Steven Hirsch and Associates

Accreditation News

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Dissecting the DEA Certificate

Practitioners who legally prescribe "controlled" medication must possess a valid license issued by the Drug Enforcement Administration (DEA).

When credentialing practitioners, it is important to carefully review all the elements of the DEA certificate. The DEA certificate should be current, the status should be Paid or Exempt, depending on your facility, and the certificate should list all the schedules.

If a certificate is paid for by the practitioner, there will be the dollar amount of $551. This indicates that the practitioner has paid for the DEA certificate and will allow the practitioner to prescribe medication in any facility. If you subscribe to the National Technical Information Service (NTIS), the status will be listed as "P."

When the status is "Exempt," the practitioners are restricted to activities within the scope of the training program (including other affiliated training sites) or the state or federal institution, (e.g. university, state or federal prison) which has paid for the certificate. The exempt DEA is not valid outside of the institution as listed on the DEA. On the certificate from the NTIS, the status will be listed as "E."

Several states require a second state-controlled substances registration prior to being authorized to order controlled medication, in addition to the DEA certificate. You can check your state regulation on the DEA website.

Does the practitioner have all the schedules listed on the DEA certificate? A "full" schedule is listed as 2 2N 3 3N 4 5. There is a listing of the medications listed under each schedule on the DEA website. The Drug Enforcement Administration application has a space to list the Drug Schedules of controlled substances that the practitioner wishes to prescribe. The practitioner will ONLY be authorized to prescribe those drugs that are checked on the application form.

If the certificate does not display all of the schedules listed above, do you notify Director of Pharmacy? It is the responsibility of the Pharmacist to ensure that the practitioners are only prescribing medications as listed on their DEA certificate, and unless the Pharmacist is collecting his own copies of the practitioners' DEA certificates, it is the responsibility of the Medical Staff Office to provide the DEA number and a listing of the schedules as listed on the DEA certificate.

What do you do if you find an Exempt DEA certificate? Notify the practitioner and the Pharmacist and suspend prescribing privileges until there is evidence that the certificate is listed as "Paid." If the DEA does not have the listing of the full schedules, notify the practitioner and request clarification as to why the full schedules are not listed (usually an oversight when completing the application), but the Medical Staff Services personnel should immediately notify the Pharmacist of all DEA certificates that are lacking the listing of the full schedule of drugs.

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Dissecting the DEA Certificate Continued…

Changes to the DEA certificate, which include, name, address, status and increasing of the schedules, can be done online at the DEA website.

If the hospital does not subscribe to the NTIS, be aware that the DEA Duplicate obtained online will not contain the DEA certificate status or the schedules, so be sure to always obtain a copy of the actual certificate from the practitioner.

I would recommend that an audit of credentials files be conducted to ensure that your practitioners have the correct DEA certificate for your facility. If it is determined during an accreditation survey that controlled substances have been disposed on the order of a practitioner who does not possess the required authorization, the organization's accreditation may be placed at risk, as this can be construed as practitioners practicing outside of their scope of licensure.

Written by Margo Smith, RHIT, CPMSM, CPHQ of Associates

The Joint Commission Laboratory Accreditation Standards

COMPETENCE ASSESSMENT allows the Joint Commission surveyors to learn about the assessment process for the staff and about the organization's orientation, education, and training processes. The assessment process may take up to sixty minutes and should include individuals responsible for human resource processes, for the orientation and training of staff, as well as the individual responsible for laboratory services.

HR.01.06.01 Staff are competent to perform their responsibilities. Hospitals must remember to document on their Competency Assessment and Validation tools the following elements (the elements of competency):

- Direct Observation: patient testing, patient preparation, specimen collection, handling and processing (DO)
- Monitoring: monitoring, recording and reporting of test results (M)
- Review of test results: review of intermediate test results or worksheets, quality control, proficiency testing and preventive maintenance performance (R)
- Direct observation: of performance of instrument maintenance, function tests and calibration (I)
- Test performance as defined by laboratory policy: for example, proficiency testing, blind testing, external proficiency or testing samples (T)
- Problem solving skills as appropriate to the job (P)

The initial(s) for each validation method can be placed on a grid on the Initial, Six month and Annual Competency Assessment and Validation Tool and then documented with each element on the tool, along with the date, perfomer's initials and validator's initials.

