MSOS Member Briefing
July 2023

Moderated by: E. Robert Feroli, PharmD, FASHP

MSOS
MEDICATION SAFETY OFFICERS SOCIETY

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Practice Pearl

Cyclic Parenteral Nutrition – an EPIC solution

Jennifer Williams PharmD, BCPS
Mercy Medical Center – Cedar Rapids, Iowa

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Mercy Medical Center
Cedar Rapids, Iowa

- 'Stand-alone' health system
  - 450 bed community hospital
  - Urgent care, Specialty, and Primary care clinics
  - 2 ER locations
- EPIC system
  - Dedicated local team
- My position: Clinical pharmacist
  - Inpatient surgical/oncology unit
  - Oncology infusion clinic
  - Hybrid schedule (days/overnights)

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Situation

Cyclic PN infusions do not run over 24 hours as continuous infusions

Require tapering on and off by nursing staff

Rate adjustments are getting delayed or missed

2 patients transferred to ICU for fluid overload related to rate change omissions in past 3 months

1 patient with overfeeding complications in past 6 months

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Background

- Current state
  - Only indicators that an order is cyclic is title "Adult Cyclic PN" and administration instructions box (free text box) on MAR

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Assessment

Delays or omissions in rate changes place patients at risk of overfeeding and other complications

Safety webinar at ASHP MidYear mentioned EPIC "taper button"

- Local EPIC team determined that it only autopopulates admin instructions
- Assumes volume dispensed = volume administered
  - Mercy utilizes premixed base solution product, dispensed in 1L increments

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Recommendation

Project goal updated to using MAR prompts for rate changes

- Turn red when overdue, similar to other medications
- New PN entry for MAR created in Epic test environment, acts as "Due" time but for a rate change (no scanning, does not drop charge)

Process/Standard of work

- Nursing education
  - Range rate prompts review of admin instructions
  - Scan needed only for initial due time
- Pharmacist education
  - Labor-intensive order entry/verification, manual add of new due times

Approval via several committees

- Clinical Readiness committee: review for correct scanning/billing

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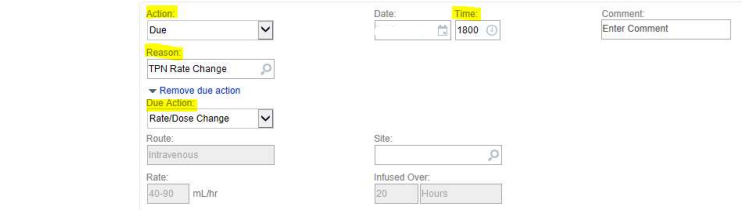
Implementation



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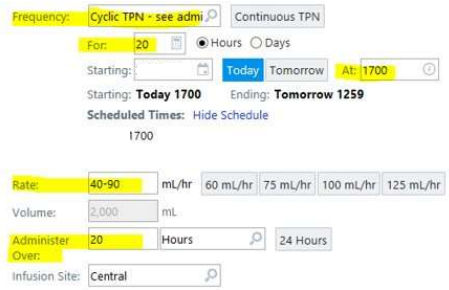
Implementation



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Evaluation

- Reviewed every cyclic PN order for 6 months
  - Charging correctly, placeholders getting added correctly
  - 1 error in rate change
    - RN misread administration instructions
    - Patient had fluid overload, resolved with minor intervention
- Re-validated by Clinical Readiness committee
  - Triggered by pump integration project
  - Now able to assess real-time changes to rates
    - Less manual typing into MAR for RNs
  - Did update RN process to include dual sign-offs
  - Affirmed current process
    - do not use comment boxes with each rate due time, just admin instructions box on main order

    (matches process for insulin, heparin, crit care drips)

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Next Project

- Perioperative PN > better communication
  - Fluids
  - Anesthesiology
  - Order discontinuation
    - Unintended
    - Intended (but then no taper)…

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Questions?

Jennifer Williams PharmD, BCPS
Mercy Medical Center – Cedar Rapids, Iowa

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What is the Prescription for Adherence?

Rachel DiPaolantonio, PharmD

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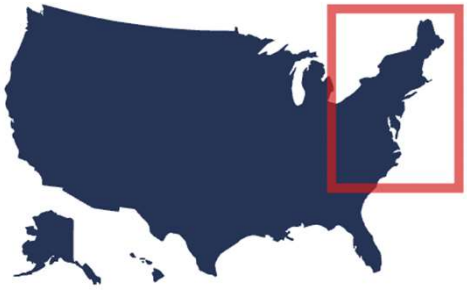
FROM THE VIEW OF A COMMUNITY PHARMACIST



Weis Markets is a regional grocery pharmacy chain with locations in Delaware, Maryland, New Jersey, New York, Pennsylvania, Virginia, and West Virginia.

~130 pharmacy locations

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PRESENTATION OBJECTIVES

Objective 1

- Understand the benefits of a medication alignment and automatic prescription refill service on both medication adherence and patient safety.

Objective 2

- Briefly discuss the study design and results of a mid-implementation research study conducted at a regional grocery chain pharmacy to investigate the feasibility of workflow strategies for enrollment in automatic prescription refill.

