



## **JOINT COMMISSION REQUIREMENTS UPDATE**

**April 2011**

### **PREPARE FOR WHATS TOPICAL AND CURRENT**

You may have noticed the news headlines last month about a high tech compounding pharmacy vendor in Alabama whose neonatal total parenteral solutions (TPN) were implicated in unexpected deaths. The solutions were found to be contaminated with *Serratia marcescens*. In past newsletters we have talked about LD.04.03.09 and clinical contracting and mentioned that high tech pharmacy compounding on the basis of a prescription is subject to review under this standard. Given the wide distribution of information about this event in the general media, the subject of high tech compounding through contracts is likely to gain more notice on survey than it might have prior to this news. Our advice is to take a look to determine if you have any of these contracted services working for your hospital. If you do make sure your contract spells out performance expectations, there is an evaluation of the contractor's performance, and the medical staff has been involved in evaluating the performance. Many of these high tech compounding firms are Joint Commission accredited and maintaining accreditation in good standing can be one of your performance expectations. The types of products often purchased from these off site pharmacies include TPN, concentrated analgesic injections, and radio-isotopes. Some of these pharmacy compounders are also manufacturers, regulated by and inspected by the FDA. Products they ship to you as a manufacturer would not be subject to LD.04.03.09, but any product they ship to you on the basis of a prescription would be subject to this standard.

### **PREPARE FOR THAT WHICH IS NEW**

We have also advised accredited organizations to prepare for those issues which are new to the standards. When the Joint Commission introduces a new standard they also do surveyor training, thus the new issue is at the forefront of your surveyor's minds as soon as the implementation date arrives. We have just passed the implementation deadline for MS.01.01.01 and we will soon be approaching the implementation deadline for the new NPSG.03.06.01 for medication reconciliation. If you kept your medication reconciliation program up and running during the hiatus in scoring you should be better prepared for the new version of this safety goal. Please note however that in the new safety goal each element of performance is an A

element of performance, meaning absolute perfection is required. The prior iteration had many C elements for performance issues. Thus we have lost the opportunity for post-survey audits to demonstrate 90% or better compliance. The good news is there is only 1 safety goal and only 1 potential RFI whereas the previous version had potentially 4 RFI's.

There are several requirements in the new medication reconciliation safety goal we would like to point out. The first element of performance states that we should "obtain and document a list or other useable format when a patient is admitted as an inpatient or seen as an outpatient." That seems clear and consistent with the prior version of the safety goal, but Note 2 states: "make a good faith effort to obtain the list from the patient or other sources." Since a "good faith effort" is a subjective term we suggest creating a hospital definition of what defines a good faith effort. For example: *We interview the patient. If the patient cannot recall the information about their medications we ask the family if they know the medications or ask them to bring medications into the hospital for staff to review. If the family is not aware or involved we ask their physician or community pharmacy.* In carrying out your good faith effort be sure to give your staff sufficient time to get it done. For example: *We interview the patient immediately upon admission. If they cannot recall the information we have X hours to obtain information from the family and if family cannot help we have up to Y hours to try and obtain if from the physician or community pharmacy.* Lastly on this subject, if the answer is unknown because the patient cannot recall be sure to document that the good faith effort was made and the information could not be obtained. To a surveyor, blank spaces on a medication reconciliation form look like failure to carry out the effort.

We have also had several inquires about including "purpose" on either the admission reconciliation form, or discharge reconciliation form. Knowing the purpose of a medication can be useful on the admission side to validate that the patient is recalling the drug name correctly. For example if the patient says they take digoxin for hormone replacement therapy, you know you probably have the wrong drug name. Including purpose on the discharge side can also be useful for teaching purposes; however as this safety goal is written inclusion of purpose is optional on your part. Both EP 2 for admission and EP 4 for discharge are both listed purpose as examples not as mandates. Our advice is to make inclusion of purpose on either admission or discharge medication reconciliation paperwork an optional field, to be used at the discretion of the interviewer. If you mandate that purpose be included, then you can't have any blank spaces. If it's optional staff can include it when used to help differentiate similar sounding drugs, or for teaching purposes at discharge.

Element of performance 5 describes teaching the patient about their list at the time of discharge. It appears that hospitals are freed from responsibility to fax medication reconciliation forms to providers in the community, but the replacement

is for the patient to understand they should bring it to their physician, update it as changes are made and carry it in the event of an emergency. This is all good advice, but there is a potential tracer problem if the surveyor interviews a patient who does not recall any of this teaching. Our advice is to preprint any paper or computer generated discharge instruction forms with the verbatim language from the Joint Commission. An example of what might be printed as a footer on your forms might be: *Please bring this medication reconciliation form to your next doctor's appointment(s). Please update the form if you stop taking any of these medications or you start taking any new medications including over the counter medications. Also please carry a copy of this form with you at all times in the event of an emergency.* The advantage of having this advice preprinted on the form eliminates any chance that there will not be evidence that this advice was not given to the patient.