Recently surveyed hospitals have been found to be out of compliance with this requirement, so review of current tools is advisable to ensure all components are addressed for HR.01.06.01

Written by Linda Paternie, RN, BS, MHA of Associates

Don't Forget to Check the Glucose Meter

A clean environment is essential to a successful infection prevention program. Ensuring that equipment is cleaned between patient use contributes to a safe environment for the patient. A policy is helpful to delineate cleaning of patient care equipment. The policy should address who has responsibility for cleaning each piece of equipment, how frequently the equipment is cleaned, and what cleaner/disinfectant must be used. One piece of equipment that is sure to catch the eye of a surveyor is the blood glucose meter.

OSHA states to adequately disinfect blood from a surface, a 1:10 bleach solution must be applied to the surface and allowed to dry according to the manufacturer's recommended contact time. OSHA allows additional disinfectants that are approved by the Environmental Protection Agency (EPA) to disinfect a surface that contains blood. However, the surface must be cleaned first and *then* disinfected if using a disinfectant other than bleach. *Cleaning* is the removal of visible soil (e.g., organic and inorganic material) from objects and surfaces. Using a disinfectant other than bleach means that the healthcare provider must remember to clean the meter

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Don't Forget to Check the Glucose Meter Continued…

first and then wipe the surface a second time – a two-step process (the EPA approved disinfectant can be used to clean the surface prior to disinfection). Because the glucose meter must be disinfected after each use, many facilities have implemented a bleach product to simplify the process.

By Shannon Oriola, RN, BSN, CIC, COHN of Associates

30 Minutes or Less Per CMS: Administration of Scheduled Medications

CMS has revised its Interpretive Guidelines that previously refined medications must be administered within 30 minutes of their scheduled time. This change came as result of a survey of 18,000 nurses conducted by the Institute for Safe Medical Practices (ISMP). Respondents to this survey self reported a high degree of unsafe practices and work arounds that were the direct results of attempting to meet patient care needs while adhering to the 30 minute time requirement. ISMP formed an interdisciplinary advisory group and a consensus building process that resulted in the publication of "Acute Care Guidelines for Timely Administration of Scheduled Medications" on May 19, 2011. CMS has revised its Interpretive Guideline language, clarifying that hospitals are to adopt medication administration policies and procedures as required by regulation 42 CFR 482.23(c) and (c)(1).

So what should hospitals be doing?

Hospitals are expected to establish their own policies and procedures for determining the timing of medication administration, appropriately based on accepted standards of practice. They should take into consideration the nature of the prescribed medications, including complexity and variability, specific clinical applications or indications for which the medications are prescribed, and the needs of the patients receiving them. Keep in mind when developing the policies, that The Joint Commission, in Medication Management standard MM.02.01.01 EP2, requires the hospital to develop and approve criteria for selecting medications which, in 2012, now includes consideration of the patient populations served (such as pediatrics or geriatrics). Once the policies are approved by the medical staff, education is to take place for the staff who are administering the medications according to the new policies and procedures, and documentation of the education is to be placed in the employee records.

Where to start?

The policies and procedures must address at least: identification of medications not eligible for scheduled dosing times, identification of medications eligible for scheduled dosing times, administration of the eligible medications outside of their scheduled dosing times, and evaluation of medication administration timing policies, including adherence to the policies.

Medications Not Eligible for Scheduled Dosing Times

These medications require exact or precise timing of administration based on diagnosis, treatment requirements and/or therapeutic goals. When writing your policies, consider the pharmokinetics involved, specific clinical applications and patient risk factors. Some examples of medications an organization may identify as "Not Eligible" for scheduled medication dosing times may be STAT doses, first time or loading doses, one time doses, time sequenced doses, investigational drugs, and drugs prescribed on an as-needed basis (PRN doses). Therefore the policies and procedures would specify timely administration. The organization also needs to determine in the policy whether this medication administration policy is to be applicable hospital wide or only for specific hospital units, clinical situations or diagnosis types.

