MSOS Member Briefing
January 2023

Moderated by: E. Robert Feroli, PharmD, FASHP

MSOS
MEDICATION SAFETY OFFICERS SOCIETY

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Baclofen Accumulation in Acute Kidney Injury

Jacqueline Hartford, PharmD, BCPS, BCCCP, CPPS
Medication Safety Officer
LifeBridge Health
Baltimore, MD

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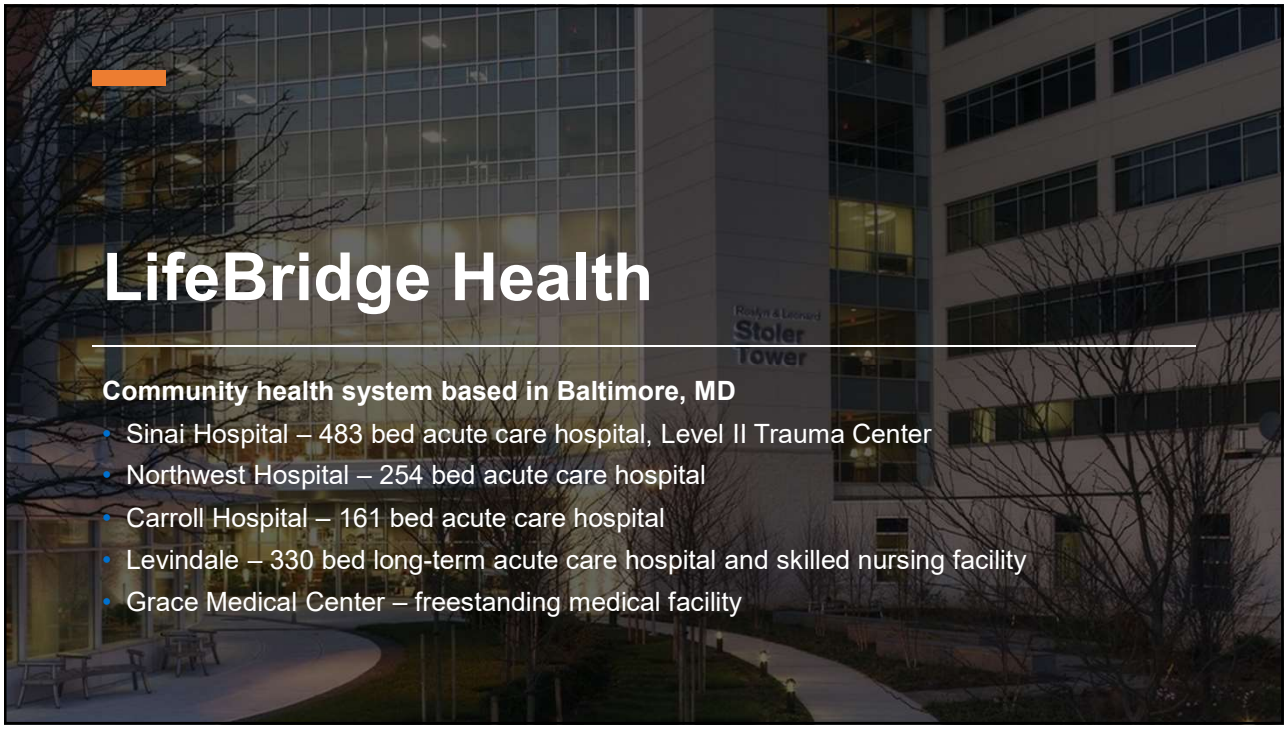

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Reported Safety Event

- A patient with history of quadriplegia and stage 2/3 CKD was admitted for nausea and vomiting and treated for cholecystitis
- Home medications were ordered, including baclofen 15 mg PO QID
- On day 6 of admission, a rapid response was called for a change in mental status and increasing lethargy for 36 hours
- The reporter noted that renal function was decreasing with minimal urine output and was concerned for baclofen overdose due to reduced clearance and high dose
- Nephrology was consulted, the patient was intubated, and dialysis was initiated for acidosis

