Wrong-tube, wrong-route connections and administration have been on the JCAHO’s radar for some time. The commission has considered issuing a Sentinel Event Alert about the issue, said Richard Croteau, MD, the commission’s executive director for strategic initiatives, during a recent teleconference.

The problem with IV connections rests on one feature—standardized ports. These ports can lead staff to hook up an IV line to hospitals will have to reduce the risk of wrong-tube, wrong-route intravenous (IV) connections and administration if a proposed 2006 National Patient Safety Goal becomes official, according to draft goals posted on the JCAHO Web site January 27.

Organizations had until February 25 to comment on the proposed goals. If the JCAHO sticks to past procedure, the Board of Commissioners will approve the goals this summer and they will become effective January 1, 2006.

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JCAHO reins in hospitals with new abbreviation scoring guidelines

**Evaluate compliance efforts to meet new rules**

A “three-strike” rule means that hospitals will receive a compliance score of 0 if surveyors find three or more instances of unapproved abbreviations in orders and medication-related documents, according to new JCAHO scoring guidelines obtained by Hospital Pharmacy Regulation Report.

The guidelines state the following:

- One strike equals one or more “slips” by the same clinician in a single record
- One or more slips by the same clinician in a second record is another strike
- One instance of an unapproved abbreviation by three clinicians in one or more records equals three strikes

“Before, if you had one
something meant for a catheter, says Rod Hicks, RN, MSN, MPA, research coordinator at the U.S. Pharmacopeia (USP) Center for the Advancement of Patient Safety (CAPS).

Manufacturers standardized IV ports when the International Organization for Standardization mandated several years ago that all tubing conform to the same benchmark, Hicks says. This way, if a hospital switches manufacturers, it won’t have to spend money upgrading tubing and other equipment.

“The intent may be to access the IV port to give medications, but because the ports look alike, you may be accessing a port that is connected to the bladder catheter,” Hicks says.

USP identified 300 cases of wrong-tube and interconnectivity errors from 1998 to 2003 in its MEDMARX error-reporting database, Hicks says.

Follow your lines
One potential error includes an epidural catheter inserted for anesthesia or pain control. Staff must insert the catheter into the central nervous system, usually the spinal column, and the catheter must be sterile, Hicks says.

USP has noticed cases in which staff have connected IVs to the epidural line and antibiotics have been delivered through the epidural catheter thereby increasing the potential for infection.

✔ Tip: Trace the line from where the tube enters the patient’s body to the point of origin. This will help staff see whether the tube is hooked up correctly, Hicks says.

Be careful with syringes
Another error USP researchers have found is in pediatric medicine. Sometimes staff push a syringe through an IV line, accidentally giving the patient medicine intravenously instead of orally, Hicks says.

✔ Tip: Use an oral syringe, which is too large to connect to tubing, Hicks says. Hospitals would need to stock these, but they are inexpensive. The general public can purchase them at a local retail pharmacy.

Check out p. 3 for more examples of errors. Use them to educate staff to drive the point home, says Diane Cousins, RPh, vice president of CAPS.

“I think that’s why the Joint Commission goal is so needed, because it will create awareness about what’s gone wrong,” Cousins says.

Use labels
Hospitals should also label IV tubes at the point at which they connect to the IV port, Cousins says.

“Some of these JCAHO goals might be a challenge to eliminate what they’re addressing, but this is a preventable error,” Cousins says.

Review other goals
Several other goal revisions affect medication use, including eliminating the use of multiple-dose vials, labeling medication containers or other solutions, giving patients copies of their medication administration records, and eliminating harm associated with anticoagulants and narcotics.

Missing from the list is bar coding—a goal that was proposed last year for implementation in 2007, but didn’t make the final cut for the 2005 goals.

“Bar coding is politically hot, and it’s expensive from a capital expenditure standpoint,” explains Robert Marder, MD, practice director for quality and patient safety for The Greeley Company, a division of HCPro.

Despite that, Marder believes bar coding may make a future list of goals, so organizations should keep the issue in mind.

Editor’s note: Hospital Pharmacy Regulation Report will spotlight other proposed goals in the coming months.
The U.S. Pharmacopeia received the following cases involving tubing connections to its MEDMARX error-reporting database between 1998 and 2003:

**Case 1:** An intensive care nurse was caring for a patient with a ventricularostomy, drainage of the brain ventricles. The drain used standard intravenous (IV) extension tubing to connect the drain port to the collection bag. The nurse mistakenly connected a small infusion bag of antibiotics, commonly known as IV piggy-back, into the y-connector of the drain, infusing the antibiotic via the wrong route. The patient had to undergo additional monitoring as a result of the error.

