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ASHP Comments on 2009 National Patient Safety Goals (submitted online)

The American Society of Health-System Pharmacists (ASHP) is pleased to provide comments on the 2009 National Patient Safety Goals. ASHP is a 35,000-member national professional association that represents pharmacists who practice in hospitals, health maintenance organizations, long-term care facilities, home care, and other components of health care systems.

The following comments address only those National Patient Safety Goals (NPSG) that are relevant to medication use in hospitals. References to problematic NPSGs are from The Joint Commission Hospital Update*, presented by Dr. Darryl Rich at the ASHP Midyear Clinical Meeting in December 2008 and are included at the end of these comments.

Goal 1. Patient identification

Goal 1 is applicable, essential to safety and quality of care, requires minimal additional effort for compliance and should be retained.

ASHP recommends clarifying whether using two patient identifiers is the expectation in those settings where pharmacists dispense prescriptions directly to a patient, e.g. counseling inpatients on discharge prescriptions; at the outpatient pharmacy.

Goal 2. Communication

Goal 2 is applicable, essential to safety and quality of care, requires minimal additional effort for compliance and should be retained.

“Medications” are now included as an update during patient handoff communication in NPSG.02.05.01 EP2. ASHP requests clarification regarding whether this communication includes any information distinct from that required in Goal 8 Medication Reconciliation.

Compliance with NPSG 02.02.02 appears to have improved significantly. ASHP recommends re-evaluating whether this goal can be incorporated into the MM standards after 2010. If not done recently, a reassessment of the abbreviations that are mandatory in "do not use" lists should be performed to determine if the list needs updating.

Goal 3. Medication Safety

Goal 3 is applicable, essential to safety and quality of care, requires significant additional effort for compliance and should be retained.

ASHP encourages TJC to continue emphasis on NPSG 03.03.01 (look-alike/sound-alike drugs) despite a reported low noncompliance rate. While policies on handling of look-alike drugs are present in most organizations, they may not be fully implemented. Drug mix-ups continue to occur as evidenced by recent heparin mix-up reports.

NPSG 03.05.01: EP 2.

ASHP recommends providing more guidance on this EP. We have heard differing interpretations from members on implementing this requirement, i.e., either that all unfractionated and LMW heparin must be prepared in pre-filled syringes or that only available ready-to-administer form have to be used and vials can be used for other doses. An FAQ that clarifies the expectation would be helpful.

EP 4 and EP 7: ASHP is unaware of evidence that supports obtaining a baseline INR for patients not currently treated with warfarin. However, we believe that the Sentinel Event Advisory Group must have such evidence or other basis to support this requirement and recommend that providing this information to accredited organizations. ASHP has heard reports of resistance to this aspect of EP 4 due to the perception that a baseline INR is unnecessary and therefore wasteful.

Additional EP: ASHP recommends consideration of an additional EP that requires a process for ensuring appropriate dosing of unfractionated heparin in response to changes in aPTT lots or laboratory instrumentation. The process should include criteria for determining the need to adjust current therapeutic dosing ranges, timely updating of pre-printed orders, protocols, and electronic ordering systems, and a communication plan for notifying the medical staff and the pharmacy. ASHP has heard compelling reports of adverse patient outcomes due to dosing adjustment based on outdated therapeutic ranges.

Goal 7. Healthcare associated infection

Goal 7 is applicable, essential to safety and quality of care, requires some additional effort for compliance and should be retained.

The goal addresses infection control standards for identifying and managing patients colonized or infected with multi-drug resistant organisms. ASHP recommends a future addition to the goal that specifically addresses monitoring and preventing the emergence of antimicrobial resistance, if appropriate within the intent of Goal 7.

Surveillance data on both institutional and community pathogen susceptibility patterns should be considered when developing antimicrobial medication-use policies. Examples of guidance documents include [ASHP Statement on the Pharmacist's Role in Infection Control](#) (and the SHEA/IDSA "[Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship](#)")

Goal 8. Med Reconciliation

Goal 8 is applicable, essential to safety and quality of care, requires considerable additional effort for compliance and should be retained. ASHP applauds TJC's collaborative efforts with healthcare professionals to facilitate achievement of this goal. The current version is more explicit and less subject to misinterpretation. Nonetheless, Goal 8 is still the most challenging in terms of implementation for many

organizations. ASHP has developed policy that supports Goal 8: [The Pharmacist's Role in Medication Reconciliation](#).

Goal 9 – Reduce falls

Goal 9 is applicable, essential to safety and quality of care, requires varying degrees of additional effort for compliance and should be retained.

Medications are a significant factor in falls. ASHP believes medication evaluation is essential for preventing harm from falls in at-risk populations and strongly encourages requiring, rather than recommending, this assessment in the rationale for the goal. Lists of medications that may affect equilibrium or coordination to be used in assessment are available, but may not be all-inclusive or applicable to organization-specific patient populations. ASHP recommends including pharmacists in the development of fall reduction programs and assessment individual patients at heightened risk for falls.

***Update on Joint Commission Hospital Standards and NPSG for 2009**

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Presented at the ASHP Midyear Clinical Meeting December 2008

Top Med-related NPSG Scored Non-Compliant in 2008*

| NPSG Requirement | 2008 | 2007 | 2006 |
|---|------|------|------|
| 8A Entry Medication Reconciliation | 22% | 16% | 34% |
| 3D Medication Labeling in Procedure Areas | 19% | 19% | 9% |
| 2B Unapproved Abbreviations | 18% | 23% | 37% |
| 8B Transfer/DC Med Reconciliation | 16% | 11% | 27% |
| 3C: Look-Alike, Sound-Alike Drugs | 5% | 5% | 6% |

***Jan-Jun 2008: 638 surveys**

<http://www.ashp.org/DocLibrary/BestPractices/InfectionControl.aspx>