

# Navigating The Joint Commission Performance Improvement Standards: *Issues for Pharmacy*

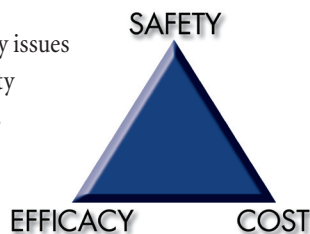


## ● INTRODUCTION

Medication management is a major component of patient safety. Since publication of the 1999 Institute of Medicine report, *To Err is Human*, the issue of medication safety has attracted the attention of the consumer as well as the medical community.

## ● SUMMARY

Safety continues to be the apex of the safety-efficacy-cost triad. Quality issues have developed on a different, though similar, track. Many of the quality indicators initiated by the Centers for Medicare and Medicaid Services (CMS) and adopted by accreditation organizations (such as The Joint Commission) and insurers are medication-related.



Medication-related quality measures should be used as a part of a health-care organization's Performance Improvement (PI) plan. The Joint Commission's PI standards provide a framework that can be used to structure medication performance improvement activities.

## ● ISSUES BRIEF

Collection of data is central to the ability to monitor performance. Medication management performance indicators should be set in conjunction with the health-care organization's process. The Joint Commission standard PI.01.01.01 requires that health-care leaders set priorities for data collection and identify the frequency of collection. This standard specifically notes that data is to be collected on significant medication errors and significant adverse drug reactions (ADRs). Medication error data is also used to meet the intent of MM.08.01.01 which requires that the performance of the medication management system be evaluated by collecting, analyzing, and comparing data over time for trends indicating risk points.

For consistency, a health-care organization should define "medication error" and determine, as precisely as is practical, how significance or seriousness will be assigned. For medication errors, the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) definition of errors and stratification algorithm may be used. The stratification algorithm groups reports into categories such as no error, error with no harm, error with harm, or error that caused death. A health-care organization can set a cutoff at one of the levels. Further guidance may be obtained from the ASHP Guidelines on Preventing Medication Errors in Hospitals.

Organizations often desire to compare their error rates with others. NCC MERP believes that there is no acceptable incident rate for medication errors and that comparing error rates is of no value. Differences in the culture of reporting errors, definitions of error, patient populations, and the reporting and detection systems used introduce too many variables to make such comparisons meaningful. A health-care organization's medication-use policy-generating body or safety committee should determine how medication error data is to be used to identify risk, what corrective action(s) are to be taken, and how changes will be monitored.



For more information about the QII, please visit [www.ashp.org/QII](http://www.ashp.org/QII).



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## RESOURCES

- Joint Commission PI standards include data collection, compilation and analysis of the data, and improving performance. The elements of performance under each standard provide a framework and, in some cases, specific information to be addressed.

- ASHP Best Practices documents, including those detailing information about medication safety, medication errors, and adverse drug reactions can be viewed at [www.ashp.org/bestpractices](http://www.ashp.org/bestpractices), click on Medication Misadventures.

- Information about NCC MERP, including definitions and recommendations to prevent medication errors, can be viewed at [www.nccmerp.org](http://www.nccmerp.org).

- NCC MERP's statement on comparing medication error rates, Use of Medication Error Rates to Compare Health Care Organizations is of No Value, is available at [www.nccmerp.org/council/council2002-06-11.html](http://www.nccmerp.org/council/council2002-06-11.html).

- The Joint Commission's Sentinel Event Alerts can be viewed at [www.jointcommission.org](http://www.jointcommission.org), click on Sentinel Events, then click on Sentinel Event Alerts.

- ISMP's Quarterly Action Agendas are available at [www.ismp.org](http://www.ismp.org).

Determining a precise level of significance for ADRs may not be as objective as that for medication errors, since the multiplicity of factors involved can cause more variation. A health-care organization should adopt a standard definition of an ADR and then set levels of significance based on that definition. The ASHP Guidelines on Adverse Drug Monitoring and Reporting contains definitions, categorizations, and key components of an ADR program, including guidance on determining the significance of an ADR.

Pharmacy participation in the health-care organization's PI initiatives should not be limited to the collection and analysis of medication error and ADR data. CMS' Core Measures and The Joint Commission's ORYX® measures require data collection and analysis, including medication use, for acute myocardial infarction, heart failure, and pneumonia. The Surgical Care Improvement Project measures and The Joint Commission's National Patient Safety Goal 7 (reduce the risk of health care associated infections) require monitoring of pre- and post-operative antibiotic use and selection. Pharmacy should provide a lead role in each of these performance improvement areas, particularly with regard to medication use measures. The Joint Commission's standard PI.02.01.01 should be reviewed to identify the requirements of compilation and analysis of data.

Data collection and analysis are tools used to orchestrate performance improvement. Standard PI.03.01.01 requires that a health-care organization takes action on improving priorities (as identified by the first PI standard) and evaluates them to confirm that the anticipated improvement was achieved. If the results show that the indicators did not demonstrate improvement, further action needs to be taken which will lead to the desired goal.

The Joint Commission's Sentinel Event Alerts also provide guidance for PI activities. Many of the Sentinel Event Alerts have medication improvement components and suggested strategies for improvement in safety and quality. The Institute for Safe Medication Practices (ISMP) publishes a Quarterly Action Agenda as part of its *Medication Safety Alert!* which can be systematically reviewed to ensure compliance with best practices.