Another element of performance in field review would require hospitals to have secure medications areas outside of the pharmacy for nonpharmacists to access after hours. Qualified nonpharmacy personnel may now access medications at night, but those staff would no longer be able to enter the main pharmacy if the standard is approved.

“The biggest safety step involves this pharmacy review,” Smetzer says. “Perhaps some practitioners don’t have an adequate level of [awareness] about it. I think they understand the risks, but that they think they’re doing what they should be doing.”

Some of the problems with PCA that the ISMP found include
• allowing PCA by proxy (i.e., someone other than the patient pushes the button on the pump in order to release the medication)
• failing to properly educate the patient about PCA and explaining how they should use it
• failing to tell family
Standard changes

Patricia Kienle, MPA, FASHP, operations manager for Cardinal Health in Houston, told pharmacists during the December American Society of Health-System Pharmacists Midyear Clinical Meeting in Orlando. “Even if it doesn’t end up in the 2006 standards, it’s probably going to [be added eventually].”

Get a late-night solution
The pharmacist’s prior review of medication orders is key to a safe medication process, said John Uselton, BSPharm, vice president of operations improvement for Cardinal Health. This safety issue is why the JCAHO is taking a close look at medication orders.

“You’re going to have to defend the system you have in place at your hospital,” Uselton said.

The standards changes may mean more pharmacists will have to be on call after hours to review orders, Uselton said. Another option includes remote order review, or telepharmacy.

Cardinal Health offers telepharmacy through its RxeSource service. MedNovations of Laurel, MD, also provides after-hours review for pharmacists.

Costs for these services depend on medication-order volume and the hospital’s size. Prices for both RxeSource and MedNovations’ PharmaChek After Hours can range from $30,000 to $400,000.

Start watching pharmacy access now
The standard regulating access to the pharmacy seems more likely to pass field review, Uselton said. Certain states already have laws restricting late-night access to the pharmacy.

This standard will require hospitals to place medications approved for late-night use in a locked area outside of the main pharmacy. Authorized nonpharmacy staff would be able to access the medications from this area.

Placing medications approved for after-hours use in a locked night cabinet outside of the pharmacy would meet this element of performance, said Darryl Rich, PharmD, a JCAHO field representative.

Tip: Start restricting nursing access to the pharmacy and designate a secured area for these medications, Uselton said. This will help prepare for the standard if it becomes official.

There may be rare occasions when staff would need to access medications from inside the pharmacy at night, Rich said. In those cases, staff would need to call a pharmacist to come into the hospital or obtain the medication from another hospital or retail pharmacy, he said.

Give your feedback
These changes may be difficult for some pharmacists to accept. “It seems like they are taking away some of the control from nursing,” said one pharmacist, who spoke on the condition of anonymity. “I’m not sure how feasible this will be.”

Pharmacists can comment to the JCAHO about these standards, Kienle said. Hospitals must complete the field review questions by January 10.

Go to www.jcabo.org/accredited+organizations/field_reviews.htm for more information. ■

Questions? Comments? Ideas?

Contact Associate Editor Matt Bashalany

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The following changes to the JCAHO medication management standards take effect in 2006 if they pass field review:

**Elements of performance for MM.2.20**
#16. The hospital creates a policy covering the management of medications it provides practitioners for patient care. The policy covers
• how practitioners carry and maintain the medications
• medication identification and, at a minimum, a visual check of the drug’s integrity before administering it
#17. The hospital puts its policy in place.

**Elements of performance for MM.4.10**
#3. When a pharmacy is not open around the clock, the hospital makes arrangements for a pharmacist to review after-hours medication orders.
#8. The hospital assesses the risks of medications used in a procedure when there is not a specific medication order or the pharmacy does not directly provide the medication.
#9. The hospital creates strategies to cover the risks of medications used during a procedure without a specific order. The hospital bases the strategies on literature, best practices, and its own data in collaboration with the medical staff and pharmacy.
#10. The hospital puts its strategies in place.

**Elements of performance for MM.4.20**
#8. The hospital develops a policy covering the safety and use of medications that a practitioner obtains from outside the organization for a patient’s care. The policy addresses
• when practitioners may use those medications
• a process to assess the integrity of those medications
#9. The hospital puts the policy in place.