**Case 2:** A postoperative patient had both an indwelling Foley catheter and a peripheral IV line. The physician ordered a continuous bladder irrigation for the indwelling Foley and maintenance fluid for the IV line. Using a dual-chamber infusion device, the staff connected the bladder infusion to the IV line. The error was discovered within a half hour. No patient harm was reported.

**Case 3:** In a similar case, another patient had both an indwelling Foley catheter with continuous bladder irrigation and a peripheral IV line. The routinely scheduled antibiotic was mixed in a small-volume infusion bag, and the infusion was initiated into the bladder irrigation tubing. No harm was reported in this patient.

**Case 4:** A patient had a nasogastric tube in place. The patient was scheduled to receive an intermittent dose of IV medications (famotidine). The IV medication was discovered infusing through the nasogastric tube rather than through an IV line. No patient harm was reported.

**Case 5:** In a labor and delivery setting, a patient had an epidural catheter line in place for pain control during the labor process. The nurse erroneously initiated a pitocin (a medication used to augment labor) infusion through the epidural line as opposed to the peripheral IV catheter.

The error resulted in mild fetal distress and a decreased heart rate. The error resulted in prolonged hospitalization with increased observation and monitoring.

### DEA seeks comments on pain medication guide

The Drug Enforcement Administration (DEA) will accept comments from physicians and other healthcare providers to prepare a document that will define the agency’s role in regulating pain medications, according to the January 18 Federal Register.

Healthcare providers and other interested parties may go to [www.regulations.gov](http://www.regulations.gov) until March 21 to submit comments.

The request for comments is the latest in a continuing saga regarding a set of guidelines posted on the DEA’s Web site in August 2004. The DEA and a partnership of pain experts drafted the guidelines. The DEA pulled the document from its Web site in October 2004, citing “misstatements” and saying it “was not approved as an official statement of the agency and did not and does not have the force and effect of law,” the administration’s Web site said.

The new guidelines will stay within the scope of the DEA’s enforcement authority and will address the Controlled Substances Act and other laws and regulations, according to the Federal Register notice. The new document will provide guidance on how to prescribe pain medications within legal limits, the administration said.

Prescribers heralded the original guidelines released in 2004 as a valuable education about the DEA’s drug-diversion enforcement.
Abbreviations guidelines

Doctor out of 100 using an unapproved abbreviation, you could be in compliance (at 90%)," says Michael Hoying, RPh, MS, pharmacy director at Fairview and Lutheran hospitals in Cleveland. "Now you're going to have to collect data down to the practitioner level to check how many doctors are using unapproved abbreviations. You'll need to show how many doctors are out of compliance."

Abbreviations still contribute to errors. The U.S. Pharmacopeia received 196 error reports involving abbreviations to its MEDMARX database between 1998 and 2003, according to the organization.

A daily obstacle
The guidelines clearly explain what surveyors will look for, Hoying says. But they may either help or hinder hospitals, depending on each organization's situation.

For example, if one physician is normally compliant but uses "QD"—an unapproved abbreviation that means daily—seven times in one record, the commission counts it as one strike.

In that case, the guidelines are friendly, as all slips are lumped into one strike, Hoying says.

However, if a physician routinely uses unapproved abbreviations and writes three new admissions in one day, at least 10 or more opportunities exist in each admission order to write QD, says Hoying.

If the physician writes QD at least once in each of the three charts, that would count as three strikes and a score of 0.

Get a clarification
The guidelines give little leeway for clarifying an order. To prevent an unapproved abbreviation from becoming a slip, the practitioner must clarify it on the spot.

For example, if the practitioner writes QD and then immediately corrects it, it does not count as a slip. However, if a nurse or pharmacist clarifies the order, it counts as a slip.

That may penalize organizations unfairly and make them wait for clarification before filling the order, which could harm patient safety, Hoying says.

In cases where the order says “first dose now,” Hoying believes the JCAHO should make an exception to allow organizations to clarify the abbreviation in the chart after caregivers initiate the therapy. The only other exception the commission allows is when a practitioner who writes an unapproved abbreviation does not work for the hospital. In those cases, clarification prior to implementing the order does not count as a slip.

Do your own audits
The number of observations a surveyor conducts may affect compliance, says Robert Marder, MD, practice director of quality and patient safety for The Greeley Company, the Marblehead, MA–based consulting division of HCPro, Inc., this newsletter’s publisher.

