MSOS Member Briefing
January 2021

MSOS Member Briefing
January 2021

Moderated by: E. Robert Feroli, PharmD, FASHP

MSOS
MEDICATION SAFETY OFFICERS SOCIETY

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CHOCTAW NATION HEALTH SERVICES AUTHORITY

Tribal Medication Safety Program

LCDR MORGAN GREUTMAN, PHARM.D., BCPS

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Choctaw Nation Health Services Authority
Excellence in Rural Health Care

- Tribal facility serving Native American patients in the Choctaw Nation jurisdiction (10 1/2 counties in Southeastern Oklahoma)
    - First tribe to build its own hospital with tribal funds in 1999
- Nine total health care locations:
    - Hospital location, 44 beds (Talihina): ER, Med/Surg, OB, OR, outpatient clinics, specialty services
        - Inpatient and outpatient pharmacy services
    - Regional medical center (Durant): family practice, specialty services, and outpatient ambulatory surgery center
        - Outpatient pharmacy services with sterile compounding room
    - 7 clinic locations throughout the rest of the counties
        - 6 outpatient pharmacies

Choctaw Nation Health Services Authority. https://www.choctawnation.com/tribal-services/health-services-authority

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Journey to Full-time Medication Safety Officer

2016: Clinical Staff Pharmacist with Medication Safety as an ancillary duty

March 2017: Attended ISMP Medication Safety Intensive

November 2017: Started CNHSA multi-disciplinary Medication Safety Workgroup

July 2018 - ISMP White paper "The case for Medication Safety Officers" released

July 2019 - present: Medication Safety Officer full time

The case for Medication Safety Officers (MSO).

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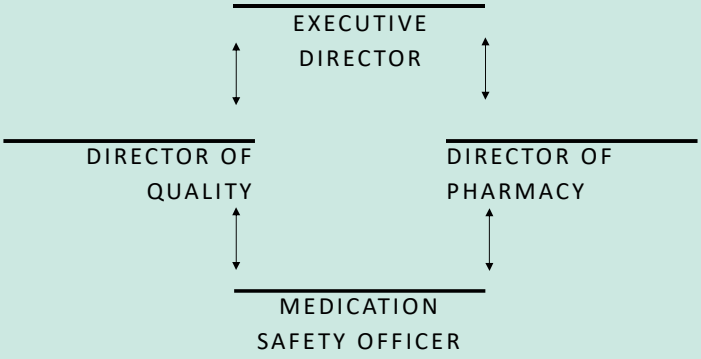
MSO Reporting Structure



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MSO Duties

Process improvement

Proactive:

- Longitudinal medication safety projects
  - ISMP Targeted Medication Safety Best Practices
- Medication safety workgroup
  - Regular review of ISMP action agendas and newsletters review

Reactive:

- Involvement with medication error investigation and risk reduction strategies

Regulatory and Accreditation

- Assist with compliance of USP chapters 795, 797, and 800
- State Board of Pharmacy regulations
- Joint Commission medication management standards
- Policy and procedure management
- Participation on quality health system tracer team
- Participation in Joint Commission surveys
- Serve on several health system wide committees such as opioid stewardship, antibiotic stewardship, and quality

Special projects

- COVID-19 adverse drug reporting line
- Root cause analysis involvement

SEPTEMBER 2020 VOL. 14

MEDICATION SAFETY NEWSLETTER

Providing the highest quality health care to the people we serve.

IN THIS ISSUE

MEDICATION SECURITY UPDATES

OPIOID STEWARDSHIP - FACT SHEET ON OPIOIDS AND BENZODIAZEPINES

PHARMACY AND THERAPEUTICS UPDATES

ANTIBIOTIC STEWARDSHIP RESOURCES

Medication security update

The CNHSA medication security policy has been updated.

Please note:

Access to medication storage is restricted to personnel authorized to do so by virtue of their license and/or annual demonstrated medication

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CNHSA Medication Safety Activities

- Regular review of ISMP's acute care and ambulatory care quarterly action agendas
- Developed protocol for emergency department for emergency reversal of oral anticoagulants
- Removed IV promethazine from formulary and managed quick orders
- Increased education on medication event reporting to frontline staff
- Started health-system wide Medication Safety Newsletter
- Implemented tall man lettering in our Electronic Health Record system for medication quick orders
- Began trending medication events as a multi-disciplinary team
- Education on immunization storage and monitoring per CDC's recommendations
- Created immediate use sterile compounding video and competency for nursing staff
- Implemented regular review of IV smart pump compliance throughout CNHSA

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Helpful strategies

- Start small

-Determine a staff member with an interest in medication safety and allow them to work on medication safety related projects. (Ex. Error investigations, RCA teams, longitudinal medication safety project).