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"Drugs don't work in patients who don't take them"

–

US Surgeon General C. Everett Coop

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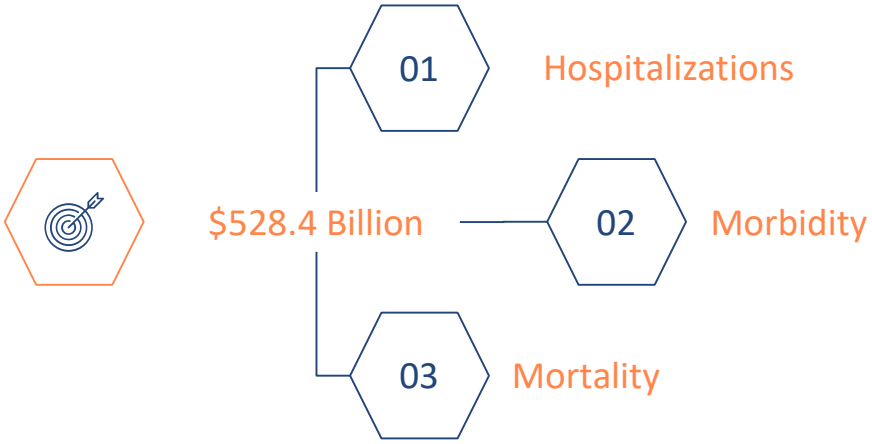
THE COST OF NONADHERENCE



Peterson AM, Takiya L, Finley R. Meta-analysis of trials of interventions to improve medication adherence. Am J Health Syst Pharm. 2003;60:657-65.
Watanabe JH, Mcinnis T, Hirsch JD. Cost of prescription drug-related morbidity and mortality. Ann Pharmacother. 2018.

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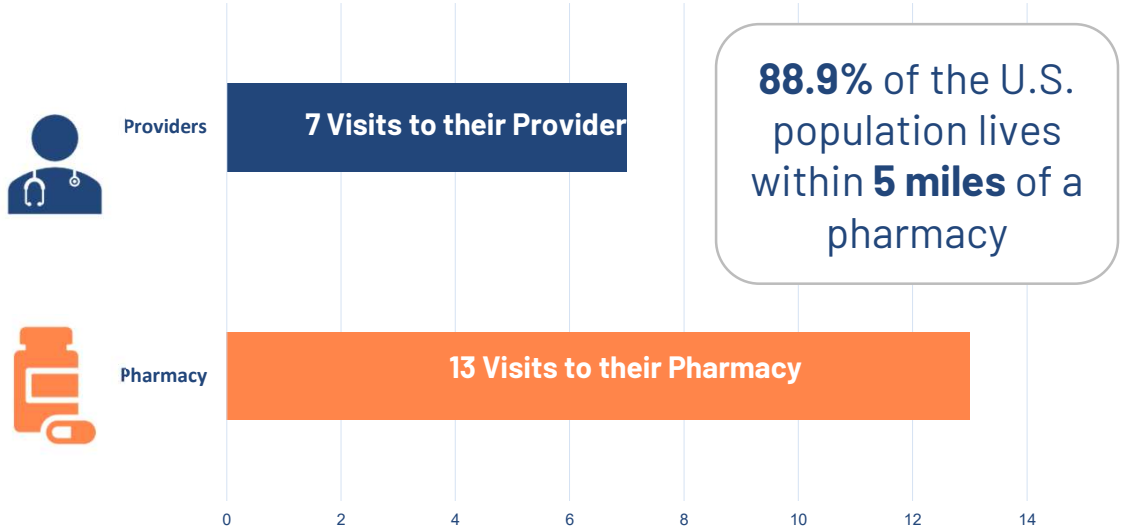
PATIENT ACCESS TO CARE



88.9% of the U.S. population lives within **5 miles** of a pharmacy

Berenbrok LA, Gabriel N, Coley KC, Hernandez I. Evaluation of frequency of encounters with primary care physicians vs visits to community pharmacies among medicare beneficiaries. *JAMA Netw Open*. 2020; 3e209132
Berenbrok LA, Tang S, Gabriel N, Guo J, Sharareh N, Patel N, Dickson S, Hernandez I. Access to community pharmacies: A nationwide geographic information systems cross-sectional analysis. J Am Pharm Assoc (2003). 2022 Nov-Dec;62(6):1816-1822.e2.

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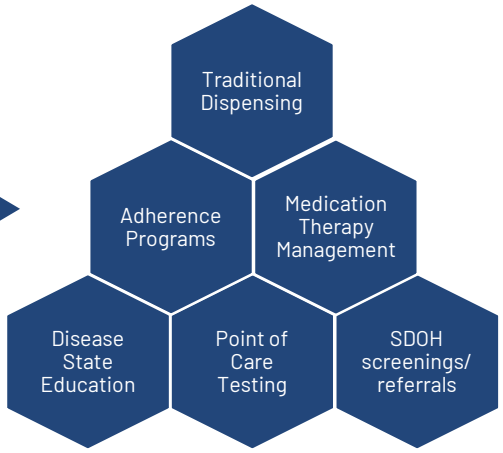
THE CHANGING VISION OF COMMUNITY PHARMACY

"Count, pour, lick, stick"



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ISMP TIME GUARANTEE STUDY

Background

- Conducted by an ISMP Fellow with collaboration from the American Pharmacist Association (APhA)
- Inquired about the community pharmacist's viewpoint on the effect time guarantees have on pharmacy practice and prescription accuracy.

