PATIENT SAFETY: PAST, PRESENT, FUTURE
INTRODUCTION, AND OVERVIEW OF TOP PATIENT SAFETY CONCERNS

PRESENTATION

2016 ANNUAL MEETING

OBJECTIVES-PHARMACISTS
• Describe the evolution of patient safety issues identified by the Joint Commission National Patient Safety Goals
• Identify significant improvements made in patient safety and recognize areas where improvement is still needed
• Discuss patient safety issues that require professional oversight for review and action

OBJECTIVES-PHARMACY TECHNICIANS
• Describe the evolution of patient safety issues identified by the Joint Commission National Patient Safety Goals
• Identify significant improvements made in patient safety and recognize areas where improvement is still needed
• Discuss patient safety issues that benefit from technician observation and actions which can be taken to address

A BRIEF INTRODUCTION TO MEDICATION ERRORS AND PATIENT SAFETY
• Adverse Medication Events include Non-Preventable events (such as allergic reaction with no previous history) and Preventable events (Medication Errors)
• Although there are many reasons for medication errors to occur, system issues are the most common
• Medication error points occur at: Ordering (Prescribing), Transcribing, Dispensing, and Administration
• Medication errors harm an estimated 1.5 million Americans each year, resulting in upward of $3.5 billion in extra medical costs (IOM, 2006)
• This was recognized early in the history of the practice of medicine, and as recent as the beginning of the 20th century efforts were made to identify safe practices and put the best practices into common use

DISCLOSURE STATEMENT
• Disclosure statement: these individuals have the following to disclose concerning possible financial or personal relationships with commercial entities (or their competitors) that may be referenced in this presentation.
• Eric Renker has nothing to disclose

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PATIENT SAFETY ISSUES AND THE HISTORY OF TJC

• Mitigation of Patient Safety Issues is not a new focus for the Joint Commission
• Roots are in 1910 when Ernest Codman, MD, founded the American College of Surgeons (ACS) and established the “end result system of hospital standardization”
• Continued in 1951 when the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association joined with the ACS as corporate members to create the Joint Commission on Accreditation of Hospitals (JCAH)
• ACS transferred its Hospital Standardization Program to JCAH in 1953 when JCAH began offering accreditation to hospitals

NATIONAL PATIENT SAFETY GOALS (NPSG)

• The Joint Commission established its National Patient Safety Goals (NPSGs) program in 2002
• The first set of NPSGs was effective January 1, 2003
• The NPSGs were established to help accredited organizations address specific areas of concern in regard to patient safety
• NPSGs are developed by a panel of experts who advise TJC
• The panel is called the Patient Safety Advisory Group and is composed of widely recognized patient safety experts
  - Includes: nurses, physicians, pharmacists, risk managers, clinical engineers and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings

WHAT WERE THE 2003 NPSGS?

• 1: Improve the accuracy of patient identification
• 2: Improve the effectiveness of communication among caregivers
• 3: Improve the safety of using high-alert medications
• 4: Eliminate wrong-site, wrong-patient and wrong-procedure surgery
• 5: Improve the safety of using infusion pumps
• 6: Improve the effectiveness of clinical alarm systems

WHAT ARE THE CURRENT (2016) NPSGS?

• Identify patients correctly
  - NPSG.01.01.01 Two ways to identify patients
  - NPSG.01.03.01 Make sure correct patient gets correct blood for transfusion
• Improve staff communication
  - NPSG.02.03.01 Get important test results to the right staff person on time
• Use medicines safely
  - NPSG.03.04.01 Before a procedure, label medicines that are not labeled
  - NPSG.03.05.01 Take extra care with patients who take blood thinners
  - NPSG.03.06.01 Record and pass along correct information about a patient’s medicines
• Use alarms safely
  - NPSG.06.01.01 Ensure medical equipment alarms are heard and responded to on time
• Prevent infection
  - NPSG.07.03.01/NPSG.07.04.01/NPSG.07.05.01/NPSG.07.06.01 CAUTI/CLABSI/Enteroviruses/Influenza/MDRO/SSI/VAP
• Identify patient safety risks
  - NPSG.13.01.01 Find out which patients are likely to commit suicide
• Prevent mistakes in surgery
  - UP.01.01.01/UP.01.02.01 Correct surgery in correct place/Mark the correct place
• Use alarms safely
  - UP.01.03.01 Time Out requirement

RESULTS OF 12 YEARS OF NPSG EMPHASIS

• The Joint Commission does not publish metrics on the results of their NPSG efforts
• Results are reflected in hospital success during surveys (increase in the number of 95% compliant hospitals in 2015, for example)
• Reductions in readmissions and length of stay for individual institutions can be tracked- and are by CMS for reimbursement purposes
• Patient outcomes and quality of experience are reported publicly, and these goals affect both
WHAT'S NEXT?

- NPSGs are reviewed annually by the advisory panel (Patient Safety Advisory Group) and additions or changes made for the next year.
- These become effective at the beginning of the calendar year.
- Training and institutional focus on these goals helps both in patient care and survey preparation and performance.
- TJC accepts feedback and makes adjustments based on frontline commentary.
- Pharmacy takes a leadership role in the "Use medication safely" items.

WHAT CAN BE DONE TO HELP?

- The pathway between a clinician's decision to prescribe a medication and the patient actually receiving the medication consists of several steps:
  - Ordering: the clinician must select the appropriate medication and the dose and frequency at which it is to be administered.
  - Transcribing: in a paper-based system, an intermediary (a clerk in the hospital setting, or a pharmacist or pharmacy technician in the outpatient setting) must read and interpret the prescription correctly.
  - Dispensing: the pharmacist must check for drug–drug interactions and allergies, then release the appropriate quantity of the medication in the correct form.
  - Administration: the correct medication must be supplied to the correct patient at the correct time. In the hospital, this is generally a nurse's responsibility, but in ambulatory care this is the responsibility of patients or caregivers.

ANYTHING ELSE?

- Screen for polypharmacy.
- Be aware of age issues (geriatrics and pediatrics).
- CPOE adds new opportunities for issues (changing medication names or administration times or routes in "comments" area).
- ISMP lists of Look Alike/Sound Alike drugs and use of TALLman lettering.
- ISMP "Do Not Use" abbreviations (still live in the written order world).
- Double check products when filling lists and before they leave Pharmacy.
- Have open communications with all staff to ensure ideas and observations are reviewed and followed up.

QUESTIONS?

- Please ask your questions during the panel discussion portion of our presentation.

REFERENCES

- The Joint Commission: https://www.jointcommission.org, 515 West 22nd Street, Suite 1300W, Oak Brook, Illinois 60523
- US Department of Health and Human Services, Agency for Healthcare Research and Quality: http://www.ahrq.gov, 5600 Fishers Lane, 7th Floor, Rockville, MD 20857
- National Coordinating Council for Medication Error Reporting and Prevention: http://www.nccmerp.org, USP (Secretariat), 12601 Twinbrook Parkway, Rockville, MD 20852-1790

https://psnet.ahrq.gov/primers/primer/23/medication-errors