- Training

-Allow staff to receive medication safety specific training. (Ex. ISMP Medication safety intensives, ISMP/ASHP Medication Safety Certificate Program

- Show value

-Help start or work on a medication safety initiative within your health system

-Collect data on medication safety initiatives and ensure that leadership is aware of the impact.

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CHOCTAW NATION HEALTH SERVICES AUTHORITY

Questions?

LCDR MORGAN GREUTMAN, PHARM.D., BCPS

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Specialist Pharmacy Service

NHS

Medication Safety Officer Network

Nicola Wake

Specialist Pharmacist Lead: Medication Safety, NHS Specialist Pharmacy Service

Lead Clinical Pharmacist, Safety & Governance, Northumbria Healthcare NHS Foundation Trust

The first stop for professional medicines advice

www.sps.nhs.uk

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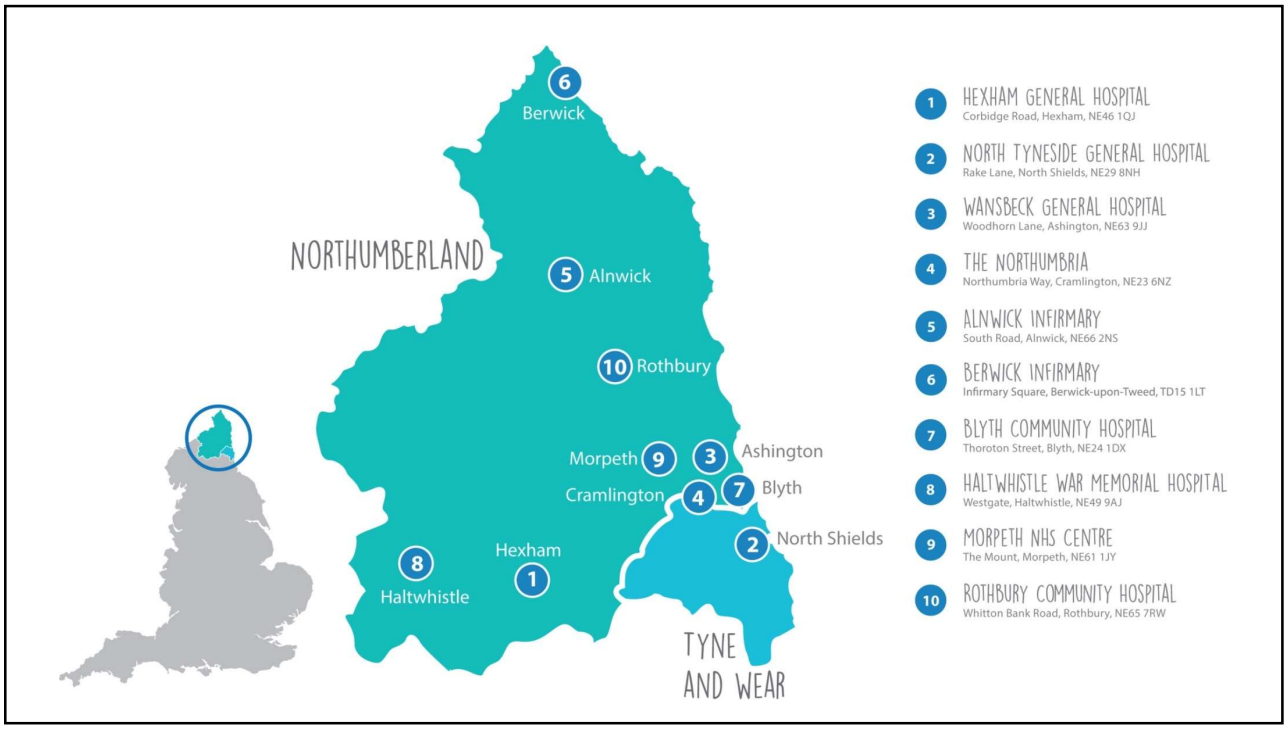