Tip: Conduct 20 mock observations, Marder suggests. Aim for a 95% compliance rate—one strike—to provide a cushion against any other possible strikes.

For example, if surveyors perform 30 observations, and an organization receives a third strike as part of those last 10 observations, it is unfair based on the percentages, says Marder.

In that case, the organization may submit an evidence of standards compliance to the JCAHO demonstrating its percentage compliance.

A clinical pharmacist at Fairview and Lutheran hospitals audits two or three charts per day, Hoying says. One individual collates the compliance data and provides a report to the quality assurance, medicine, and surgery departments as well as the nursing units and practitioners.
Editor’s note: The following is adapted from the scoring guidelines available to JCAHO surveyors. A source close to the JCAHO has confirmed that this information is used by surveyors and considered “the Bible” for scoring National Patient Safety Goals (NPSG).

NPSG scores
Compliant (100%, as of January 1) = 2
Noncompliant = 0
Partial compliance = N/A (no exceptions)

All NPSGs require 100% compliance for a score of 2, except for the following, which require 90% compliance:

- Goal #2b (handwritten prohibited abbreviations)
- Goal #7a (hand hygiene)

Strikes
The JCAHO will survey the two NPSG requirements using a frequency-based, three-strike rule. A strike is an observation of noncompliance. Organizations are permitted two strikes, and a third signifies noncompliance.

Prohibited abbreviations strike: One or more observations of noncompliance in a single record = one strike.

Hand-hygiene strikes: Fix any observation of noncompliance with the Centers for Disease Control and Prevention’s Category One recommendations = one strike.

Other scoring facts
- Track record: Organizations need to carry out the goals as of January 1; goals implemented after that date result in a score of 0.
- The JCAHO considers free-text keyboard entries or other medication-related documentation as the equivalent of handwritten forms.
- Preprogrammed or hardcoded use of abbreviations, acronyms, and symbols won’t be a factor in scoring decisions made in 2005.
- Preprinted forms must be 100% compliant.
- An order clarification made before carry-out is a strike, unless it is made by a caregiver not employed by/without medical staff relation to the organization (e.g., home health obtaining order from physician not on the medical staff). The JCAHO expects clarification.
- An order entry for an unapproved abbreviation is not a strike if corrected immediately by the practitioner who wrote it (but not by someone else).
**JCAHO standard of the month—MM.4.10**

**JCAHO changes stance on LIP-controlled meds**

The JCAHO now requires pharmacists to perform a timely retrospective review of medication orders during urgent situations, even in a licensed independent practitioner (LIP)-controlled environment, a departure from a previous stance, a source close to the JCAHO says.

Standard **MM.4.10** requires that a pharmacist check all medication orders before distributing them unless an LIP controls the medication ordering, preparation, and administration—typically the case in the emergency department (ED) or operating room (OR)—or when any delay would cause harm to the patient.

The JCAHO told surveyors in January during its annual surveyor conference in Chicago that would only be the case if the LIP is present and giving the medication or is watching someone else give it, according to the source. If the physician is not present and the situation is urgent, the pharmacy must conduct a timely retrospective review.

The JCAHO did not define timely, but the source expects the commission will mandate that the review be completed by the next day.

“That’s going to really affect the field because there are not enough pharmacists out there,” the source says. “It’s just one more thing for them to do. It’s going to be a nightmare to get all that information together in the [emergency room] for the pharmacy to review.”

**Elizabeth DiGiacomo-Geffers, RN, MPH, CNA, BC** a healthcare consultant in Trabuco Canyon, CA, says the JCAHO Standards Interpretation Group told her that surveyors would require a pharmacist’s prior review of orders in nonurgent situations if the LIP is not at the bedside. The JCAHO failed to return several requests for comment by press time.

**Change in interpretation**

The JCAHO’s interpretation is a marked departure from the intent of the standard and its element of performance, says **Bud Pate, REHS**, director of clinical operations effectiveness for The Greeley Company, the Marblehead, MA–based consulting division of HCP, Inc., which publishes this newsletter.

“My concern is that it is not what the standard is intended to require,” Pate says. “None of those settings [e.g., the ED or the OR] are currently set up to do a prospective or retrospective review.”