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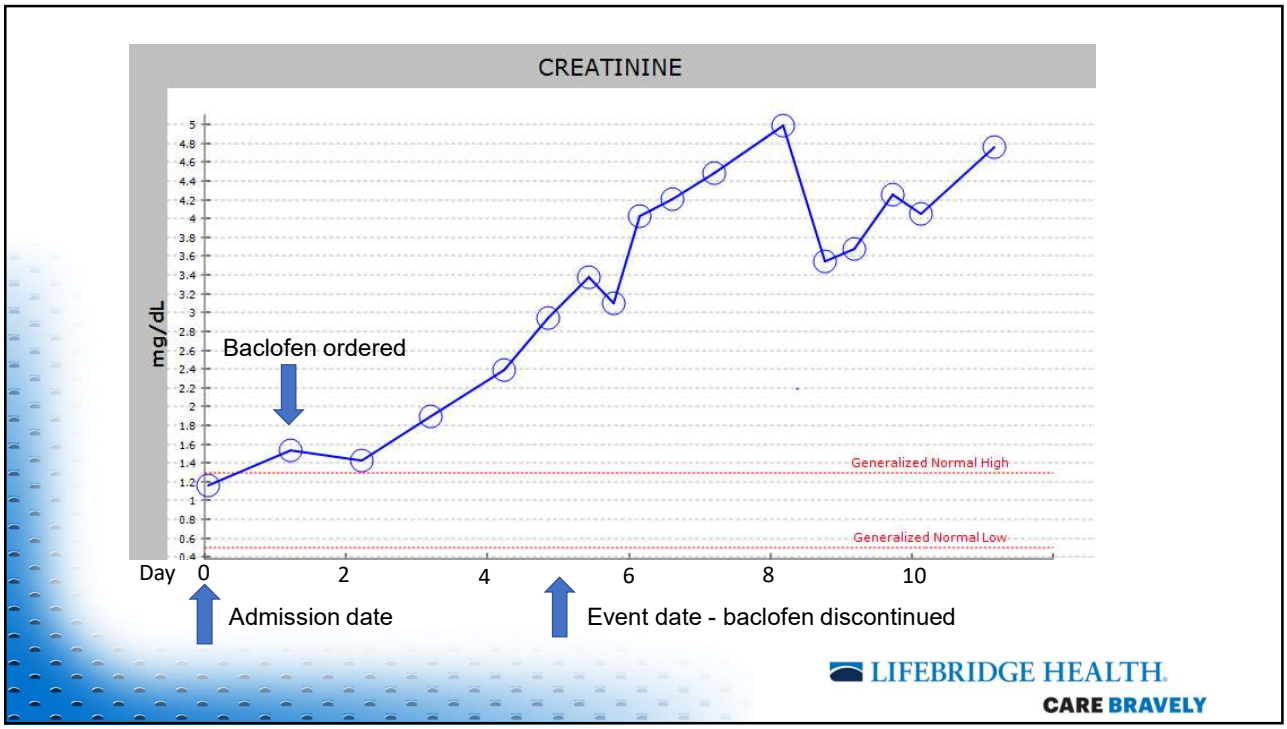

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Initial Review

The baclofen order was appropriate at the time it was ordered, so no pharmacist intervention was warranted upon verification.

The care team noted the rising serum creatinine but did not adjust the baclofen dose.

An automatic pharmacy renal dosing policy is in place for multiple medications.

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RCA - Cause & Effect Analysis

- ★ Human factors
- Equipment performance
- Environmental factors
- ★ Policies, procedures, guidelines
- ★ Staff training, competency, credentialing, performance
- Staffing levels
- Availability of information
- Communication
- Technology
- Leadership
- Organizational culture

Key finding: Lack of process redundances to identify risk of baclofen accumulation with renal impairment

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Intervention – Assessment Trigger
Asynchronous Alert

Renal dosing protocol does not include baclofen as dose adjustments are not straightforward

→

Created a task to fire to pharmacist worklist if a patient is on baclofen and has a SCr ≥ 1.5 mg/dL

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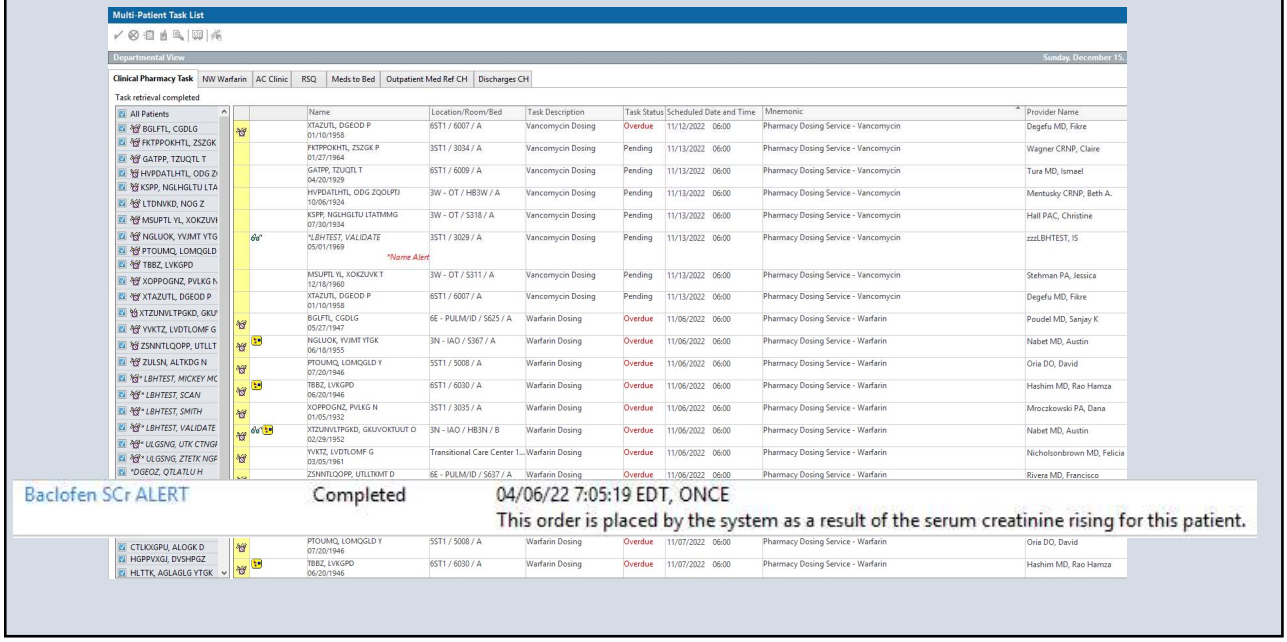
January 2023