**Elements of performance for MM.4.50**
#2. When nonpharmacist staff obtain medications (as allowed under laws and regulations) after the pharmacy closes, the hospital follows these safety procedures:
• Staff may only access an approved set of medications. The hospital stores the medications outside of the pharmacy and locks them in a secure area.

**Elements of performance for MM.8.10**
#4. The hospital makes the improvements that result from its own medication management system evaluation and research into technological advances and best practices that may increase patient safety.
#5. The hospital measures the performance of new and improved medication management processes.
#6. The hospital reviews and uses data analysis to identify changes to improve the medication management system.
members that only the patient or the nurse should press the button to release medication

Note: Turn to the sidebar on p. 5 for examples of what can go wrong when these problems occur. The ISMP provides a checklist on p. 6 to help organizations take steps to reduce PCA pump errors.

Keep the patient’s best interest in mind
Research conducted at the University of Pittsburgh Medical Center has shown that if the wrong patient population is selected for a certain drug, such as Demerol in a PCA pump, the patient is at a higher risk of experiencing an adverse drug event, says Robert Weber, MS, the medical center’s executive director and department chair of pharmacy and therapeutics.

For example, an elderly patient or a patient with renal failure might be more susceptible to drug toxicity because his or her body cannot break down the medication as quickly.

Also, some patient populations may receive a higher dose than what is considered safe for them, Weber says. To prevent this, for example, healthcare providers need to prescribe lower than normal doses of morphine for elderly patients or those with renal failure.

The pharmacy’s role
Pharmacists must ensure that prescribers write the medication order correctly and that the order is dispensed properly, Weber says. Pharmacists must then make sure that nurses completely understand the therapy prescribed, he says.

Nurses may ask questions about orders, including how they are written, so pharmacists must be able to explain orders or know where to find the answers.

Beware of programming errors
Many errors seen by the ISMP involve staff incorrectly programming a PCA pump, Smetzer says. Sometimes staff may accidentally enter the wrong numbers when programming a pump, including missing a decimal point or entering the decimal point at the wrong time.

For example, a nurse wants to enter 1.5, but misses the decimal point when typing, and enters 15 by mistake.

Design flaws on the pump could lead to those mistakes, Smetzer says. The ISMP alerts companies when the organization becomes aware of problems, but it sometimes takes years for manufacturers to make changes, she says.

Smart technology helps reduce errors
Newer pumps, known as “smart” pumps, allow the hospital to set minimum and maximum dosage parameters, Smetzer says. These pumps will alert staff if they accidentally enter a dose outside of the acceptable range.

The San Diego–based Alaris Products, a division of Cardinal Health, manufactures PCA pumps that include continuous monitoring of oxygen saturation in the patient’s bloodstream as well as the patient’s carbon dioxide output. They also allow the hospital to set minimum and maximum dose limits, which Alaris calls Guardrails®.

Staff at St. Joseph’s/Candler Health System in Savannah, GA, caught several potential pump

**PCA quick tip**

If you are having trouble explaining to patients and their families that only patients or nurses should touch the PCA pump, try what Metropolitan Hospital in Grand Rapids, MI, did. The hospital created colorful, multilingual signs to attach to all PCA pumps, warning family members not to touch them, says Regina Ricketts, RN, the hospital’s quality management coordinator.
programming errors because the system alerted staff that the programmed dose fell outside the preset range, says Ray Maddox, PharmD, director of clinical pharmacy, research, and pulmonary medicine.

Most of the cases involved potential overdoses of drugs such as hydromorphone or meperidine, but staff also caught an underdose of fenatynl, Maddox says. An underdose of pain medication can be just as problematic as an overdose, he says, because the patient will not receive effective treatment.

Assess pharmacy competence
The University of Pittsburgh Medical Center requires PCA competency assessments for pharmacists, Weber says. Pharmacists must take specific tests to indicate that they understand the concentrations of medications, the doses for different patients, and to assess their competency in PCA pump operation, he says.

Tip: Observe pharmacists processing PCA medication orders.