Lastly we should talk about EP 3, the requirement to compare and resolve discrepancies in medication information. This issue lead to a large percentage of RFI's in the previous version of the safety goal and will probably be the most frequently cited element of performance in the new safety goal. There are two potential pitfalls with this requirement. The first is that the medications ordered for the patient upon admission do not match the medications documented on the medication reconciliation form, and there is no clear evidence that the change was intentional. Many organizations use their medication reconciliation interview form and an order form. In this case there is the required evidence of continue, discontinue and change on the form. Some organizations have the historical documentation on the interview form, but still have the physician write new orders. This system can potentially work providing the decision documented on the interview form, correspond to the orders actually written by the physician. The third type of system often used in hospitals is most problematic is when the medication reconciliation interview form serves only as background information for the physician, who then writes orders on a different chart form or computer screen. Very often these orders will differ from the interview list and someone needs to "compare and resolve" the discrepant information. This can of course be done by a nurse or pharmacist after the fact, but they will have to talk with the physician and verify that the failure to prescribe or a change in dose was a decision and not an error of omission. Documentation of decision making could also be done by a physician in a progress note. Either of these systems will be a lot of work and a time waster for all involved. Bear in mind the Joint Commissions surveyors are never going to question the rationale for the change, but they will want to know that the change was a decision and not an error.

This same element of performance can be scored if discrepant information is noted between the medication reconciliation list and the medications noted on the admission history and physical. It was a common finding to see the surveyor looking at and comparing these two lists and asking why does the medication reconciliation list include 10 medications and the history and physical lists 12 medications. Which

one is wrong? Staff from Northwestern University Medical Center in Chicago have coined a phrase “single source of truth” for medication information. They have done work for the state QIO’s and AHRQ and advise hospitals to find one location for all staff to document what we know about medication taking in the community and not to have redundant and possibly discrepant listings. This is very sound advice as scoring begins again for this safety goal.

There is one more potentially problematic issue with EP 3 and that this the standards cross reference the Joint Commission listed to HR.01.06.01, EP 6. You will note that EP describes the requirement for documented competency validation. For those hospitals that have nursing staff, pharmacy staff, radiology staff, pulmonary function lab staff or others perform the reconciliation process you will want to make sure that this function is included in existing competencies. This may require a bit of analysis and work prior the July implementation deadline.

There is a Powerpoint slide set posted to our Continuous Accreditation Support web page for CAS customers who want to see more about the new medication reconciliation requirement.

### **CHANGE THE CHANGE**

In January the Joint Commission had announced the change to EC.02.03.05, EP 2 regarding fire protection systems. At that time it was announced that the frequency for testing water flow devices and tamper switches would move from every six months to quarterly. An announcement in Joint Commission Online April 13, 2011 stated that this change will only be required for the water flow devices, not the tamper switches.

### **IT’S APRIL, ARE ALL OF YOUR 2010 PLAN EVALUATIONS COMPLETED AND ALL THE 2011 PLANS REVISED?**

It’s just a reminder but with this being the 4<sup>th</sup> month of the new year it is reasonable to expect that all of your 2010 plans or annual reports are completed and the changes have been made as needed to the 2011 plans. We would encourage our readers to use the checklist we previously published to make sure you have closed out 2010 completely.

## BEHAVIORAL HEALTH RISK ASSESSMENTS

In survey reports we very commonly see an environmental hazard that has been identified by a surveyor where the organization is asked if they have conducted a risk assessment on the potential hazard. All too often staff report that they “considered it, but decided it was not a risk.” Unfortunately without a documented risk assessment the Joint Commission can cite your hospital for a failure to provide a safe environment for patient care. There is an excellent resource made available through the National Association of Psychiatric Health Systems that provides insight into designing safer behavioral health environments. It is available free of charge from their website at the following address:

<http://www.naphs.org/Design%20Guide%204%20Submitted%203%2027%2011.pdf>

This guide mentions hundreds of good ideas for designing a safer environment. Most hospitals we visit on mock surveys have units of variable age and variable amounts of retrofitting has taken place to make the environment safer. Not every hazard can be eliminated in an older building and the Joint Commission doesn't require you to eliminate every potential hazard. They do expect that you evaluate the environment and if there are potential hazards, risk assess and mitigate those from being true hazards. Again, all too often the risk assessment has been informal and undocumented and mitigation strategies have not been identified.

We have attached to this month's newsletter an Excel spreadsheet that can be used to identify potential behavioral health unit hazards and risk assess them all on one tool. There are many tools available to help identify hazards, but then there is a second step needed to formally risk assess each one. In this tool we have identified potential hazards and included a column for you to identify if you have the hazard. Then each hazard can be evaluated for the 1. Likelihood of use or risk; 2. Criticality of outcome if used; and your ability to; 3. Detect someone's use of the hazard before they can injure themselves. For example the risk that someone could use an exit sign in a public corridor as a ligature point is going to be less because it would be easier for staff to detect than would a hazard contained inside a patient's private bathroom. We have also included a column to identify if you can mitigate the hazard and to document how you would mitigate the hazard. We have proposed a 3 point scale for likelihood, criticality and detect ability. High likelihood that someone would use the hazard is 3. High criticality if they gained access is 3, and poor detect ability is 3. Detect ability is somewhat of an inverse scale. If you can easily detect it and prevent patient injury it is a 1 and if you cannot easily detect use to prevent patient injury it would be a 3. The formulas are already embedded into the spreadsheet to help you prioritize what you will fix now, what you will fix later while mitigating the risk. Feel free to add additional rows of hazards as you identify them in your hospital. Most importantly please use someone's tools to help identify

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the potential hazards and to evaluate your risk from each hazard. If the surveyor points out a hazard that you have not identified, or you have not evaluated you can get an RFI.