Pharmacist Multi-Patient Task List



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Impact

- An audit was conducted for 3 months after implementation
- The alert was triggered for 15 patients during this timeframe
- Baclofen orders were discontinued in 2 cases, and dose was reduced in 1 case
- Continuation of baclofen was clinically appropriate in the remaining cases
- No adverse drug reactions attributed to baclofen were noted

Local incident and finding → Implementation across the health system

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Questions?

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Medication Safety Officer
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Look-alike Sound-alike Drug List Update

Mona Hammam, PharmD, MS, BCPS, FISMP
Medication Safety Officer

January 2023

Dana-Farber Cancer Institute

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Dana-Farber Cancer Institute (DFCI)

- Dana-Farber Cancer Institute is a mostly outpatient ambulatory setting specializing in cancer care for children and adults.
- An affiliate of Harvard Medical School and a Comprehensive Cancer Center designated by the National Cancer Institute.
- Annually at Dana Farber there are 364,577 outpatient visits and 188,242 infusion treatments at our 8 locations within Massachusetts and New Hampshire.
- We use Epic as our EHR and anticancer treatment must be ordered through an approved, diagnosis linked Beacon treatment order set. If a provider wishes to order a treatment that is not linked to the patient's diagnosis, the order needs to provide a reference and is further verified and approved by a pharmacy manager before patient can receive treatment.

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How often are others updating their LASA drug list?

- Annually
- Every 2 years
- Right before an accreditation visit
- Never, just update the date on the document

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Where do I start to update our annual list at an ambulatory oncology center? (adding pairs)

1. Download and analyze 6 months barcode dispense, prep, and administration data
2. Check safety reports entered at my institution
3. Check ISMP newsletters within the past year
4. Get a list of new formulary added medications over the past 12 months

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Start Making a List of Possible Pair Additions

1. Dispense and prep data
   - Any barcode error that appeared at least twice after an employed mitigation strategy or at 2 different locations for the same drug pair
   - Automatic add to LASA list
2. Safety reports entered at DFCI
   - Add reported drug pair to LASA worksheet
3. Check ISMP newsletters within the past year
   - Add pair if we carry both drugs mentioned in newsletter
4. New formulary additions
   - All new drugs to be vetted using LASA worksheet
   - Biosimilars are an automatic add to LASA list

