



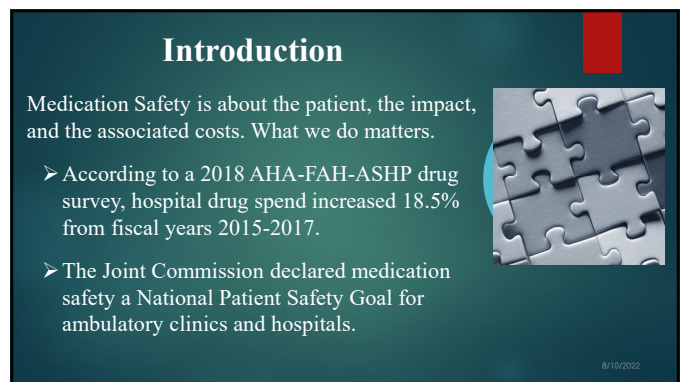
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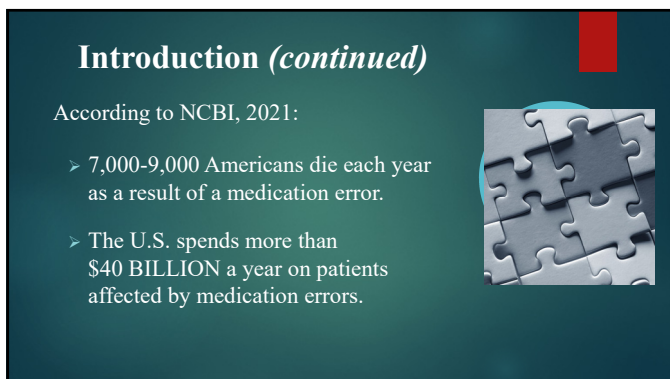
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Medication Safety Components

Committees: Medication
Exec/Medication Safety and P&T

Facility Teams: Buy-In and Follow Up

Data: Tracking/Discussing/Reporting



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Check-In

#1: *True or False?*

The U.S. spends \$4 BILLION a year on patients affected by medication errors.

8/10/2022 8

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Check-In

#1: *Answer*

FALSE – The U.S. spends \$40 BILLION a year on patients affected by medication errors.

8/10/2022 9

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Learning Objectives

- 1) Describe the purpose of the Hospital P&T Committee.

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AHA, ASHP, FDA, ISMP, TJC, WHO...

Voluntary? Necessary?

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Medication Safety Institutions

Large number of institutions

- Who do we follow? Does it matter?

Sorting through “Best Practices”

- Determining priorities, creating a calendar.
- Ever changing/archived items.

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Medication Safety Institutions

Are “Best Practices” voluntary?

- What are the consequences of not implementing?
 - Loss of accreditation.
 - Loss of payers.

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Organizations Interested In Medication Safety

ISMP

The Gold Standard

- ▶ A Non-Profit Organization.
- ▶ Over 30 Years of Dedication to the Promotion of Safe Medication Practices.

TJC

- ▶ Evaluate and Inspire Organizations to Provide Safe and Effective Patient Care.

FDA

- ▶ Ensure the Safety, Efficacy, and Security of Human and Veterinary Drugs, Biological Products, and Medical Devices.

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Organizations Interested In Medication Safety (*continued*)

AHA

- ▶ Represents, Educates, and Advocates for Hospitals, Healthcare Networks, Patients and Care Providers.

ASHP

- ▶ Advocacy, Education, Accreditation, Policy & Practice Standards, and Drug Information.

WHO

- ▶ United Nations Agency – Direct and coordinate world response to health emergencies and promotion of healthier lives.

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Check-In Question #2: Which one of these is a non-profit organization?

A

FDA

B

ISMP

C

TJC

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Check-In #2: Non-Profit Organization—*Answer*

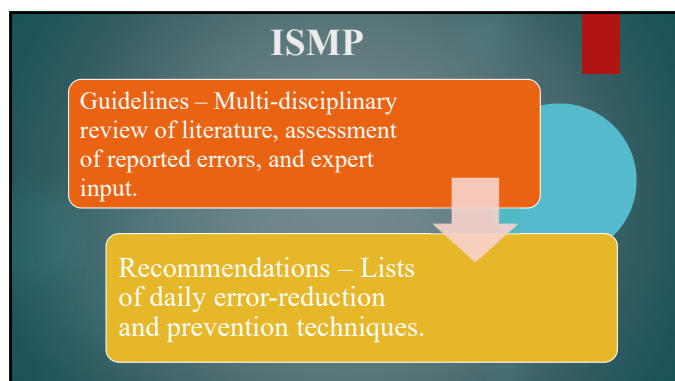
B: ISMP – Institute for Safe Medical Practice (The Gold Standard).

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Learning Objectives

- 2) Distinguish between a facility “Best Practice” and an ISMP “Recommendation.”

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ISMP Best Practice #7: NMB Safety

- ▶ **Policy requirement:** Inpatient care areas, segregate, sequester, and differentiate all neuromuscular blocking agents (NMBs) from other medications.
- ▶ **Assessment requirement:** Evaluate if all auxiliary labels contain:
 - “WARNING: PARALYZING AGENT, CAUSES RESPIRATORY ARREST. IS THE PATIENT VENTILATED?”
 - Assess level of segregation of product (locked/lidded container).