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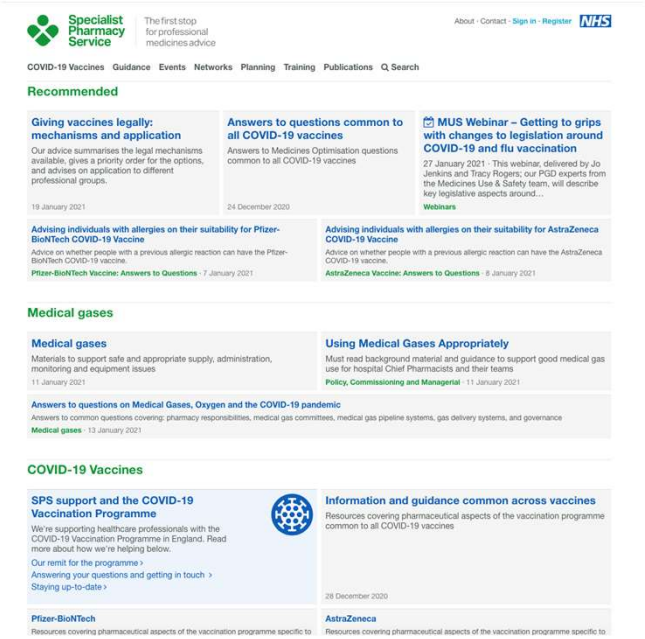
Specialist Pharmacy Service

Specialist Pharmacy Service

Our main purpose is simple: to improve the use of medicines to help people live longer, fuller lives. We do this by joining together experts to create a rich source of impartial advice for pharmacists, GPs and clinicians to use free of charge. We are very proud to play our part in the NHS and the work it does in keeping Britain healthy. We are SPS.



www.sps.nhs.uk 27/01/2021 14

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Medication Safety Officers

- Joint NHSE & MHRA Patient Safety Alert
- Published 20th March 2014
- Instructed providers to take specific steps that will improve data report quality
- Establishment of national network to maximise learning and provide guidance on minimising harm
- Large healthcare provider organisations, along with healthcare commissioners, to identify named leaders in medication safety role
- Leaders will be supported by a national network for medication safety
- Partner alert for Medical Device Safety Officers

MHRA

NHS England

Patient Safety Alert

Stage Three: Directive

Improving medication error incident reporting and learning

20 March 2014

Alert reference number: NHS/PSA/D/2014/005 Alert stage: Three - Directive

NHS England and MHRA are working together to simplify and increase reporting, improve data report quality, maximise learning and guide practice to minimise harm from medication errors by:

- sharing incident data between MHRA and NHS England reducing the need for duplicate data entry by frontline staff;
- providing new types of feedback from the National Reporting and Learning System (NRLS) and MHRA to improve learning at local level;
- clarifying medication safety roles and identifying key safety contacts to allow better communication between local and national levels; and,
- setting up a National Medication Safety Network as a new forum for discussing potential and recognised safety issues, identifying trends and actions to improve the safe use of medicines. The network will also work with new Patient Safety Improvement Collaboratives that will be set up during 2014.

The Yellow Card Scheme for reporting suspected adverse drug reactions to the MHRA will continue to operate as normal.

Actions (Target date for completion 19 September 2014)

All *large** healthcare providers including NHS Trusts, community pharmacy multiples, home healthcare companies and those in the independent sector should:

1. identify a board level director (medical or nursing supported by the chief pharmacist) or in community pharmacy and home health care, the superintendent pharmacist, to have the responsibility to oversee medication error incident reporting and learning;
2. identify a Medication Safety Officer (MSO) and email their contact details to the Central Alerting System (CAS) team. This person will be a member of a new National Medication Safety Network, support local medication error reporting and learning and act as the main contact for NHS England and MHRA; and,
3. identify an existing or new multi-professional group to regularly review medication error incident reports, improve reporting and learning and take local action to improve medication safety.

*Small** healthcare providers including general practices, dental practices, community pharmacies and those in the independent sector should:

4. continue to report medication error incidents to the NRLS using the e-form on the NRLS website, or other methods and take action to improve reporting and medication safety locally, supported by medication safety champions in local professional committees, networks, multi-professional groups and commissioners.