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LASA Worksheet

Look-alike Sound-alike Worksheet

Generic name	Brand Name	Indication	Lexicomp list of pairs (bold face also in POCA	Possible POCA pair	Notes	Decision
Belumosudil	Rezurock	chronic GVHD	belimumab(lupus), belinostat(t-cell lyphoma), budesonide(corticosteriod)	rezulin(international drug), rezira(discontinued)		Will not add pair
belzutifan (permantly disconitued)	Welireg	von Hippel-Lindau disease who require therapy for associated renal cell carcinoma, central nervous system hemangioblastomas, or pancreatic neuroendocrine tumors, not requiring immediate surgery.	**belantamab**, belimumab(lupus), **belinostat(t cell lymphoma)**, belumosudil, busulfan			
ciltacabtagene autoleucel	Carvykti	Treatment of relapsed or refractory multiple myeloma	axicabtagene ciloleucel(b-cell lymphoma, follicular lymphoma), betibeglogene autotemcel (beta thalassemia), brexucabtagene autoleucel(ALL, mantle cell lymphoma), elivaldogene autotemcel(cerebral adrenoleukodystrophy), idecabtagene vicleucel(MM), lisocabtagene maraleucel(large b cell lymphoma), sipuleucel-T(prostate cancer), tisagenlecleucel (acute lymphomablastic leukemia,diffuse large B-cell lymphoma, follicular)		idecabtagene vicleucel(MM relapsed or refactory)	Add pair given indictation similiarity
Dostarlimab-gxly	Jemperli	endometrial cancer, solid tumors (recurrent or advanced)	atezolizumab, cemiplimab, daratumumab, dinutuximab, durvalumab, ipilimumab, nivolumab, pembrolizumab			will not add pair
idecabtagene vicleucel	Abecma	Treatment of relapsed or refractory multiple myeloma	follicular lymphoma), betibeglogene autotemcel (beta thalassemia), brexucabtagene autoleucel(ALL, mantle cell lymphoma),ciltacabtagene autoleucel (MM relapsed or refactory), elivaldogene autotemcel(cerebral adrenoleukodystrophy), lisocabtagene maraleucel(large b cell lymphoma), sipuleucel-T(prostate cancer), tisagenlecleucel (acute lymphomablastic leukemia,diffuse large B-cell lymphoma, follicular)		ciltacabtagene autoleucel (MM relapsed or refactory)	will not add pair
nivolumab/relatlimab-rmbw	Opdualag	Unresectable or metastatic cutaneous melanoma with failure of nivo or pembro +/- ipi	ipilimumab, nivolumab, pembrolizumab, rituximab, Opdivo		Opdivo (brand of nivolumab)	opdIVO, opdUALAG nivolumab/RELATLIMAB, nivolumab
pacritinib	Vonjo	intermidiate or high risk primary or secondary myelofibrosis with platelet count below 50 x 10^9 /L	afatinib, baricitinib, ceritinib, **dasatinib(ALL,CML,GI stromal tumors)**, entrectinib, fedratinib, gilteritinib, pazopanib, **ponatinib(ALL,CML)**, ruxolitinib, tofacitinib, upadacitinib			will not add pair

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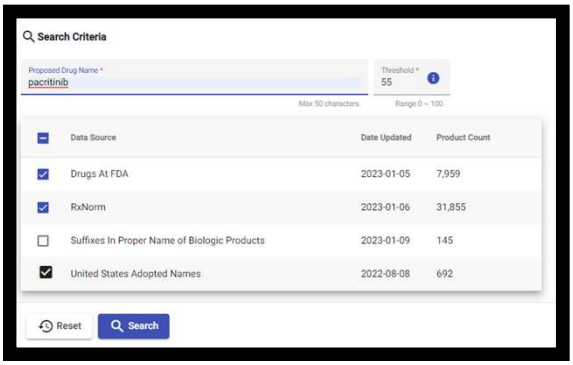
What is POCA?

- Phonetic and Orthographic Computer Analysis software created by the FDA
- POCA finds drug pair matches and assigns them phonetic similarity, orthographic similarity and a combined score.
- https://poca-public.fda.gov/name_search



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POCA Results

Proposed Drug Name: pacritinib

Threshold: 55

Show Results By: ○ All ◉ Combined ○ Phonetic ○ Orthographic ○ USAN Stem

Combined Results (374 Hits)

70% and Higher: 20 | Between 55% and 69%: 354 | 54% and Lower: 0

Name of Concern	Combined Score (%) ↓
PACRITINIB	100
CERITINIB	80
AVAPRITINIB	79
BARICITINIB	76
FEDRATINIB	76
RIPRETINIB	76
AXITINIB	74
CAPMATINIB	74
CRIZOTINIB	74
TUCATINIB	74

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Removing Pairs

- Check each drug pair on list for number of dispenses within the past 3 years.
  - If it has not been dispensed or ordered in the past 3 years, mark for deletion

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List Approval

- Pharmacy policy committee approved all edits to list.

Afatinib	Axitinib	Alectinib
Ciltacabtagene autoleucel	Idecabtagene vicleucel	
CISplatin	CARBOplatin	Oxaliplatin
Carmustine	Lomustine	
CloFARabine	ClaDRIbine	
Cetuximab	Siltuximab	
DAPTOmycin	DACTINomycin	
DAUNOrubicin	DOXOrubicin	
DAUNOrubicin	DAUNOrubicin Liposomal	
Dacarbazine	Procarbazine	
Darzalex	Darzalex Faspro	
DOCEtaxel	PACLItaxel	Cabazitaxel
DOCEtaxel	DOXOrubicin	
DOXOrubicin	DOXOrubicin Liposomal	
DOXOrubicin	IDArubicin	
Duvelisib	Durvalumab	Daratumumab
Etoposide	Etoposide phosphate	
PACLItaxel	Albumin-bound PACLItaxel	
EpiRUBicin	EriBULin	
Elotuzumab	Eculizumab	
Gefitinib	Gilteritinib	
Herceptin	Herceptin Hylecta	
IDArubicin	DAUNOrubicin	

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Questions?