Hospitals need to review an order prior to adminis-

---

**Elements of performance for MM.4.10**

1. A pharmacist checks all medication orders before distributing them unless either a licensed independent practitioner controls the medication ordering, preparation, and administration or any delay would cause harm to the patient.
2. Not applicable
3. A qualified staff member reviews orders when an on-site pharmacy is not open 24 hours per day.
4. The pharmacist reviews the order once he or she is available or the pharmacy opens.
5. The hospital reviews all prescriptions for the following:
   - The dose, frequency, and administration methods
   - Therapeutic duplication
   - Allergies or sensitivities
   - Possible interactions between the drug and other medications, food, or laboratory values
   - Other impairments to treatment
   - Any variation from hospital policy regarding medication use
   - Other relevant issues
6. The person prescribing the medication addresses all concerns, issues, or questions before a pharmacist fills the order.
vation, which pharmacists typically do, Pate says. If the pharmacy is closed, a designated caregiver such as a night supervisor can conduct the review and dispense the medication, and then the pharmacy must do a retrospective review, he says.

✓ **Tip:** Clearly define “physician-controlled environment” in policies to avoid confusion about where prior reviews must take place, Pate says.

One way that hospitals could facilitate a retrospective review of ED orders is to put stock for that unit in an automated dispensing device, such as a Pyxis machine, Pate says. The pharmacy can then track which staff remove from the machine.

**Involving pharmacy**

Critical care unit staff at Tennessee Christian Medical Center in Madison, TN, have access to medications they can give prior to a pharmacist review in urgent or emergency situations only, says pharmacy director David Kellogg, DPh, MS. Two licensed caregivers, such as nurses and supervisors, must review the order and place their initials on the patient’s medication administration record.

Staff must then fax the order to the pharmacy as soon as possible. A pharmacist then reviews the order, typically within 30 minutes, Kellogg says.

The process also holds true for orders when the pharmacy is closed, but a pharmacist’s review would not take place until morning.

Staff must follow the same procedure even for seemingly innocuous medications such as those used to treat nausea, Kellogg says.

“We believe we can substantiate that for the Joint Commission,” Kellogg says. “Not every pharmacy can be 24-hour. We want to do the safest thing for the patient. That’s our prime objective in our hospital.”

**Report: Dispensing devices linked to med errors**

A U.S. Pharmacopeia (USP) report links automated dispensing devices to medication errors, highlighting the importance of educating staff about how to operate the machines correctly.

Automated dispensing devices were the 10th-leading cause of error in 2003, according to records from the USP MEDMARX medication error-reporting database. These dispensing devices range from centralized pharmacy robots to unit-based dispensing machines, says John Santell, MS, RPh, USP director of educational program initiatives.

Pharmacists and nurses are the primary users of the devices, Santell says, emphasizing the need for more interaction between the two departments. “Pharmacy and nursing need to collaborate to identify problems,” Santell says. “There is a need for ongoing training and monitoring to make sure [dispensing device] use is optimal.”

Among voluntary reports submitted to the database, 361 facilities submitted 8,862 records citing automated dispensing devices involved with the medication error.

Nearly 31% of those errors reached the patient, and 1.3% resulted in harm, according to the report. Almost 44% of errors occurred during the dispensing phase.

**Fill with care**

Errors related to improper drug dose or quantity were the most-frequently reported at 52.9%, or 4,368 reports. Unauthorized drug errors were second at 16.7%, or 1,379 reports.

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**Correction**

Due to a reporting error, Glenn Lichtman’s name was misspelled in the February health care staffing services article. **Hospital Pharmacy Regulation Report** regrets the mistake.
Those errors often resulted from improperly filling the device or retrieving the wrong product from the machine, Santell says. Improper filling can result from similar packaging or labeling on a drug, he says.

For example, a pharmacy technician improperly filled one device with 25 vials of heparin 10,000 units per mL instead of 10 units per mL. A pediatric patient received two doses during the night, receiving an overdose that required additional treatment.

A registered nurse on the day shift noticed the error and removed the remaining 23 vials, Santell says.

**Tip:** Conduct a Failure Mode and Effects Analysis on the use of automated dispensing devices. Identify potential problem areas.

**Error reporting up**
USP asked professional organizations and manufacturers to review automated dispensing devices to create best practices for their use. Manufacturers note that they continually evaluate their systems for safety and that automated technology is not the direct cause of error.

“What we have to do is put it in perspective,” says **Jim Baker, MS, RPh**, national director of professional services for Cardinal Health’s Pyxis Products. “There’s been a real increase in reporting errors.”