Beware of free-flow problems
National Patient Safety Goal #5 requires organizations to prevent free, or uncontrolled, flow on all PCA and general-use IV infusion pumps. U.S. Pharmacopeia researchers found in reports to the 2002 MEDMARX error-reporting database 1,846 errors involving an infusion pump, 161 of which caused patient harm.

Staff often programmed the pumps incorrectly, giving patients too much or too little of a medication.

Free-flow problems still occur with PCA pumps used in hospitals, Smetzer says. The ISMP recently received a free-flow error report about a newer pump used in hospitals, which is unusual because newer pumps tend to have free-flow protection built in, she says.

Tip: Conduct a Failure Mode and Effects Analysis on a PCA pump in your organization.

Look at all the potential problems with the pump, including programming and free-flow errors, Smetzer says. For example, determine whether a free-flow problem could occur or whether tubing could become dislodged from the pump or the patient.

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Error reports involving PCA

The following are examples of error reports involving patient-controlled analgesia (PCA) submitted to the Institute for Safe Medication Practices (ISMP) and the U.S. Pharmacopeia:

- **PCA by proxy**: is when someone other than the patient pushes the button to release pain medication. When patients are sedated, they aren’t able push the button. Problems arose when other people (i.e., family members, someone designated by proxy) pressed the button for patients. The ISMP has received reports of patients experiencing respiratory arrest because of oversedation. For example, a 16-year-old girl died after her mother oversedated her with PCA medication.
- **A lack of patient education** can cause problems. The ISMP has received reports stating that patients don’t understand what staff mean when they tell them “to press the button.” They fail to understand how PCA pumps operate. In addition, most pumps currently in use don’t indicate whether a dose was administered after the button was pushed. This may lead patients to ask for more medication.
- **Errors and mix-ups** can occur with the drugs used in the pumps. For example, morphine comes in two different concentrations, and staff might pick up the 5 ml concentration and program the pump as a 1 ml concentration by accident. The ISMP has also received reports of sound-alike problems (i.e., morphine and hydromorphone).

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Sample PCA pump safety checklist

The following checklist from the Institute for Safe Medication Practices (ISMP) outlines efforts that can reduce risks associated with patient-controlled analgesia (PCA).

**Purchasing a PCA pump**

- Perform a Failure Mode and Effects Analysis using the PCA pump under evaluation. Questions to ask include the following:
  1. Can the pump be programmed easily to deliver the desired concentrations?
  2. Could unsafe administration sets that allow free-flow be used accidentally?
  3. Is the pump operation intuitive for the clinician and the patient?
  4. What are the default settings for the opiate concentrations in use?
  5. Do the drugs, units of delivery, and strengths appear in a logical sequence?
- Limit PCA pumps to a single model to promote proficiency with programming.
- Before distributing the new pumps, verify that all pump default settings are set up as expected, and place a warning label on the activation button that reads “for patient use only.”

**Prescribing, dispensing, or initiating PCA**

- Require PCA prescribers to undergo a privileging process to verify proficiency with this type of pain management. Limit the prescribing of fentanyl for epidural PCA to anesthesia staff, pain management teams, or critical care prescribers.
- Design standard order sets to guide drug selection, doses, and lockout periods; patient monitoring; and precautions, such as avoiding concomitant analgesics and how and when to administer oxygen and naloxone. Test the order sets using the pump's programming sequence to reduce the risk of errors.
- Provide nurses with relevant information about opiates used for PCA. Alert them to the dangers of administering a dose for a patient (PCA by proxy) and the differences between hydromorphone and morphine.
- Teach nurses and pharmacists how to program PCA pumps and verify their ability to enter a PCA prescription accurately. Ensure that training occurs close to the introduction of new pumps, not months before use, and offer practice sessions, as needed, to maintain proficiency.
- Run simulations in which staff purposely write incomplete orders, select an inappropriate drug or dose, misprogram a pump, ignore double checks, forget critical monitoring points, and miss obvious signs of toxicity so clinicians can identify these at-risk behaviors.
- Ensure that nurses recognize the signs and symptoms of opiate toxicity and withdrawal, the need to assess patients with minimal verbal or tactile stimulation, and the ability to distinguish between oversedation and other pulmonary, neurologic, or cardiovascular complications.
- Provide ongoing education to clinicians about PCA errors to increase awareness and encourage internal and external (i.e., FDA, ISMP, U.S. Pharmacopeia) reporting of PCA errors.
- Require annual competency assessments for all professionals who prescribe, dispense, and administer PCA.
- Establish patient selection criteria for PCA. Candidates should have an appropriate level of consciousness and cognitive ability to self-manage pain. Infants, young children, and confused patients are unsuitable candidates.