Thank you!

Contact information:

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Standardizing Communication/Feedback on Reported Medication Events

HEATHER ELLIS, PHARMD
MEDICATION SAFETY COORDINATOR
ADVENTHEALTH ORLANDO

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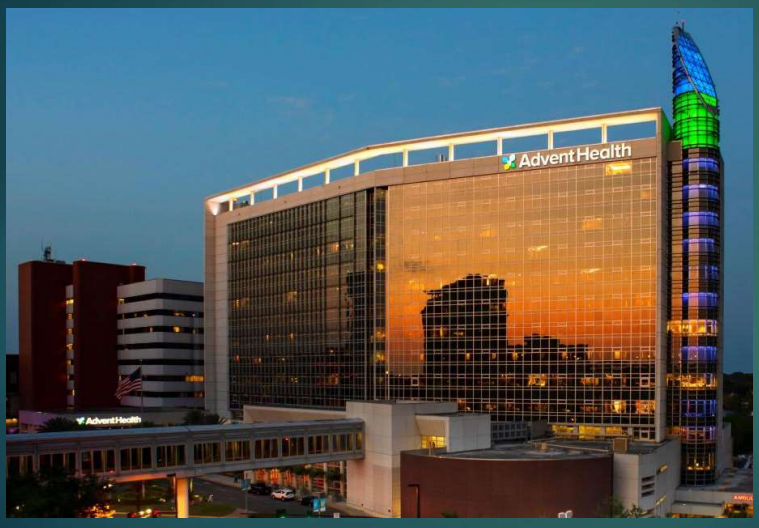
AdventHealth Orlando



- Located north of downtown Orlando
- Beds = 1,368
  - 200 ICU beds
- Non-profit, research, teaching medial center
- Pharmacy Department:
  - 115 Pharmacy Technicians
  - 118 Pharmacists
    - 6 clinical decentralized pharmacist teams

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Background

- Does anyone have something in current state to discuss medication errors with staff?

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Getting Started

- Continuous Quality Improvement Meeting
  - Clinical and Operations managers
- Have a set process for staff AND for management
  - Sent for "awareness and feedback"

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Response to Medication Events

- Standardized
- Concise
- Share the "why"
- Respectful

Subject [secure] Medication Event Review Request

Good afternoon,

I wanted to ask if you may be able to forward this request to __ for feedback on the timeline of the medication event listed below. We are looking for system issues and possible fixes. The information provided is for quality improvement only.

Patient Account Number:
Medication order:
Short summary:

Many opportunities for process improvement have been identified by staff reviewing reported medication events and I value your time and input!

Thank you!

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How to Implement

- Share your approach
  - Team energizers

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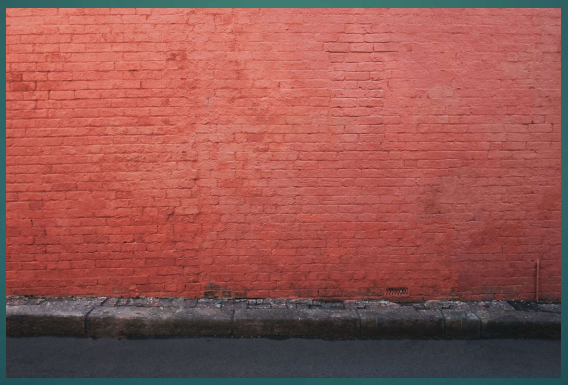
Possible Barriers

- Current communication to staff who report medication events
  - From outside the pharmacy department



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Status Check

- Culture of reporting
- Appropriate escalation
- Positive feedback on safety surveys

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ISMP
Institute for Safe Medication Practices
An ECRI Affiliate

ISMP Update
MSOS Briefing January 2023

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

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MSOS Briefing. ISMP Report for January 26,2023

- Changes to Joint Commission Standards and National Patien6 Safety Goals
- ASTM Standard for color coded labels in anesthesia withdrawn
- ISMP updates its tall man letter list
- ISMP acting as co-investigator in FDA-funded study on tall man letters
- Next week, ISMP will release Targeted Medication Safety Best Practices for Community/Ambulatory Pharmacy

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Changes to TJC MM standards and NPSGs

- The Joint Commission has withdrawn certain National Patient Safety Goals and Medication Management Standards. ISMP is concerned that some will adversely impact medication safety.

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The Joint Commission

• Issued December 20, 2022 •

Prepublication Requirements

Select Retired and Revised Accreditation Requirements

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online *E-dition*®), accredited organizations and paid subscribers can also view them in the monthly periodical The *Joint Commission Perspectives*®. To begin your subscription, call 800-746-6578 or visit http://www.jcrinc.com.

Please note: Where applicable, this report shows deleted language struckthrough and new language underlined.