83% Time guarantees were a contributing factor to medication errors made in community pharmacies.

44% Were personally involved in a dispensing error related to hurrying to meet time guarantees.

37% Of those involved in these dispensing errors, 37% did not report the error(s) that resulted.

Carson S. Prescription Drug Time Guarantees and Their Impact on Patient Safety in Community Pharmacies. ISMP Medication Safety Alert. 2012 Sep 6;1–4.c

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THE HARM OF TIME GUARANTEES

May not allow for appropriate time to:

- Resolve insurance adjudication issues
- Clarify with prescribers
- Provide counseling to patients
- Perform a drug utilization review (DUR)
- Investigate drug interactions

How do we move away from this potentially harmful view of community pharmacy?

Carson S. Prescription Drug Time Guarantees and Their Impact on Patient Safety in Community Pharmacies. ISMP Medication Safety Alert. 2012 Sep 6;1–4.c

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HOW DO YOU INCREASE ADHERENCE?

Medication Alignment	Automatic Prescription Refill
• Precursor to "medication synchronization" / "med sync" • One time event • Aligning the refill dates for a patient's chronic disease medications to a specific day, usually once a month. • By hand or via 3rd party companies	• "Autofill" • The pharmacy dispensing software incorporates the prescription into workflow at the scheduled refill time • An automated process

Barnes B, Hincapie AL, Luder H, Kirby J, Frede S, Heaton PC. Appointment-based models: A comparison of three model designs in a large chain community pharmacy setting. J Am Pharm Assoc (2003). 2018 Mar-Apr;58(2):156-162.e1.

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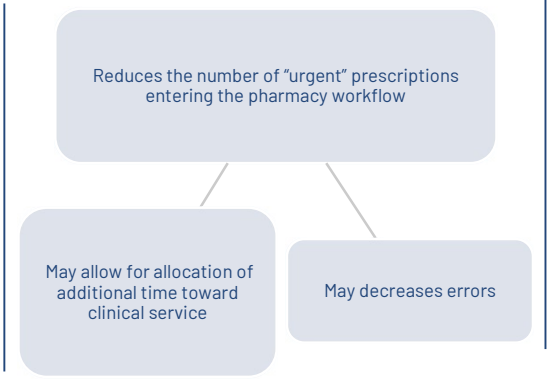
AUTOFILL KEY BENEFITS

- One solution to increase convenience
- Ensure a refill is available before the current supply is exhausted
- May aid in adherence without contributing to oversupply
- Prevents out of stock delays
- Allows more prescriptions to go to central fill to reduce the fill burden at the store level



Carson S. Prescription Drug Time Guarantees and Their Impact on Patient Safety in Community Pharmacies. ISMP Medication Safety Alert. 2012 Sep 6;1-4.
Lester CA, Chui MA. The prescription pickup lag, an automatic prescription refill program, and community pharmacy operations. J Am Pharm Assoc (2003). 2016 Jul-Aug;56(4):427-32.
Matlin OS, Kymes SM, Averbukh A, Choudhry NK, Brennan TA, et al. Community Pharmacy Automatic Refill Program Improves Adherence to Maintenance Therapy and Reduces Wasted Medication. AJMC. 2015. 21(11).

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Research Objective

To identify feasible strategies for improving the implementation of an automatic prescription refill service

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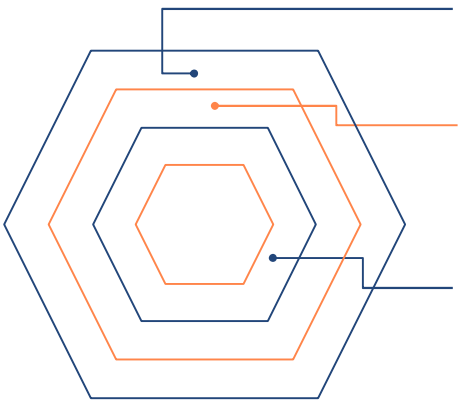
DATA COLLECTION - SURVEY



Workflows

5 proposed workflow strategies

Evaluate the following statement:

This is a feasible workflow strategy to implement at my pharmacy.

Responses

- Agree (can implement as is)
- Agree with modifications → What modifications would you make to this workflow to make it feasible for your pharmacy?
- Disagree → Why would this strategy not work at your pharmacy?

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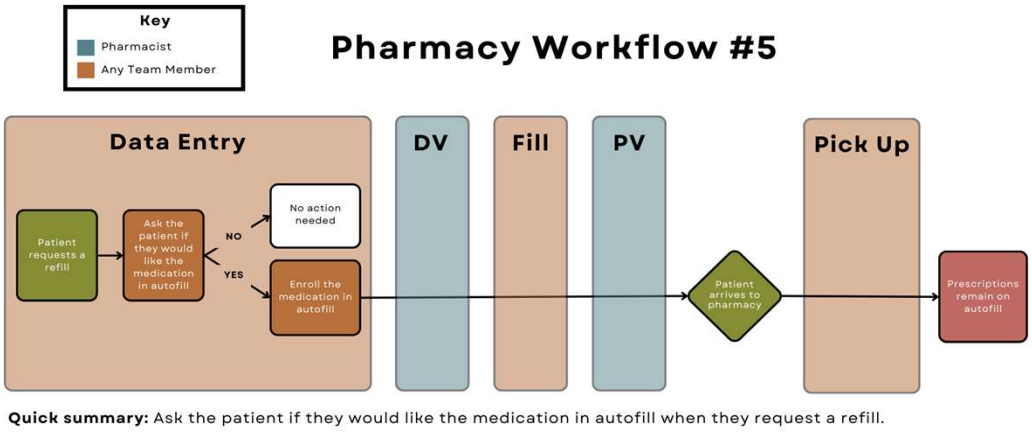
EXAMPLE SURVEY WORKFLOW



Quick summary: Ask the patient if they would like the medication in autofill when they request a refill.