Healthcare commissioners including Area Teams, and Clinical Commissioning Groups are invited to:

5. identify a MSO and email their contact details to the CAS team. This person will be a member of the National Medication Safety network, support reporting and learning and take local actions to improve medication safety. The MSO can also use learning to influence policy, planning and commissioning as part of clinical governance in the commissioning organisation; and,
6. regularly review information from the NRLS and the MHRA to support improvements in reporting and learning and to take local action to improve medication safety. This should done by working with medication safety champions in local professional committees and networks, and with a new or existing multi-professional group.

Supporting information

*More detailed information to support the implementation of this guidance is available at: www.england.nhs.uk/patientsafety/PSA

Patient Safety | Domain 5
www.england.nhs.uk/patientsafety

Contact NHS England: patientsafetyenquiries@nhs.net
Contact MHRA: pharmacovigilanceservice@mhra.gsi.gov.uk

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NHS

Medication Safety Officers – Roles and Responsibilities

- Being an active member of the National Medication Safety Network
- Improving reporting and learning of medication error incidents in the organisation
- Managing medication incident reporting in the organisation
- Receiving and responding to requests for more information about medication error incident reports from NHS England and the MHRA
- Working as a member of the medication safety committee – a multi-professional committee to support the safe use of medicines in the organisation
- Supporting the dissemination of medication safety communications from NHS England and the MHRA throughout the organisation

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Name	Sector
Community Pharmacy Patient Safety Group https://pharmacysafety.org/	Community Pharmacy
Dorset MSO Group	All
East Of England MSO Network	All
East Midlands Medicines Safety Pharmacist Group	Acute hospitals
East Midlands Community Service and Mental Health Medicines Safety Group	Community services & mental health
Hampshire Medicines Safety Group	All
Hertfordshire and W Essex STP Medication Safety Group	All
Kent Surrey & Sussex MSO Network	All
London MSO Network	All
North East and North Cumbria MSO Network	All
North West England MSO Network	All
Northern Ireland Medicines Governance Team	All
Nottinghamshire/Derbyshire CCG MSO Network	CCG
South West England NHS Commissioner MSO Network	Commissioners and independent sector providers of NHS services (but all welcome)
South West England MSO NHS Provider Network	NHS Providers (incl. States of Jersey and SWMIT)
Thames Valley MSO Network	All
West Midlands Medication Safety Group	All
West Yorkshire and Harrogate ICS Medicines Safety Group	Commissioners and provider organisations
Wales	All
Yorkshire MSO Network	All

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Monthly WebEx Topics

Observatory

- Recent regulator and statutory body activity
- Pharmacovigilance Risk Assessment Committee
- Direct HCP communications
- Manufacturer educational risk minimisation material
- Drug shortages and discontinuations
- UKMI product safety reports
- National guidance, publications and resources
- Overview of recently published papers

https://www.sps.nhs.uk/articles/ukmi-medication-safety-officer-evidence-observatory/

MSO Led Shared Learning

- Teicoplanin adverse reactions – an MSO response
- Alfentanil – wrong strength/wrong dose errors
- Extravasation of Ferinject
- 'Near Miss' Never Events
- Reducing LASA errors
- Daily blisterpacks for COVID-19 wards

National / Expert Updates

- NHSE/I & MHRA updates
- PSIMS update (national incident reporting system)
- #MedSafetyWeek
- Opiate Substitution Therapy Provision in Secondary Care
- Increased frequency of high INR results with vitamin K antagonists during COVID-19 (June-20)
- Anticoagulant safety check for patients switching from warfarin to DOAC during COVID-19

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NHS

Moving Forward

- Medicines Safety Improvement Programme https://www.england.nhs.uk/patient-safety/national-medicines-safety-programme/
- Working together:
  - Medical Device Safety Officers
  - Patient Safety Specialists https://www.england.nhs.uk/patient-safety/patient-safety-specialists/
  - Patient Safety Partners (framework launch in 2021)
- Continuing to share learning and improvements

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NHS

Questions?