APPLICABLE TO THE HOSPITAL ACCREDITATION PROGRAM

Effective February 19, 2023

RETIRED ELEMENTS OF PERFORMANCE

Environment of Care (EC) Chapter

Standard EC.02.01.03
The hospital prohibits smoking except in specific circumstances.

EC.02.01.03, EP 1
The hospital develops a written policy prohibiting smoking in all buildings. Exceptions for patients in specific circumstances are defined.
Note: The scope of this EP is concerned with all smoking types—tobacco, electronic, or other.

Human Resources (HR) Chapter

Standard HR.01.02.07
The hospital determines how staff function within the organization.

HR.01.02.07, EP 5
Staff supervise students when they provide patient care, treatment, and services as part of their training.

Standard HR.01.07.01
The hospital evaluates staff performance.

HR.01.07.01, EP 5
When a licensed independent practitioner brings a nonemployee individual into the hospital to provide care, treatment, and services, the hospital reviews the individual's competencies and performance at the same frequency as individuals employed by the hospital.

Page 1 of 10
Prepublication Standards
Effective February 19, 2023

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MM.03.01.01, EP 9
The hospital keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration.

NPSG.03.05.01, EP 8
When heparin is administered intravenously and continuously, the hospital uses programmable pumps in order to provide consistent and accurate dosing.

https://www.jointcommission.org/-/media/tjc/documents/standards/prepublications/retired-2023/hap_standards_simplification_prepub_feb2023.pdf

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Changes to TJC MM standards and NPSGs

- American Society of Testing and Materials (ASTM) has withdrawn Standard Designation: D4774 – 11, "User-applied Drug Labels in Anesthesiology" (color-coded labels, by pharmacologic class, for drugs commonly used in anesthesia).

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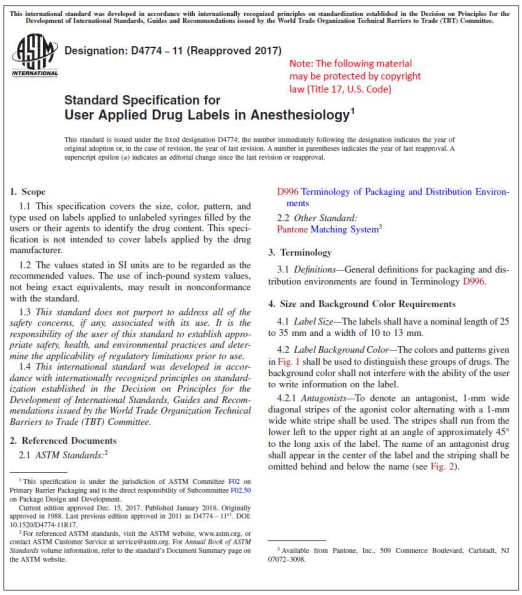
MSOS Member Briefing
January 2023



This international standard was developed in accordance with internationally recognized principles on standardization established in the Decision on Principles for the Development of International Standards, Guides and Recommendations issued by the World Trade Organization Technical Barriers to Trade (TBT) Committee.

Designation: D4774 – 11 (Reapproved 2017)

Note: The following material may be protected by copyright law (Title 17, U.S. Code)

Standard Specification for User Applied Drug Labels in Anesthesiology[1]

This standard is issued under the fixed designation D4774; the number immediately following the designation indicates the year of original adoption or, in the case of revision, the year of last revision. A number in parentheses indicates the year of last reapproval. A superscript epsilon (ε) indicates an editorial change since the last revision or reapproval.

1. Scope

1.1 This specification covers the size, color, pattern, and type used on labels applied to unlabeled syringes filled by the users or their agents to identify the drug content. This specification is not intended to cover labels applied by the drug manufacturer.

1.2 The values stated in SI units are to be regarded as the recommended values. The use of inch-pound system values, not being exact equivalents, may result in nonconformance with the standard.

1.3 *This standard does not purport to address all of the safety concerns, if any, associated with its use. It is the responsibility of the user of this standard to establish appropriate safety, health, and environmental practices and determine the applicability of regulatory limitations prior to use.*

1.4 *This international standard was developed in accordance with internationally recognized principles on standardization established in the Decision on Principles for the Development of International Standards, Guides and Recommendations issued by the World Trade Organization Technical Barriers to Trade (TBT) Committee.*

2. Referenced Documents

2.1 *ASTM Standards:*[2]

D996 Terminology of Packaging and Distribution Environments

2.2 *Other Standard:*

Pantone Matching System[3]

3. Terminology

3.1 *Definitions*—General definitions for packaging and distribution environments are found in Terminology D996.

4. Size and Background Color Requirements

4.1 *Label Size*—The labels shall have a nominal length of 25 to 35 mm and a width of 10 to 13 mm.