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RESULTS – MOST FEASIBLE WORKFLOW

Quick Summary

"Ask the patient if they would like the medication in autofill when they request a refill."

Results

- 82% of participants responded "feasible (can implement as is)"

Other Findings

- Ranking: Most feasible
- Workload: requires the least number of steps, distributed among pharmacy team member type
- Was favored among the stores with the top autofill percentages

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BOTTOM LINE

INCREASE ADHERENCE

Autofill helps patients avoid running out of medication

- Use touch points with patients to educate about adherence programs
- Go back to the basics and ask the patient at each opportunity you can

INCREASE SAFETY

- Encourage change in patient perspective on the refill process and enrollment in autofill
- Decreases "urgent" prescriptions & increases lead time for the pharmacy
- Prevent development of at-risk behaviors by the pharmacy team caused by time guarantees

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"The *unrushed* pharmacist will be the accurate pharmacist, and the *unhurried* patient will be the safe patient."

Carson S. Prescription Drug Time Guarantees and Their Impact on Patient Safety in Community Pharmacies. ISMP Medication Safety Alert. 2012 Sep 6;1–4.c

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Questions?

Rachel DiPaolantonio, PharmD
rachel.dipaolantonio@weismarkets.com

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HAMST-R PRO:

explaining the reason why one-size CANNOT fit all

High-**A**lert **M**edication **S**tratification **T**ool – **R**evised, **Pro**spective

Joel Daniel, PharmD, MS, CPPS

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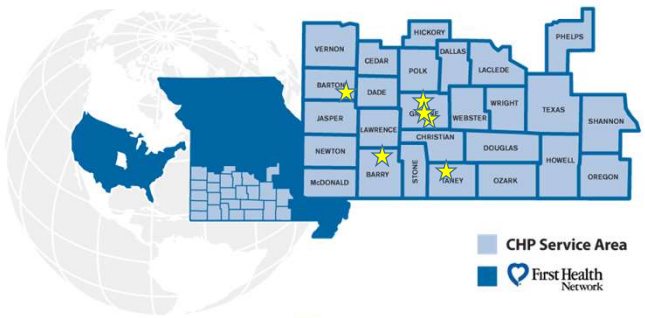
Who are we? Two health-systems?

Background | Basics of HAMST-R PRO | Usage | Utilization at our systems

CoxHealth



CoxHealth

Facilities
- 6 hospitals
- 80+ clinics
- 1,194 licensed beds
- 25 counties served

Staff
- 12,178 employees
- 537 physicians
- 217 residency graduates
- 2,343 bedside nurses

CareChex
AMERICA'S TOP QUALITY HOSPITALS
ACCREDITED Hospital
DNV ISO 9001
MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER
CERTIFIED
CERTIFIED

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Who are we? Two health-systems?

Background | Basics of HAMST-R PRO | Usage | Utilization at our systems

Eskenazi Health

Facilities
- 333-bed safety-net, academic medical center
- Marion County, IN
- Level One Trauma Center, Burn Center, and Stroke Center
- 11 FQHCs

Staff
- 6,000 employees
- 1,200 physicians
- 1,000 bedside nurses
- 100 pharmacists, 90 pharmacy technicians

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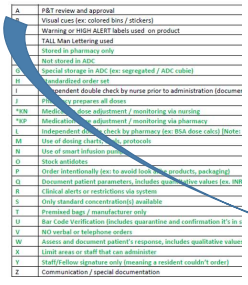
Standing on the shoulders of giants…

Background | Basics of HAMST-R PRO | Usage | Utilization at our systems

ICPS A-Z List

What is in our toolbox?



A	P&T review and approval
B	Visual cues (ex: colored bins / stickers)
C	Warning or HIGH ALERT labels used on product
D	TALL Man Lettering used
E	Stored in pharmacy only
F	Not stored in ADC
G	Special storage in ADC (ex: segregated / ADC cubie)
H	Standardized order set
I	Independent double check by nurse prior to administration (docume
J	Pharmacy prepares all doses
*KN	Medication dose adjustment / monitoring via nursing
*KP	Medication dose adjustment / monitoring via pharmacy
L	Independent double check by pharmacy (ex: BSA dose calcs) [Note:
M	Use of dosing charts/tools, protocols
N	Use of smart infusion pump
O	Stock antidotes
P	Order intentionally (ex: to avoid look-alike products, packaging)
Q	Document patient parameters, includes quantitative values (ex. INR
R	Clinical alerts or restrictions via system
S	Only standard concentration(s) available
T	Premixed bags / manufacturer only
U	Bar Code Verification (includes quarantine and confirmation it's in c
V	NO verbal or telephone orders
W	Assess and document patient's response, includes qualitative value
X	Limit areas or staff that can administer
Y	Staff/Fellow signature only (meaning a resident couldn't order)
Z	Communication / special documentation

Heather Dossett, *et al.* Unpublished.