Thank you for listening

nicolawake@nhs.net

MSO network @msonetwork

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Einstein
HEALTHCARE NETWORK
More than Medicine

Einstein Montgomery Opioid-induced Ventilatory Impairment Assessment (EMOVIA©) Screening Tool

Scott D. Alcott, MSN, RN
Director of Nursing Education & Professional Development
Safety Officer

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About Einstein Medical Center Montgomery

- Four residency education programs in Family Medicine, Vascular Surgery, Internal Medicine, and Diagnostic Radiology.
- *U.S. News & World Report* ranking as a High Performing Hospital in Congestive Heart Failure.
- Women's Choice® Awards as one of America's Best Hospitals for heart care, orthopedics, breast care and bariatric surgery.
- PA Patient Authority Award for multidisciplinary team project that increased patient safety for a high-risk population.
- Advanced Primary Stroke Center designation by The Joint Commission.
- Chest Pain Center with PCI accredited by the American College of Cardiology.
- Cancer Care accredited by the Commission on Cancer of American College of Surgeons.
- Breast Imaging Center of Excellence designated by American College of Radiology and accredited by the National Accreditation Program for Breast Centers by the American College of Surgeons.
- Bariatric Surgery Center of Excellence national designation.
- Maternity Care Blue Distinction+ by Blue Cross and Blue Shield.
- Level III Arthur and Lea Powell Neonatal Intensive Care Unit (NICU) staffed by neonatologists from Children's Hospital of Philadelphia.
- Earned Joint Commission Gold Seal of Approval for Hip and Knee Joint Replacement

By the Numbers

- **191**-bed tertiary care hospital
- **11** Primary Care locations
- **8** Outpatient centers
- **8,200** Inpatients per year
- **186,000** Outpatients per year
- **40,000** emergency patients per year
- **2,100** newborns per year

Updated August 2020

American Heart Association
American Stroke Association
CERTIFICATION
Meets standards for
Primary Stroke Center

Commission on Cancer®
ACCREDITED PROGRAM

NAPBC®
NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS
ACCREDITED BREAST CENTER

Independence Blue Cross
Designated BlueDistinction® Center+ Maternity Care

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Einstein Montgomery Opioid-induced Ventilatory Impairment Assessment (EMOVIA)

The 6 Criteria for OIRD Risk:
1. Opioid Infusion Therapy—PCA (with or without basal), CADD pump, or Epidural infusion.
2. Recent Unplanned Administration of Reversal Agents.
3. Known or Suspected OSA/Sleep Disorder as assessed by STOP-BANG score ≥ 6.
4. Opioids and/or Concomitant sedatives. Stacking (Be aware of overlapping half-life and potencies, repeat IV/IM opioids, addition of PRN benzodiazepine/sedative)
5. General Anesthesia in the past 1 to 24 hrs.
6. Pasero Opioid-Induced Sedation Scale (POSS)—$etCO_2$ for POSS of 3. Goal is for a score of (5, 1, 2).

My patient has **(2) TWO OR MORE** criteria...

HIGH RISK

1.) Initiate $etCO_2$ Monitoring.
2.) Initiate continuous pulse oximetry monitoring.

My patient has **(1) ONE** of the criteria...

MODERATE RISK*

1.) Consider initiating $etCO_2$ monitoring.
2.) Consider initiating continuous pulse oximetry monitoring

My patient has **NONE** of the criteria...

LOW RISK*

$etCO_2$ monitoring is not indicated.

* Even if stratification does not directly indicate use of $etCO_2$ monitoring, nursing judgement to monitor patient may be considered appropriate for any patient to ensure patient safety.

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"Thinking Outside the Box"

"If you always do what you always did,
You will always get what you always got."
- Albert Einstein

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Nurse Driven Protocol

- Assessment completed on admission and on every patient, every shift
- If two or more criteria are met, patient is placed on continuous electronic monitoring
  - Continuous waveform capnography $etCO_2$
  - Continuous pulse oximetry
- If nursing is concerned for patient's safety, then patient should be placed on capnography
- No physician orders needed to start capnography

Milligan E., Zhang, Y., & Graver S. (2018). Continuous bedside capnography monitoring of high-risk patients receiving opioids. *Biomedical Instrumentation & Technology*, *52*(3), 208-217