Medications Eligible for Scheduled Dosing Times

These medications are prescribed on a repeated cycle of frequency, such as once a day, twice a day, three times a day, hourly intervals, etc. The goal of the scheduling time(s) is to achieve and maintain therapeutic blood levels of the medication over a period of time. Typically a hospital's policy for twice a day medication administration may define the administration times as 8AM and 8PM. Another hospital may choose times of 7:30AM and 7:30PM. The policies and procedures for medications identified as "Eligible for Scheduled Dosing Times" must also address (a) first dose medications and the timing of the first and subsequent doses, (b) retiming of missed or omitted doses, (c) medications that will not follow scheduled dosing times, and (d) patient units identified as not subject to following the scheduled dosing times (if any).

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30 Minutes or Less Per CMS: Administration of Scheduled Medications

Time Critical Scheduled Medications

These medications are those which early or late administration of greater than 30 minutes may cause harm or significant negative impact on the intended therapeutic or pharmacological effect. The medications identified by the organization as "Time Critical" must be administered within 30 minutes before or after their scheduled dosing time (total window of one hour). The hospital in its policy, must address the process for determining whether specific scheduled medications are always "Time Critical" or only under certain circumstances. Some examples of "Time Critical" medications may be antibiotics, anticoagulants, insulin, anticonvulsants, immunosuppressive medications, pain medications, medications prescribed for administration within a specified period of time of the medication order, medications that must be administered apart from other medications and/or medications prescribed more frequently than every 4 hours.

Non Time Critical Medications

These are medications for which a longer or shorter interval of time since the prior dose does not change the intended therapeutic effect or cause harm. Specifically, medications prescribed for daily, weekly or monthly administration may be within 2 hours before or after the scheduled dosing time, for a total window not exceeding 4 hours. In addition, medications prescribed more frequently than daily but no more frequently then every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window not exceeding 2 hours.

Missed or Late Administration of Medications

The policies and procedures that you are writing need to address the actions to be taken when medications eligible for dosing times are not administered within the permitted window. Included are doses missed when a patient is away from the nursing unit for tests or procedures, patient inability or refusal to take the medication, problems related to medication availability or any other reasons resulting in missed or late medication administration. Remember to include in the policy guidelines for the administration and timing of new medications initiated between standardized dosing times. The policies and procedures are to identify parameters within which nursing staff are permitted to use their own judgment regarding rescheduling of missed or late doses and also when the physician or other practitioner responsible for the care of the patient is to be notified. Reporting of medication errors that are a result of missed or late dose administration must be reported to the physician in accordance with CMS Conditions of Participation, §482.25(b).

Evaluation of and Adherence to Medication Administration Policies

Hospitals must have mechanisms in place to monitor adherence to medication administration policies, including the ones mentioned in this article. Medication errors, including those related to timing of medication administration, must be tracked, analyzed and reported. Based on the evaluations of the policies and on medication error information, the medical staff may consider whether revisions are necessary for the policies and procedures governing medication administration timing.

As you are preparing your policies and procedures on administration of medications, keep in mind that they must comply with all applicable Federal and State laws, and also be consistent with accepted standards of practice based on recommendations or guidelines from nationally recognized organizations with expertise in medication preparation and administration. The policies and procedures developed should reference the organization(s) you have selected for guidance. Examples may be: Institute for Healthcare Improvement (IHI), Institute for Safe Medication Practices (ISMP), U. S. Pharmacopeia (USP), National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP), the Infusion Nurses Society, and the Centers for Disease Control and Prevention (CDC).

Written by Linda Paternie, RN, BS, MHA of Associates

About Steven Hirsch & Associates

As recognized experts on Joint Commission, HFAP, and DNV accreditation, licensure preparedness and facility management issues, Steven Hirsch & Associates has been providing healthcare management consulting services including accreditation preparation services to hospitals and other healthcare related organizations throughout the United States since 1987.

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