**Prescribing PCA**

- Require the use of PCA standard order sets (all sections completed) and limit verbal orders to dose changes.
- Always dose PCA opiates in mg or mcg, not by volume (mL).
- Check patient allergies before selecting the opiate used with PCA.
- Use morphine as the opiate of choice. Use hydromorphone for patients who require high doses of opiates. Reserve meperidine for patients who are allergic to both morphine and hydromorphone.
Consider other medications that the patient has received (e.g., analgesics taken at home, intraoperative medications) or currently has prescribed (e.g., antihistamines, nighttime sedatives) when determining the loading and maintenance doses. Reassess the appropriateness of PCA therapy at regular intervals.

Dispensing PCA
- Establish one standard concentration for each opiate used for PCA.
- Stock only the standard concentrations of morphine and hydromorphone in patient care units. (Meperidine for PCA should be dispensed by the pharmacy.)
- Separate the storage of hydromorphone from morphine in the pharmacy and patient care units to avoid mix-ups.
- Check patient allergies and ensure that they are listed in the interactive allergy field on the patient profile before entering PCA orders into the computer.
- Set maximum dose limits for PCA opiates in the pharmacy computer so an alert appears if safe doses are exceeded during order entry.
- Affix prominent warnings when dispensing an opiate in a nonstandard concentration.
- Use prefilled syringes, bags, and cassettes whenever commercially available. The pharmacy should prepare all PCA products that are not commercially available.
- Require a pharmacist to review all PCA orders before initiation—except when a pharmacist is not on site—and suggest renal dose adjustments or an alternative opiate when appropriate. If meperidine PCA is used, have pharmacy set dose limits and reassess the patient every 24 hours.
- Use tall-man lettering on pharmacy-applied labels for hydromorphone (i.e., HYDROMorphine) to help avoid confusion with morphine.
- Alert clinicians to potential drug shortages with PCA opiates and, if encountered, recommend an alternative drug with clear dosing instructions.

Initiating PCA
- Check patient allergies, which should be visible on the medication administration record (MAR), before initiating PCA.
- Connect PCA to a port close to the patient (to avoid dead space) and prominently label the infusion line at this connection to avoid confusion with other lines.
- Provide laminated instructions for programming PCA pumps to nurses who may infrequently initiate PCA.
- Require two clinicians to independently double-check the patient’s identification, drug and concentration, PCA pump settings, and the line attachment before use (and before pump refill or programming change). Bedside bar-coding can be used to verify the patient and drug/concentration; however, pump settings may still require an independent double check.
- Avoid nurse-controlled PCA unless special monitoring is in place.
- Verify PCA settings each shift, immediately after receiving a report.
- Avoid administering concomitant opiates (an alert should appear on the MAR).
- Ensure that oxygen and naloxone are readily available.
- Educate patients about the proper use of PCA before initiation—begin during the preoperative testing visit so patients are not too groggy to understand. Warn family members and visitors about the danger of PCA by proxy.

Monitoring PCA effects
- Establish a standard measurement scale to assess patients’ level of pain.
- Develop monitoring requirements for patients who are receiving PCA and be alert for signs of oversedation. At a minimum, evaluate patients’ level of pain, alertness, and vital signs, including the rate and quality of respirations, every four hours.
- Evaluate all patients with minimal verbal and tactile stimulation to obtain an accurate assessment of their level of sedation.
- Monitor patients more frequently during the first 24 hours and at night, when hypoventilation and nocturnal hypoxia may occur.