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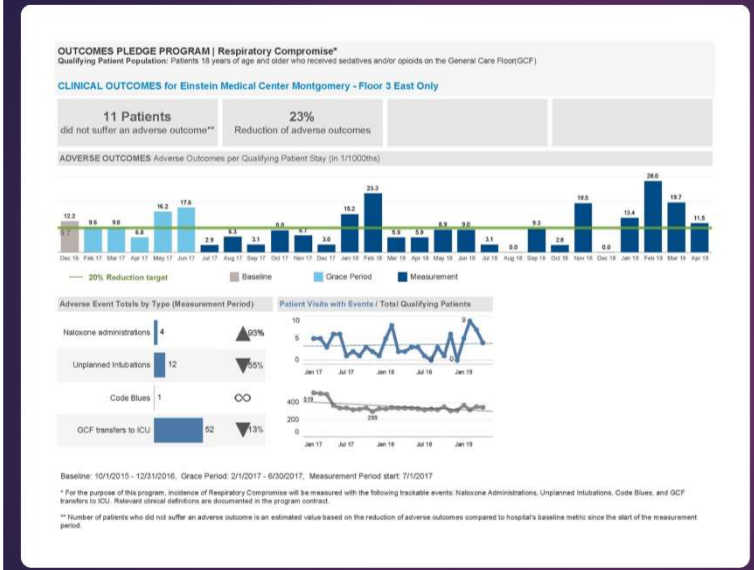

Outcomes Data

Einstein MEDICAL CENTER MONTGOMERY

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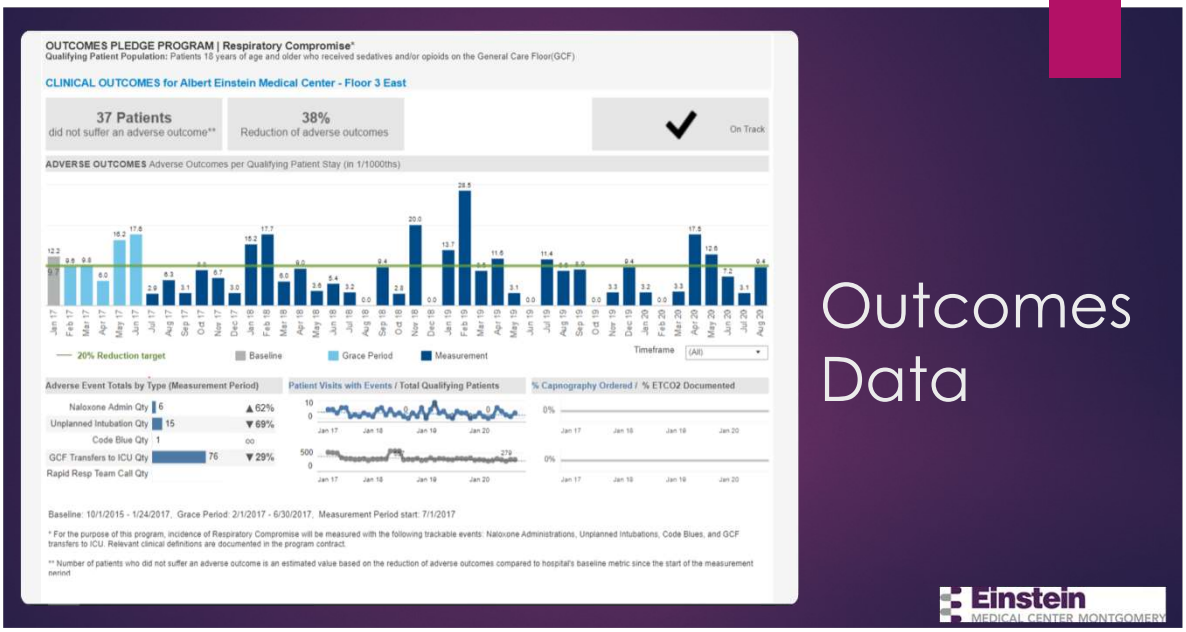

Outcomes Data

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Questions

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ISMP
Institute for Safe Medication Practices
An ECRI Affiliate

ISMP Update
MSOS Briefing January 2021

Michael R. Cohen, RPh, MS, ScD (hon.), DPS (hon.), FASHP
President, Institute for Safe Medication Practices