HAMST-R

What on our formulary is a high-alert medication?

ORIGINAL ARTICLE

High-Alert Medication Stratification Tool—Revised Phase II: A Multisite Study Examining the Validity, Interrater Reliability, and Ease of Use of the High-Alert Medication Stratification Tool—Revised

Todd Walroth, *et al.*

HAMST-R PRO

1. What new med should be considered a high-alert medication?
2. What items should we do to help prevent harm?

McKenzie Shenk, *et al.*

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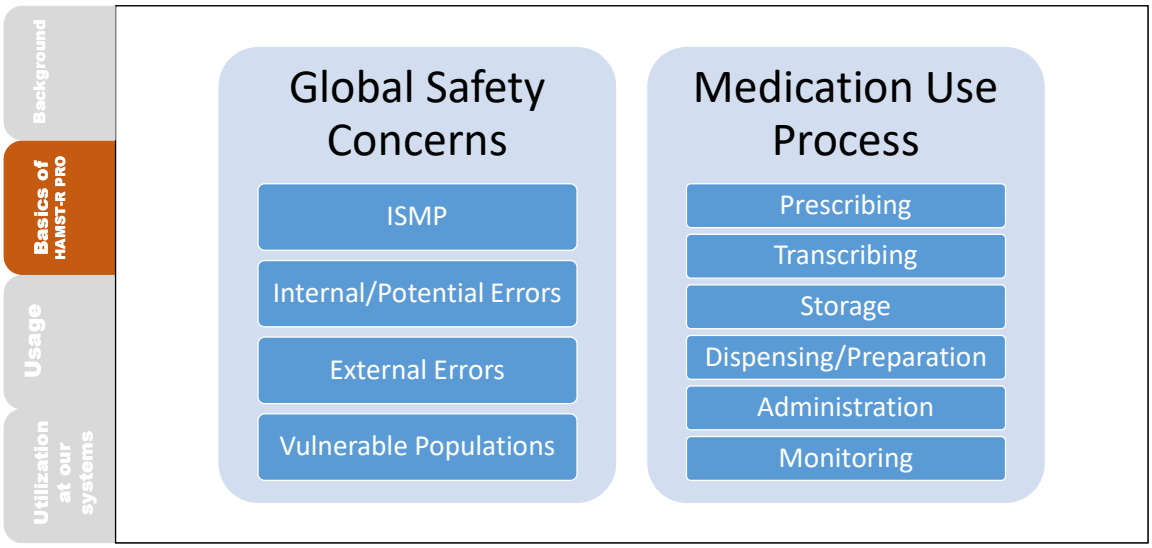
In essence, what is HAMST-R PRO?



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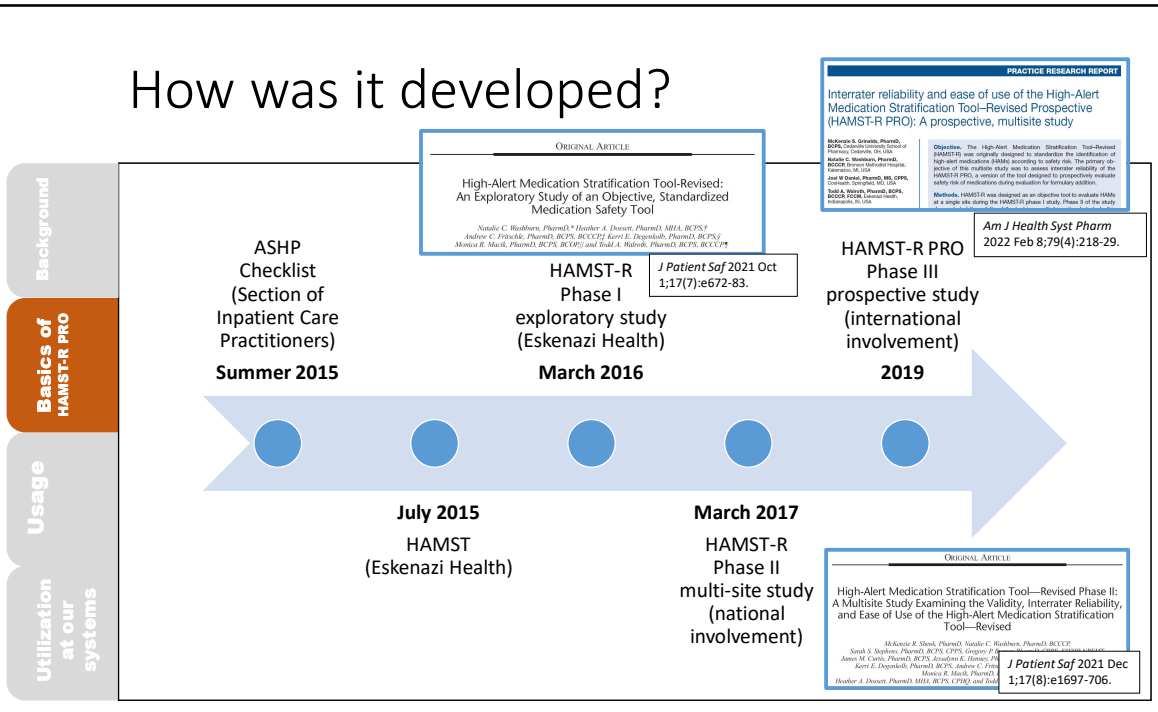
How was it developed?