Cardinal Health’s Pyxis products, which include unit-based dispensing technology, have the ability to discover errors, helping hospitals track, report, and prevent them, Baker says. Prior to that technology, many errors went unreported.

**Ken Perez,** vice president of marketing for Omnicell, another automated dispensing device maker, likened errors to automobile accidents. If a report says 50 people were killed in Volvos last year, most often it can’t be determined whether the car or the driver caused every accident. For example, improper seat-belt use—not the cars themselves—causes half of all deaths in Volvos, he says.

“Our intent is to prevent errors,” Perez says. “They’ve always pointed out that user error is the leading source of error. Without the systems, there would clearly be more errors.” Omnicell provides on-site training and testing for user competence, he says.

—John Santell, MS, RPh

**Upcoming events**

**Audioconferences:**

**March 15**—Tools and Strategies for Continuous Survey Readiness

**March 16**—Concurrent Coding

**March 29**—Assessing a Patient’s Falls Risk to Comply with JCAHO Goals

**March 30**—The Problem Physician

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Baby steps can help boost reconciliation rates

Keep it simple.

Milford (MA) Regional Medical Center followed that philosophy when implementing a medication reconciliation program to comply with one of the JCAHO’s new 2005 National Patient Safety Goals. By doing so, reconciliation rates went from 77% at admission and discharge in April 2003 to 95% by September 2004.

The key: Rolling out the program unit-by-unit and starting small—as small as having only one nurse perform reconciliation tasks initially.

“Start with just a couple of nurses, maybe just one physician, and on one unit,” advised Maureen Gibbs, RN, BSN, nurse manager of the telemetry unit at Milford Regional, during a recent HCPro audioconference. “Don’t feel you have to do it in each unit right away.”

The JCAHO goal requires hospitals to accurately and completely reconcile a patient’s medication list and communicate it to the patient’s next care provider. The JCAHO began surveying for compliance with the goal on January 1.

Surveyors will check during surveys to make sure that hospitals have a plan in place to be fully compliant by January 1, 2006.

Do group work to begin

Medication reconciliation at Milford Regional began as part of a statewide collaborative with the Massachusetts Hospital Association in 2003, well before the JCAHO issued the goal.

The hospital created a team to head the reconciliation efforts, Gibbs said. The team included Gibbs, the pharmacy director, the performance improvement director, and the medical director of risk management.

The performance improvement committee conducted a baseline audit in April 2003, looking at 12 inpatient records, Gibbs said. The committee found 87 medication transcriptions, and staff reconciled about 77% of medications upon admission.

Be selective

Milford Regional’s telemetry unit became the pilot unit in May 2003. Gibbs chose one skilled nurse ambassador who was respected and well-liked to articulate the process to other staff, she said.

“You’re going to hear, ‘Oh, this is just another piece of paper,’ ” Gibbs said. “You want those ambassadors to be able to explain why [reconciliation] is so important.”

By July 2003, the hospital rolled out medication reconciliation to the medical unit using the same concept of ambassador nurses.

By September 2003, all telemetry nurses were trained in the reconciliation process and 75% of patients were involved, Gibbs said.

Remind, remind, remind

Nurses used a medication reconciliation form, but the hospital made sure to prompt them to use it, Gibbs said. As a reminder for nurses to conduct an assessment upon admission, Gibbs stapled the form to the admission assessment tool (see p. 10 for sample).

The pharmacy department handled reconciliation when a patient was transferred to a new unit, such as from the intensive care unit to an inpatient bed, Gibbs said.

✔ Tip: Keep the medication reconciliation form in one location so staff know where to find it.

Milford Regional staff place the reconciliation form in the order section of the patient’s chart, Gibbs said.

# Sample medication reconciliation form

**Table**: contents to be filled in.

<table>
<thead>
<tr>
<th>Date, time, initials</th>
<th>Drug name, dose, schedule</th>
<th>Last taken</th>
<th>Amount of NON compliance</th>
<th>Info source</th>
<th>Ordered on admission?</th>
<th>Ordered @ DC?</th>
<th>Reconciled @ DC?</th>
<th>Reconciled @ transfer?</th>
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</tbody>
</table>

**Comments:**

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**Medications upon admission**: check one (1)

a) **NO** medications brought to hospital: ___.

b) Medications sent to pharmacy: ___ date/time _____

c) Medications brought to hospital sent home: ___; if so, date/time ___.

