitoring

• **EP 7: Patient or family member is competent to self-administer**
• **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 reactions, and medication errors
• EP.1: Policy on how to respond
• EP 2: Prescriber notification
• EP 3: Internal and/or external reporting requirements
• EP 6: Part of the PI Plan
  • 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
• **The hospital 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
• **EP 16:** When automated dispensing cabinets (ADCs) are used, the hospital has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews
  
  • Trends: Medication; Time of Day; User; Presence of Order: Reason for Override
  
  • Not necessary to review 100% of overrides
• The hospital has an antimicrobial stewardship program based on current scientific literature

• Several elements of performance
  • Organizational priority
  • Education
  • Multidisciplinary team
  • Core elements of the antimicrobial stewardship program
  • Organization-approved multidisciplinary protocols
  • Collects, analyzes, and reports data
  • Takes action on improvement opportunities identified in its antimicrobial stewardship program

• Surveyors are expecting to see a program in place
• **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
Effective January 1, 2019, eight new elements of performance for the National Patient Safety Goal (NPSG) #3: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy

**EP 1:** Use of approved protocols and evidence-based practice guidelines for the initiation and maintenance of anticoagulant therapy
- Must address medication selection;
- Dosing, including adjustments for age and renal or liver function
- Drug-drug and drug-food interactions
- Other risk factors

**EP 2:** Use of approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to anticoagulant medication
- Should be specific for each anticoagulant medication
• **EP 3**: Use of approved protocols and evidence-based practice guidelines for peri-operative management of all patients on oral anticoagulants

• **EP 4**: Written policy addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy

• **EP 5**: Addresses anticoagulation safety practices
  • Identify, response and report adverse drug events
  • Evaluate anticoagulation practices and to take action to improve safety practices
• **EP 6:** Provides education to patients and families specific to the anticoagulant medication prescribed
  • Adherence to dose and schedule
  • Importance of follow-up appointments and laboratory monitoring (if applicable)
  • Potential drug-drug and drug-food interactions
  • Potential for adverse effects

• **EP 7:** Use only oral unit-dose products, pre-filled syringes, or pre-mixed infusion bags when these types of products are available

• **EP 8:** When heparin is administered by continuous IV, use programmable pumps in order to provide consistent and accurate dosing
Pain Management Standards

- Many different 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)

- 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
• The hospital reduces the risk of infections associated with medical equipment, devices, and supplies
• Infection Prevention and Control (IC) 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
• Can quickly become a high-risk/widespread finding
IC.02.02.01

• 71% of all acute care hospitals had this as a finding in the first half of 2018
  • Wire shelves
  • Open containers of antiseptic or bleach wipes
  • Storage in clean versus soiled utility rooms
  • High-level disinfection processes
  • Expiration dates
  • Cardboard!!

January 1 – June 30, 2018: TJC Perspectives
EC.02.05.03

- **Hospital has a reliable emergency electrical power source**
- Environment of Care (EC) standard
- **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
There are MANY resources and references available for all of these topics

- Joint Commission
  - [www.jointcommission.org](http://www.jointcommission.org)
  - Perspectives
  - Sentinel Event Alerts
  - Comprehensive Accreditation Manuals

- Institute of Safe Medication Practices
  - [www.ismp.org](http://www.ismp.org)

- Centers for Disease Control
  - [www.cdc.gov](http://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
  • “Trust but verify”

• **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.**
Assessment Questions

1. Which of the following Medication Management (MM) standards was most cited in 2018?
   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
2. Why are range orders often found as a problem during a survey by The Joint Commission?

A. The hospital has a written policy that identifies specific types of range orders that it deems acceptable for use.

B. The hospital policy on range orders have required elements, such as dose range and interval range.

C. There is inconsistent interpretation of how to carry out the range order.

D. The hospital process for range orders must also include review for therapeutic duplication.
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 drug-drug and drug-food interactions only.
   D. Includes review of therapeutic appropriateness of the medication regimen.
4. When a particular element of performance from a medication management standard is found to be in non-compliance and cited on the Survey Analysis for Evaluating Risk Matrix as a High Risk/ Widespread finding, the following will be required as part of the evidence of standards compliance.

A. Four months of tracking improvement activities that will be submitted to The Joint Commission.

B. A preventive analysis is done to ensure that the corrective action identifies and addresses any underlying reasons that might have lead to the non-compliance.

C. Any policy updates resulting from the findings will be submitted to The Joint Commission.

D. A signed attestation by the Chief Executive Officer that the corrective actions have been implemented.
Your Annual Joint Commission Update

Questions??