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How to use the tool?

Background
Basics of HAMST-R PRO
Usage
Utilization at our systems

Category	Question	Clarification	Yes/No	Score
Prescribing	Is this a look-alike, sound-alike drug?	Include medications, not limited to currently stocked products, which are recognized as LASA by any tertiary reference (e.g. LexiComp, Micromedex, ISMP (https://www.ismp.org/tools/confuseddrugnames.pdf), etc.) or internal approval body (e.g. Medication Safety Team).		0
	Is there the opportunity/need to standardize concentration and/or strengths?	Do not consider tablet formulations. Do not answer yes if only one formulation is readily available. Examples include: morphine oral solution, intravenous heparin for continuous infusion, etc.		
	Are there multiple formulations available?	Examples include: extended-release products;		
	Development of standard protocols, policies, or order sets developed to guide prescribers needed for safety purposes?			
	Is there a need for the reversal agent to be on the order set?	Inclusion of reversal agent for order sets should be considered when potential adverse effects are rapid and severe. Example: naloxone.		
	Should there be maximum dose limits when prescribing?	Examples include: maximum weight-based dose (alteplase), maximum daily dose (IM olanzapine), maximum hard limit in infusion pump (diltiazem), etc.		
	Is adult weight-based dosing required when prescribing?			
	Should medication be hidden in CPOE outside of order sets?	**Example:** heparin infusions, insulin drips, neuromuscular blocker infusions, etc. **Note:** Consider other medications in the same class.		
	Is there clinical decision support (CDS) upon prescriber order entry?	CDS more active than standard order sentences.		
	Should the medication be considered restricted access to specialized prescribers?			

Example

- ISMP Reports
- Internal Reports
- External Reports
- Vulnerable Populations
- Risks in Prescribing
- Risks in Transcribing
- Risks in Storage
- Risk in Dispensing/Preparation
- Risks in Monitoring

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How to use the tool?

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Utilization at our systems

Category	Question	Clarification	Yes/No	Score
Prescribing	Is this a look-alike, sound-alike drug?	Include medications, not limited to currently stocked products, which are recognized as LASA by any tertiary reference (e.g. LexiComp, Micromedex, ISMP (https://www.ismp.org/tools/confuseddrugnames.pdf), etc.) or internal approval body (e.g. Medication Safety Team).	✓	0
	Is there the opportunity/need to standardize concentration and/or strengths?	Do not consider tablet formulations. Do not answer yes if only one formulation is readily available. Examples include: morphine oral solution, intravenous heparin for continuous infusion, etc.	✗	
	Are there multiple formulations available?	Examples include: extended-release products;	✓	
	Development of standard protocols, policies, or order sets developed to guide prescribers needed for safety purposes?		✗	
	Is there a need for the reversal agent to be on the order set?	Inclusion of reversal agent for order sets should be considered when potential adverse effects are rapid and severe. Example: naloxone.	✗	
	Should there be maximum dose limits when prescribing?	Examples include: maximum weight-based dose (alteplase), maximum daily dose (IM olanzapine), maximum hard limit in infusion pump (diltiazem), etc.	✗	
	Is adult weight-based dosing required when prescribing?		✗	
	Should medication be hidden in CPOE outside of order sets?	**Example:** heparin infusions, insulin drips, neuromuscular blocker infusions, etc. **Note:** Consider other medications in the same class.	✗	
	Is there clinical decision support (CDS) upon prescriber order entry?	CDS more active than standard order sentences.	✗	
	Should the medication be considered restricted access to specialized prescribers?		✓	

3/10 = 0 points

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How to use the tool?

Background
Basics of HAMST-R PRO
Usage
Utilization at our systems

Global Safety Concerns

- ISMP
- Internal/Potential Errors
- External Errors
- Vulnerable Populations

Medication Use Process

- Prescribing
- Transcribing
- Storage
- Dispensing/Preparation
- Administration
- Monitoring

Total Score?

8/10

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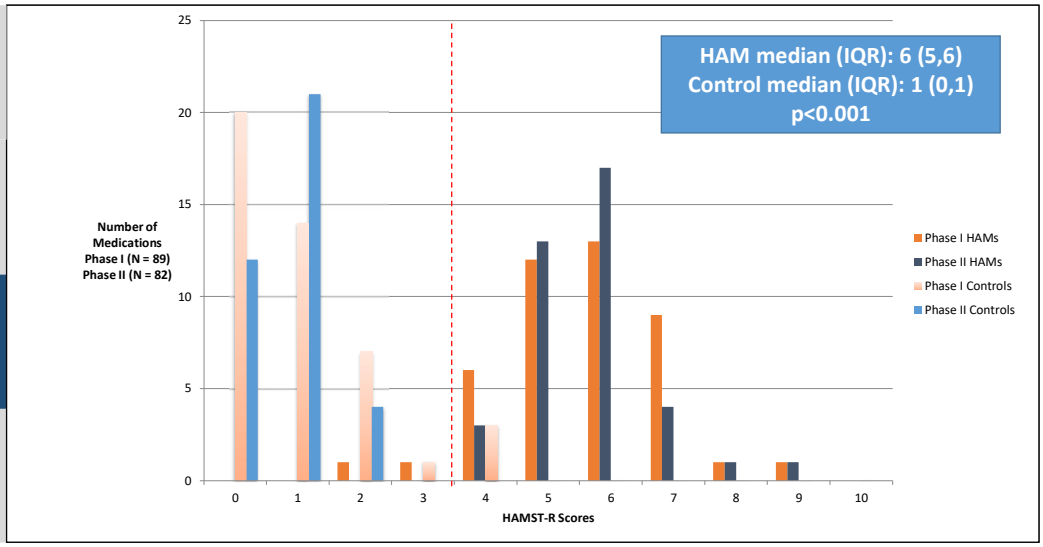
How to use the tool?