4.2 *Label Background Color*—The colors and patterns given in Fig. 1 shall be used to distinguish these groups of drugs. The background color shall not interfere with the ability of the user to write information on the label.

4.2.1 *Antagonists*—To denote an antagonist, 1-mm wide diagonal stripes of the agonist color alternating with a 1-mm wide white stripe shall be used. The stripes shall run from the lower left to the upper right at an angle of approximately 45° to the long axis of the label. The name of an antagonist drug shall appear in the center of the label and the striping shall be omitted behind and below the name (see Fig. 2).

[1] This specification is under the jurisdiction of ASTM Committee F02 on Primary Barrier Packaging and is the direct responsibility of Subcommittee F02.50 on Package Design and Development.

Current edition approved Dec. 15, 2017. Published January 2018. Originally approved in 1988. Last previous edition approved in 2011 as D4774 – 11[ε1]. DOI: 10.1520/D4774-11R17.

[2] For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard's Document Summary page on the ASTM website.

[3] Available from Pantone, Inc., 509 Commerce Boulevard, Carlstadt, NJ 07072–3008.

D4774 – 11 (2017)

	DRUG CLASS[A]	EXAMPLES	PANTONE COLOR (unwarned)	LABEL EXAMPLES
1	Induction Agents	Etomidate, Ketamine, Methohexital, Propofol, Thiamylal, Thiopental	YELLOW	PROPofol _____mg/mL Date _____ Time _____ Int _____
2	Benzodiazepines	Diazepam, Midazolam	ORANGE 151	MIDAZolam _____mg/mL Date _____ Time _____ Int _____
3	Benzodiazepine Receptor Antagonist	Flumazenil	ORANGE 151 AND WHITE DIAGONAL STRIPES	FLUMAZenil _____mg/mL Date _____ Time _____ Int _____
4a	Muscle Relaxants (Depolarizer)	Succinylcholine[B]	FLUORESCENT RED 805	SUCCINYLcholine _____mg/mL Date _____ Time _____ Int _____
4b	(Non-Depolarizer)	Atracurium, Cisatracurium, Mivacurium, Pancuronium, Rocuronium, Vecuronium	FLUORESCENT RED 805	ROCURonium _____mg/mL Date _____ Time _____ Int _____
5	Relaxant Antagonist (Non-Depolarizer)	Endrophonium, Neostigmine, Pyridostigmine	FLUORESCENT RED 805 AND WHITE DIAGONAL STRIPES	NEOSTIGmine _____mg/mL Date _____ Time _____ Int _____
6	Narcotics	Alfentanil, Fentanyl, Hydromorphone, Meperidine, Morphine, Sufentanil, Remifentanil	BLUE 297	FENTANYL _____mg/mL Date _____ Time _____ Int _____
7	Narcotic Antagonists	Levallorphan, Naloxone	BLUE 297 AND WHITE DIAGONAL STRIPES	NARCAN _____mg/mL Date _____ Time _____ Int _____
8	Major Tranquilizers	Chlorpromazine, Droperidol	SALMON 156	DROPeridol _____mg/mL Date _____ Time _____ Int _____
9a	Vasopressors	Ephedrine, Norepinephrine, Phenylephrine	VIOLET 256	EPHEDrine _____mg/mL Date _____ Time _____ Int _____
9b	Vasopressors	Epinephrine[B]	VIOLET 256	EPINEPHrine _____mg/mL Date _____ Time _____ Int _____
10	Hypotensive Agents	Hydralazine, Nitroglycerine, Nitroprusside, Phentolamine, Trimethaphan	VIOLET 256 AND WHITE DIAGONAL STRIPES	NITROglycerine _____mg/mL Date _____ Time _____ Int _____
11	Local Anesthetics	Bupivacaine, Chloroprocaine, Lidocaine, Mepivacaine, Procaine, Ropivacaine, Tetracaine	GRAY 401	LIDOcaine _____mg/mL Date _____ Time _____ Int _____
12	Anticholinergic Agents	Atropine, Glycopyrrolate, Scopolamine	GREEN 367	GLYCOpyrrolate _____mg/mL Date _____ Time _____ Int _____
13	Beta Blockers	Esmolol,[B] Labetolol,[B] Metoprolol[B]	COPPER 875U	LABETALol _____mg/mL Date _____ Time _____ Int _____

[A] Drugs that do not fit into the above classes should be labeled with black printing on a white background. The examples shown are representative, not restrictive.
[B] All printing is to be in black boldtype, with the exception that "succinylcholine" and "epinephrine" shall be printed against the background color as reversed plate letters within a black bar running from edge to edge of the label.

FIG. 1 Standard Background Colors for User Applied Syringe Drug Labels

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Changes to TJC MM standards and NPSGs

- ISMP has updated its list of medication name pairs with recommended tall man letters. A report appears in the 01/26/2023 ISMP Medication Safety Alert! (today's issue).