Source: ISMP, Huntingdon Valley, PA. Reprinted with permission.
## Sample clinical pharmacy specialist job description

*Editor’s note: Performance evaluations are never easy. Yet when conducted properly, they can be the most valuable instrument in the manager’s toolbox. The following job description is taken from HCPro’s Performance-Based Job Descriptions for Pharmacy. These job descriptions can help you meet all of the requirements for JCAHO standards [HR.3.10](#) and [HR.3.20](#). For more information about the CD-ROM, contact customer service at 800/650-6787 or visit [www.hcmarketplace.com](http://www.hcmarketplace.com).*

### Basic purpose of the job

Under the direction of the clinical coordinator and the pharmacy director, optimizes patient medication therapy by providing comprehensive clinical pharmacy services. Works collaboratively with the healthcare team to accomplish its goals.

### Job requirements

#### Minimum education
- Required: PharmD or master’s of pharmacy
- Preferred: Pharmacy practice residency or equivalent

#### Minimum work experience
- One to two years as a licensed pharmacist with enhanced clinical responsibilities

#### Required licenses/certifications
- Current state license (or eligibility for licensure) to practice professional pharmacy

#### Required skills, knowledge, and abilities

### Essential functions

Essential functions are those tasks, duties, and responsibilities that comprise the means of accomplishing the job’s purpose and objectives. Essential functions are critical or fundamental to the performance of the job. They are the major functions for which the person in the job is held accountable. Following are the essential functions of the job, along with the corresponding performance standards.

*Indicate how the employee performed relative to these standards by checking the appropriate boxes.*

1. Works collaboratively and cooperatively with pharmacy, nursing, administration, and medical staff to ensure optimization of the medication-use process.

**OVERALL RATING**
- Consistently does not meet standards
- Developmental/Needs improvement
- Consistently meets/sometimes exceeds standards
- Consistently exceeds standards

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### Performance narrative

2. Actively participates in the accomplishment and ensures the implementation of the pharmacy service’s scope of practice.

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### Performance narrative

3. Performs all functions associated with the staff pharmacist job description, as needed and assigned.

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### Performance narrative

4. Responsible for counseling all employees about their prescriptions. Responsible for counseling patients upon request.

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### Performance narrative

5. Provides clinical pharmacy practice services including primary healthcare, consultative services, and drug information services to patients and other healthcare providers directly and through committee work.

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### Performance narrative

6. Oversees, guides, and monitors the medication-use processes regarding prescribing, dispensing, administering, monitoring, and communicating patients’ medication needs.

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JCAHO checks medication security during survey. April, p. 10.
Win over JCAHO with complete and neat records. Aug., p. 8.
Quick tip: Nine proven ways to achieve JCAHO survey success in the new year

Start 2005 off right with a successful JCAHO survey. Check out the following nine tips from John Uselton, BSPharm, vice president of operations improvement for Cardinal Health in Houston, for making your pharmacy survey ready:

✓ **Clean the pharmacy and all storage areas.** Although this seems simple, it will pay off when your medications and supplies are organized.
✓ **Organize all of the materials that surveyors request.** This includes policies and procedures.
✓ **Secure medications throughout the pharmacy.** Keep an eye on respiratory therapy, anesthesia, hospital-owned clinics, and controlled substances.
✓ **Pay special attention to problem areas.** Keep an eye on respiratory therapy, anesthesia, hospital-owned clinics, and controlled substances. Make sure you control medications in these areas as you would in the pharmacy because the JCAHO medication standards cover these specialties as well.
✓ **Concentrate on the 2005 National Patient Safety Goals.** Make your goals compliance actions consistent with your policies and procedures.
✓ **Demonstrate competence.** Be able to show that staff know how to perform the tasks assigned to them. Assess staff competence periodically.
✓ **Develop good documentation.** Summarize your medication-use improvement information for surveyors. Also document your pharmacy and therapeutics committee proceedings from the past year.
✓ **Emphasize actions and improvements.** Highlight what your pharmacy does to protect patients. Graphs, charts, and tables demonstrating improvement lend credibility to your claims.
✓ **Ensure that staff are familiar with the survey process.** Practice for the survey together. Give thought to which staff members will be involved in the tracer, interview sessions, and patient-care discussion. Do not make staff participate in these meetings if they do not need to be there.