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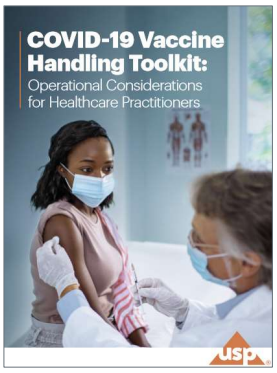
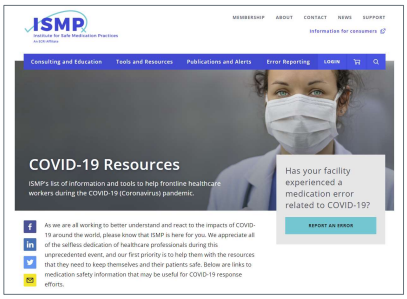
ISMP Advocacy

- ISMP participated on USP committee developing
  - https://www.usp.org/covid-19/vaccine-handling-toolkit
- FDA vincristine/vinca alkaloid labeling changes attributed
  - https://www.fda.gov/drugs/drug-safety-and-availability/fda-updates-vinca-alkaloid-labeling-preparation-intravenous-infusion-bags-only
- ISMP COVID-19 resources and vaccine safety pages
  - https://www.ismp.org/covid-19-resources
- Janet Woodcock appointed Acting Commissioner FDA





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More on dilution errors with Pfizer-BioNTech COVID-19 vaccine. The ISMP National Vaccine Errors Reporting Program (VERP) continues to receive reports of dilution errors occurring during preparation of the Pfizer-BioNTech coronavirus disease 2019 (COVID-19) vaccine. Unlike the Moderna vaccine, the Pfizer-BioNTech vaccine must be diluted prior to use. After thawing, the multiple-dose vaccine vial contains 0.45 mL of concentrated vaccine that requires further dilution using 1.8 mL of preservative-free 0.9% sodium chloride injection. After dilution, each vial contains 6 (or even 7) doses when using low dead-volume sy-

continued on page 3 — SAFETY briefs >

Safety issues during mass vaccination

- Wrong volume used
- Air injected into vaccine vial
- No dilution at all – concentrate vaccine given
- Sodium chloride injection 0.9% confused as vaccine
- Needle or transfer device then capped sans needle

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FDA

- We have rescheduled a public meeting on investigational drug labeling and medication errors for May 13-14, 2021. Not yet announced publicly. It will be a virtual meeting. Industry has agreed to participate. Will be done in cooperation with Reagan-Udall Foundation
- Stems from 2-part ISMP article calling for action due to medication errors related to poor labeling of INDs.


Acute Care ISMP Medication Safety Alert!

Investigational drugs: Product-related issues pose significant challenges (Part I)

SAFETY briefs


Acute Care ISMP Medication Safety Alert!

Investigational drugs: Strategies for sponsors, FDA, and clinical sites to prevent product-related errors (Part II)

SAFETY briefs

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Large volume parenteral solution labeling issues

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Lidocaine and Heparin Bags

In addition to the look alike possibility hospitals have reported to us that the barcode for both products is unscannable due to the crease in the overlap bag

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Educational Program

Call to Action: Experience in Adopting the ENFit System to Guard Against Accidental Tubing Misconnections

Felix Lam

Emily Spellman

Michael R. Cohen

Juuso Leinonen

- A Call to Action: Experience in Adopting the ENFit System to Guard Against Accidental Tubing Misconnections
- Wednesday, February 24, 2021 - 1:00 pm - 2:00 pm ET
- Registration open
- Supported by Avanos

https://www.ismp.org/events/call-action-experience-adopting-enfit-system-guard-against-accidental-tubing-misconnections

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Educational Programs

Medication Safety Intensive (MSI) Workshops - Virtual

- 2- day workshop with 12.5 CE credit hours for nurses and pharmacists
- December 2020 program **sold out** with 56 attendees

- Upcoming Workshop Dates:
  - February 25 & 26, 2021
  - April 22 & 23, 2021
  - June 24 & 25, 2021
    *Later workshop times for Pacific time participants
  - August 5 & 6, 2021

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Perioperative Self Assessment - FDA BAA grant for

- Project will launch late March. Endorsers asked to help promote. Media releases planned (multiple endorsers)

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- Allen Vaida, PharmD retiring March 31

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- Rita Jew, PharmD, MBA, appointed VP Operations, ISMP

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Questions?

- A copy of today's slides will be posted on our website
- Next MSOS Briefing date – March 25, 2021. Register:https://ecri.zoom.us/webinar/register/WN_Y3TLJ3FIQ0C73EzPnMPvoA

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