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ISMP Best Practice #9: Antidote, Reversal Agent, & Rescue Agent Safety

- ▶ **Policy requirement:** The facility has QAPI processes in place to ensure appropriate use of anticoagulant reversal agents (vitamin K, prothrombin complex concentrate, protamine).
- ▶ **Assessment requirement:** Evaluate monitoring plan (reversal agent trending) for appropriateness and timeliness.

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ISMP Best Practice #10: Eliminate 1,000 mL Bags of Sterile Water Outside of Pharmacy

- ▶ **Assessment requirement:** Assess documentation to ensure adequate removal of 1,000 mL IV bags for sterile water used for injection, irrigation, and inhalation.
- ▶ **If shortage situation occurs:** Request photographs of product being used and review alignment of labeling with safety alert.

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Best Practices

```

graph TD
    A[Health System – Broad System Specific] --> B[Facility Specific – In Addition to, Not Instead of]
  
```

The diagram shows two levels of best practices. The top level is 'Health System – Broad System Specific', represented by a stethoscope icon. The bottom level is 'Facility Specific – In Addition to, Not Instead of', represented by a plus sign icon. An arrow points from the Health System level down to the Facility Specific level.

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Health System/Facility Best Practices A: Medication Safety Walkaround

- ▶ **Policy requirement:** Medication Safety Walkaround findings have documented action plans, and the facility tracks the completion of action plans.

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Health System/Facility Best Practices A: Medication Safety Walkaround

- ▶ **Assessment requirement:** Assess action plans and its outcomes, to ensure the appropriate follow-up was taken with identified risks/issues.
 - Facility P&T meeting minutes.
 - Facility/Division medication safety meeting minutes.

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Health System/Facility Best Practices B: Dispensing Medications in Unit of Use

- ▶ **Policy requirement:** Pediatric medication tablets that require splitting are sent from Pharmacy as unit of use.
- ▶ **Assessment requirement:** Review the policies for both pediatric and adult medications that are not to be administered in their entirety for compliance with best practice.
 - Pediatric tablets should be sent from pharmacy pre-split.
 - Provide the policy(s) associated with medications that meet USP Chapter criteria and their associated handling guidance.

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Organizational Structure & Culture

- ▶ Top-Down
- ▶ Supportive, Non-Punitive Culture (Recent Legal Proceedings)
- ▶ Education
- ▶ Collaboration

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Learning Objectives

- 3) Explain the importance of the pharmacy purchaser's role with the P&T Committee.

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The Facility Team

"C" Suite

Physicians

Pharmacy

Nursing

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Pharmacy/Medication Safety Officer

According to ASHP, Medication Safety Statements 2019, the Medication Safety Officer has "responsibility for leadership, medication safety expertise, influencing practice change, research, and education" of the patients and caregivers.

The Medication Safety Officer does not have to be a pharmacist, although their education and expertise makes them well suited for the role.

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Committees: Med Exec, Med Safety, & P&T

- ▶ Medication Executive Committee (MEC):
 - Represents the medical staff and makes recommendations on matters that affect quality of care.
- ▶ Medication Safety Committee:
 - Provides leadership to healthcare teams and promote the highest standards for safe and effective medication usage.
 - Often a subcommittee of P&T.

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Committees: Med Exec, Med Safety, & P&T (continued)

- ▶ Pharmacy & Therapeutics Committee (P&T):
 - Creation of a facility medication formulary.
 - Responsible for the evaluation of medications, consideration of rational use of medications, develop and implement strategies for optimal medication use.

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Pharmacy Purchaser ("Magician")

- ▶ Knowledge of the Medication Inventory
- ▶ Knowledge of Medication Shortages
- ▶ Knowledge of Medication Contracts

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Learning Objectives

- 4) Identify steps taken after the P&T Committee approves a "Best Practice."

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Facility Teams: Buy-In & Follow Up

- ▶ Is each discipline represented?
- ▶ Are there additional questions to be answered before a decision can be made?
- ▶ Is there agreement among the disciplines?
- ▶ Who is responsible for ensuring implementation?
- ▶ Data and reporting.

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Data: Discussing/Tracking/Reporting

- ▶ Important to determine what data will be collected.
- ▶ Who is responsible for collecting the data?
- ▶ How will tracking take place?
- ▶ How often and to whom will reporting occur?

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Wrapping Up

- Medication selection, usage, and safety are important at all levels of facility operations.
- Interdisciplinary collaboration is essential.
- Pharmacy should have a large role on the P&T Committee.
- Follow through and follow up is important.

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References

- Food and Drug Administration (FDA) <https://www.fda.gov/>
- Institute for Safe Medical Practices (ISMP) <https://www.ismp.org/>
- National Center for Biotechnology Information (NCBI) <https://www.ncbi.nlm.nih.gov/>
- The Joint Commission <https://www.jointcommission.org/>
- American Hospital Association (AHA) <https://www.aha.org/>
- American Society of Health System Pharmacists <https://www.ashp.org/>
- World Health Organization <https://www.who.int/>

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Medication Safety Is Everyone's Responsibility

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