4 = HAM

Background
Basics of HAMST-R PRO
Usage
Utilization at our systems



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How do we use it?

Background
Basics of HAMST-R PRO
Usage
Utilization at our systems

Isavuconazonium sulfate (Cresemba®)

4. Medication Safety Considerations

High-Alert Medication Stratification Tool-Revised Prospective Score (HAMST-R PRO)	0 (not a high alert medication)
ISMP Sound-Alike/Look-Alike Drug (SALAD)	No
ISMP reported safety concerns	None reported
REMS program	No program exists
Hazardous medication	No

Lee A, Han JM, Jun K, Heo KN, Grinalds MS, Washburn NC, Walroth TA, Ah YM, Lee JY. Development of the Korean High-Alert Medication Stratification Tool (K-HAMST). *Res in Clin Pharm* 2023;1:1-9. [accepted for publication]

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How do we use it?

Background
Basics of HAMST-R PRO
Usage
Utilization at our systems

1. Policy
   - Require a score of 4 or greater to be on high-alert medication list
2. Require different levels of interventions
   - Score of 7 or higher REQUIRES a high-level intervention
3. Incorporate into process
   - Initially part of the P&T process
   - Now informal portion of the post-P&T implementation process

COXHEALTH

SYSTEM POLICY – Patient Care (PC) / Medication Use

TITLE: Rx - High Risk Alert Medications
SUBMITTED BY: Joel Daniel, System Medication Safety Pharmacist
APPROVED BY: Hospitals Pharmacy & Therapeutics and Medical Executive Committees and Evidence Based Medicine Committee

PURPOSE:
The organization will identify high-alert medications used in the system and the intervention strategies to manage risk.

POLICY:
For each high-alert medication or group of medications identified, the organization will identify specific steps to improve safety appropriate steps within the Medication Management processes: selection and procurement, storage, ordering, validation, preparing, dispensing, administration and monitoring. These intervention strategies should mirror risk points within the Medication Management process.

The High-Alert Medication Stratification Tool – Revised (either retrospective version or prospective version, HAMST-R or HAMST-R PRO respectively) will be utilized in order to maintain medications on this list for the inpatient setting (Appendix A). Only scores of a 4 or higher on the tool will be considered for the High-Alert Medication list. Medications with a score of 7 or higher must be included on the list. Risk assessment may take on another form for the ambulatory/clinic setting.

SCOPE: All hospital and clinic locations

PROCEDURE:

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How do we use it?

Background

Basics of HAMST-R PRO

Usage

Utilization at our systems

Approach to Interventions:

1. Consider where in the medication management process the highest risks lie.
2. Make sure interventions address that process.

CoxHealth

Recommendation	Intervention	
	A	Altered color/text in CPOE
	B	Visual cues (ex: colored bins / stickers)
	C	Warning or HIGH ALERT labels used on product
	D	TALL Man Lettering used
	E	Stored in pharmacy only
	F	Frequency restriction (hard stop in Pharmacy)
	G	Special storage in ADC (ex: special segregation or lidded bins)
	H	Standardized order set
	I	Independent double check by nurse prior to administration (documented)
	J	Pharmacy prepares all doses
	*KP	Medication dose adjustment / monitoring via pharmacy
	*KT	Use of "Kit" (physical: IVPB + vial + adapater; or virtual)
	*LDC	Independent double check by pharmacy (ex: BSA dose calcs) [Note: also encompasses Q and W]
	M	Use of dosing charts, tools, protocols
	N	Incorporate messge within name

Recommendation	Intervention	
	O	Stock antidotes
	P	Purchase intentionally (ex: to avoid look alike products, packaging)
	Q	Document patient parameters, includes quantitative values (ex. INR, blood glucose, End Tidal CO2)
	*RE	Clinical alerts or restrictions via system
	*RS	Storage within robot and/or utilizing hub-and-spoke distribution system restriction
	S	Only standard concentration(s) available
	T	Premixed bags / manufacturer only
	U	Bar Code Verification (includes quarantine and confirmation it's in system, process for adding a new NDC)
	V	NO verbal or telephone orders
	W	Assess and document patient's response, includes qualitative values (ex: pain, symptom management, sedation scores, bleeding)
	X	Limit areas or staff that can administer
	Y	Staff/Fellow signature only (meaning a resident couldn't order)
	Z	Communication / special documentation

No
Consider
Weak
Moderate
Strong
N/A

Adapted from the ICPS A-Z List

Key	Low Level Intevention
	High Level Intervention

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Questions?