**Signature/initials:**

1. ______________ 4. ______________

2. ______________ 5. ______________

3. ______________ 6. ______________

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## Instruction for use of medication reconciliation form

<table>
<thead>
<tr>
<th><strong>Terminology</strong></th>
<th><strong>Instructions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date, time, initials of interviewer</td>
<td>Record date and time information was gathered and initials/credentials</td>
</tr>
<tr>
<td>Drug name, dose, schedule</td>
<td>Record full name, dose, and patient’s actual usage pattern. Record deviation from labeled instructions in Comments section. Include OTC medications.</td>
</tr>
<tr>
<td>Last taken</td>
<td>Record date and time patient took last dose</td>
</tr>
<tr>
<td>Amount of NON-compliance</td>
<td>Record number of scheduled doses missed in one week. “0” = patient takes every dose as scheduled. Record number of “PRN” doses taken in a time period, “4 per day” or “6 times per week”</td>
</tr>
<tr>
<td>Information source</td>
<td>Record source of information: Pt = patient interview Fam = spouse, family member Clinic = clinic records H &amp; P = recent history &amp; physical Trans = transfer records from another facility Rx = prescription vials or pharmacy call Other = data source explained in comments section</td>
</tr>
<tr>
<td>Ordered on admission?</td>
<td>Reconcile MD’s initial medication orders with medication history. Y = continued on admission Held = MD does not want medication given at time of admission Changed = same medication but different dose or schedule Replaced = different medication with similar action ordered instead</td>
</tr>
<tr>
<td>Ordered at discharge?</td>
<td>Reconcile discharge orders with medication history. Y = continue same medication and dose Changed = same medication but different dose or schedule Replaced = different medication with similar action ordered instead D/C’d = medication stopped during hospitalization, not appropriate at discharge</td>
</tr>
<tr>
<td>Patient’s pharmacy</td>
<td>Document name(s) of pharmacy(ies) that maintain a patient profile for this patient and can be used as a reference. Include city &amp; phone number</td>
</tr>
<tr>
<td>Comments</td>
<td>Record deviations from labeled instructions. Record any pertinent observations or assessments you feel important in understanding patient’s therapy and/or ability to self medicate. Record any special requirements for discharge prescriptions.</td>
</tr>
<tr>
<td>Reconciled @ transfer? (if applicable)</td>
<td>The medication was: a) ordered @ transfer, same as upon prior nursing unit, b) ordered @ transfer different dose-and documented change of dose, c) not ordered @ transfer and documented reason= YES/reconciled If no reason documented for omitted or changed dose-reconciliation is failed=NO/nonreconciled.</td>
</tr>
<tr>
<td>Reconciled @ discharge?</td>
<td>The medication was: a) ordered @ discharge, same as upon admission, b) ordered @ discharge different dose-and documented change of dose, c) not ordered @ discharge and documented reason= YES/reconciled If no reason documented for omitted or changed dose-reconciliation is failed=NO/nonreconciled.</td>
</tr>
</tbody>
</table>

**Source:** JCAHO’s Medication Reconciliation Patient Safety Goal: Effective Strategies, Tips, and Tools to Comply ©2005 HCPro, Inc. For more information or to order, call 800/650-6787
Quick tip: Assign point person to monitor medication security in operating rooms

The JCAHO has followed in the footsteps of the Centers for Medicare & Medicaid Services (CMS) by requiring hospitals to lock medications in the operating room (OR) or keep them under supervision.

JCAHO standard MM.2.20 requires organizations to secure medications in accordance with hospital policy and law so unauthorized people cannot obtain them. CMS defines secure as being locked or under constant supervision, and the JCAHO is aligning its definition with the federal government.

“The Joint Commission will survey hospitals for compliance with the CMS requirements regarding anesthesia carts,” says JCAHO spokesperson Mark Forstneger.

Many people move in and out of the OR all day, placing greater importance on medication security.

✓ Tip: Assign a qualified staff member, such as a certified anesthesia technician, to make sure all OR medications are locked and accounted for, says Lori Griffith, RN, MS, quality coordinator for Blount Memorial Hospital in Maryville, TN.

Also consider defining who is authorized to access areas such as the OR, where medications must be stored.

“Because patients, students, maintenance, and housekeeping have access to the OR, it is vital to make sure medications are locked up or supervised at all times,” Griffith says.

However, many hospitals struggle to get OR staff to comply with CMS and JCAHO expectations.

“OR staff are especially resistant to change,” Griffith says. “Anesthesiologists and RNs [registered nurses] feel like it’s more important to have quick access to their equipment than it is to be in compliance with some standard.”

Hospital Pharmacy Regulation Report

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