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MSOS Member Briefing
January 2023

January 26, 2023 | Volume 28 • Issue 2

ISMP An ECRI Affiliate

Acute Care

ISMP Medication Safety Alert!®

Educating the Healthcare Community About Safe Medication Practices

ISMP updates its list of drug names with tall man (mixed case) letters

Several design techniques have been explored for the purpose of differentiating look-alike drug names to prevent medication selection errors. Tall man (mixed case) lettering describes a method for differentiating the unique letter characters of similar drug names known to have been confused with one another. Starting with a generic drug name expressed in lowercase letters, tall man lettering highlights the differences between similar drug names by CAPITALIZING dissimilar letters. Occasionally, brand names, which always start with an UPPERCASE letter, may require the use of tall man letters to differentiate them from other brand or generic names. The use of tall man lettering to accentuate a unique portion of a drug name with UPPERCASE letters, along with other means such as color, **bolding**, or a contrasting background can draw attention to the dissimilarities between look-alike drug names as well as alert healthcare providers that the drug name can be confused with another drug name.

Since 2008, ISMP has maintained a list of drug names with recommended, UPPERCASE and **bolded** tall man letters. The list includes mostly generic-generic drug name pairs or larger groupings, although a few brand-brand or brand-generic name pairs are also included. Periodically, ISMP updates this list; it was last revised in 2016. Each time the list is updated, we analyze reported events from our error databases, survey practitioners on the topic, and conduct an internal review of drug names that would benefit from the application of UPPERCASE and **bolded** tall man lettering. The internal assessment includes an exploration of orthographic similarity; patterns of similarities in dosage, formulation, and use; and the potential for patient harm if the drugs are confused.

Standardization of Tall Man Letters

To promote standardization regarding which letters to present in **bold**/UPPERCASE, ISMP follows a tested methodology whenever possible called the CDS rule.[1] The rule suggests working from the left of the drug name first by CAPITALIZING all the characters to the right once two or more dissimilar letters are encountered. Then, working from the right of the word back, returning two or more letters common to both words to lowercase letters. When the rule cannot be applied because there are no common letters on the right side of the word, the methodology suggests CAPITALIZING the central part of the word only. When this rule fails to lead to the best tall man lettering option (e.g., makes names appear too similar or hard to read based on pronunciation), an alternative option is considered. ISMP suggests that the tall man lettering scheme provided by the US Food and Drug Administration (FDA) and ISMP be followed to promote consistency.

ISMP Survey

One of the primary reasons for conducting this survey is to use the findings to update ISMP's current list of look-alike drug names with tall man (mixed case) letters. We believe healthcare practitioners should be involved in the process of identifying confusing drug names relevant to their respective practice settings and reviewing proposed tall man lettering for possible implementation. The CAPITALIZED and **bolded** letters should make the drug names distinguishable from the user's perspective.[2]

Respondent profile. ISMP extends our sincere appreciation to the 298 respondents who

continued on page 2 — Tall man (mixed case) letters >

SAFETY briefs

Inappropriate use of ADC overrides. One of the biggest challenges to the safe use of automated dispensing cabinets (ADCs) is the ease with which medications can be removed upon override, many times unnecessarily and with a lack of perceived risk. ISMP's affiliate, ECRI, recently released ***Top 10 Health Technology Hazards for 2023*** (www.ismp.org/ext/10739). Coming in at number three is how the inappropriate use of ADC overrides can result in medication errors. We encourage organizations to review the ***ISMP Targeted Medication Safety Best Practices for Hospitals***, *Best Practice #16*: www.ismp.org/ext/7886, and implement the following recommendations:

continued on page 2 — SAFETY briefs >

ISMP Medication Safety Alert! *Acute Care* Action Agenda

One of the most important ways to prevent medication errors is to learn about problems that have occurred in other organizations and to use that information to prevent similar problems at your practice site. To promote such a process, selected items from the **October – December 2022** issues of the ***ISMP Medication Safety Alert! Acute Care*** newsletters have been prepared for leadership to use with an interdisciplinary committee or with frontline staff to stimulate discussion and action to reduce the risk of medication errors. Each item includes a brief description of the medication safety problem, a few recommendations to reduce the risk of errors, and the issue number to locate additional information.

The **Action Agenda** is available for download as an Excel file (www.ismp.org/node/59277). Continuing education credit is available for nurses at: www.ismp.org/nursing-ce.

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Changes to TJC MM standards and NPSGs

— ISMP has developed a series of Targeted Medication Safety Best Practices for ambulatory/community pharmacies.

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Questions?

- A copy of today's slides will be posted on our website
- Next MSOS Briefing date – March 23, 2023.

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