Joel Daniel, PharmD, MS, CPPS

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ISMP
Institute for Safe Medication Practices
An ECRI Affiliate

ISMP Update
MSOS Briefing July 2023

Rita K. Jew, PharmD, MBA, BCPPS, FASHP
President
Institute for Safe Medication Practices

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Articles on REMS Program


ISMP
Acute Care
ISMP Medication Safety Alert!
Proper deployment of REMS to reduce potential drug-related harm and medication errors—Part I
SAFETY briefs


ISMP
Acute Care
ISMP Medication Safety Alert!
Incorporating REMS program requirements into systems and processes—Part II
SAFETY briefs
IMPORTANT! Read and utilize the Acute Care Action Agenda

ISMP
An ECRI Affiliate

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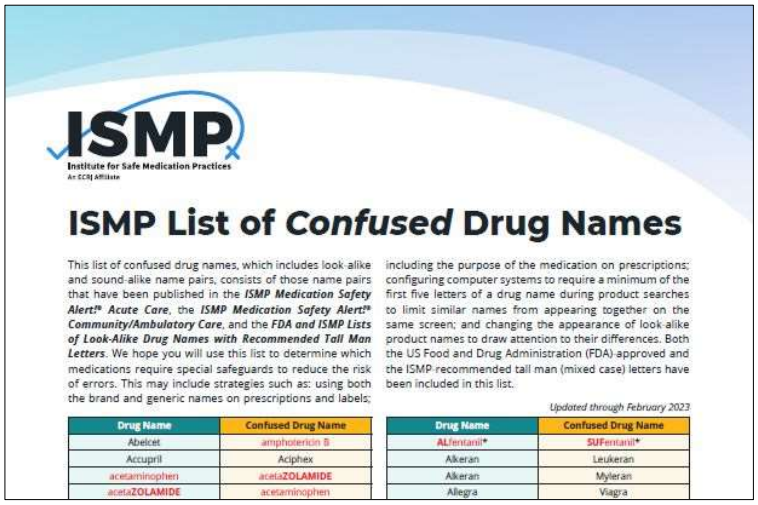
ISMP List of Confused Drug Names Updated



ISMP
Institute for Safe Medication Practices
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ISMP List of *Confused* Drug Names

This list of confused drug names, which includes look-alike and sound-alike name pairs, consists of those name pairs that have been published in the ***ISMP Medication Safety Alert!® Acute Care***, the ***ISMP Medication Safety Alert!® Community/Ambulatory Care***, and the ***FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters***. We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors. This may include strategies such as: using both the brand and generic names on prescriptions and labels; including the purpose of the medication on prescriptions; configuring computer systems to require a minimum of the first five letters of a drug name during product searches to limit similar names from appearing together on the same screen; and changing the appearance of look-alike product names to draw attention to their differences. Both the US Food and Drug Administration (FDA)-approved and the ISMP-recommended tall man (mixed case) letters have been included in this list.

Updated through February 2023

Drug Name	Confused Drug Name
Abelcet	amphotericin B
Accupril	Aciphex
acetaminophen	aceLAZOLAMIDE
acetaZOLAMIDE	acetaminophen

Drug Name	Confused Drug Name
ALfentanil*	SUFentanil*
Alkeran	Leukeran
Alkeran	Myleran
Allegra	Viagra

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https://www.ismp.org/recommendations/confused-drug-names-list

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Medication Safety Intensive

- Virtual MSI
  - **August 3-4, 2023**
  - **Oct 4-6, 2023**
  - **Nov 20-Dec 1, 2023**
- Virtual MSI for Community & Specialty Pharmacy
  - **Oct 20 & 27, 2023**

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https://www.ismp.org/education/msi-workshops

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We Want to Hear from You …

ISMP/ECRI SURVEY ON DRUG, SUPPLY, AND EQUIPMENT SHORTAGES

ISMP and ECRI are conducting a short survey on the continuing crisis with **drug shortages and supply chain disruptions** resulting in ongoing patient safety and cost concerns. We are interested in learning about your experiences with drug, single-use supplies (e.g., tubing, syringes, cassettes), and durable medical equipment (e.g., infusion devices) shortages during the past 6 months. Please take a few minutes to complete the survey and submit your responses to ISMP and ECRI by **July 27, 2023**, by clicking here. We plan to use the results of this survey to advocate for changes on a national level aimed at reducing the occurrence of serious shortages. Thank you for your participation in this survey.

- One more chance before the survey closes today, July 27, 2023

https://surveys.ismp.org/s3/Drug-Supply-and-Equipment-Shortage-Survey-2023

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Last Call for ISMP Cheers Awards Nominations

Deadline: August 6, 2023

https://www.ismp.org/cheers-awards/cheers-nominations

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Coming Soon…

- Applications for the Judy Smetzer Just Culture Champion Scholarships
  - **A team of 3 individuals from a single organization**
  - **15-hour Just Culture certification course**
- Opens August 1st, 2023

https://www.ismp.org/services/judy-smetzer-just-culture-champion-scholarships

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ISMP Represented at GEDSA Board

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Questions?

- A copy of today's slides will be posted on our website
- Next MSOS Briefing date – September 28, 2023.

MSOS
MEDICATION SAFETY OFFICERS SOCIETY

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