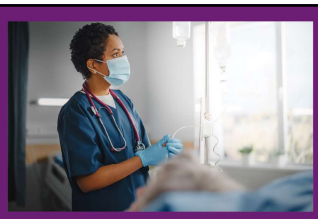
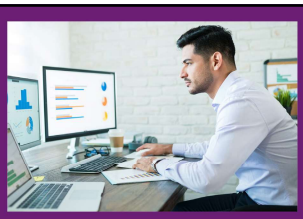
MSOS Member Briefing
March 2024

MSOS Member Briefing
March 2024

Moderated by: E. Robert Feroli, PharmD, FASHP

MSOS
MEDICATION SAFETY OFFICERS SOCIETY

1


AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

35TH AHRQ ANNIVERSARY Today's Research, Tomorrow's Healthcare

Federal Funding Opportunities for Medication Safety Research

Medication Safety Officers Society | March 2024 Member Briefing

Farzana Samad, PharmD, FISMP, CPPS
Health Scientist Administrator
Agency for Healthcare Research and Quality (AHRQ) | Center for Quality Improvement and Patient Safety (CQuIPS)

2

MSOS Member Briefing
March 2024

Objectives

- Understand the role of medication safety research in practice
- Share examples of medication safety research currently funded through AHRQ Grants
- Discuss opportunities for federal (AHRQ) funding for medication safety research

3

3

The role of medication safety research in practice

What works? How and when does it work?
Where should we focus our efforts?
What applies to our practice setting?

Research	Implementation	Measurement
• User-driven research • Collaboration • Dissemination	Use evidence-based research & tools to tailor interventions to your practice	Continuous learning

4

How do we get involved in medication safety research?

- What initiatives could benefit from research and evidence-based support?
- What could be shared so others can use your experience and results to generate ideas for their practice?

- Collaborate with your local researchers
- Collaborate with other institutions (e.g., other health-systems, academia, human factors experts)
- Collaborate with community champions (e.g., for community pharmacy services, for education, for patient experience)
- Mentored research and postdoctoral training (AHRQ NoFOs!)

Become a part of the research team!

5

5

Stages of patient safety research initiatives

- Identification of risks, hazards, and patient harm.
- Design, implementation, dissemination and spread, and evaluation of interventions to improve patient safety.
- Establishment of strategies to sustain patient safety improvements such as culture, incident/event reporting, measurement, monitoring, and surveillance.

6

6

Opportunities for AHRQ-funding: Sample active projects

Grantee	Title	Aims
Bykov R01 HS 027623 Brigham and Women's Hospital	**Drug interactions and opioid-related emergency room visits** and hospitalizations among **older adults**	1. Effects of *fluoxetine* and *paroxetine* on rates of opioid-related ER visits & hospitalizations among older adults who use *oxycodone*, *hydrocodone*, or *tramadol* 2. Effects of *diltiazem* and *verapamil* on rates of opioid-related ER visits & hospitalizations among older adults who use *oxycodone*, *fentanyl*, or *tramadol* 3. Effects of *clopidogrel* and *ticlopidine* on rates of opioid-related ER visits and hospitalizations among older adults who use *tramadol*

Exploratory: identification of risks, hazards, and patient harm.

7

7

Opportunities for AHRQ-funding: Sample active projects

Grantee	Title	Aims
Becker R01 HS 25386 Michigan State University	Optimizing OTC labels for older adults: Empirical evaluation of labels designed to provide older users the information they need to minimize adverse drug Events	1. Determine the information to be prioritized in order to reduce the likelihood of ADRs. 2. Investigate formatting techniques that attract attention to critical information when accessing it is not the participant's explicit goal (bottom-up attention). 3. Investigate formatting techniques that attract attention to critical information and promote decision making when accessing that information is the participant's explicit goal (top-down attention). 4. Evaluate the information required for older consumers to make an appropriate OTC choice. 5. Evaluate how optimized labels (based on Aims 1-3) garner attention and support appropriate OTC drug selection by older adults. 6. Evaluate whether the benefits of an optimized label generalize to commercial brands.

Identification of risks, hazards, and patient harm; intervention development and testing

.

8

8

Opportunities for AHRQ-funding: Sample active projects

Grantee	Title	Aims
Witt R18 HS 27960 University of Utah	Overcoming barriers to warfarin patient self-management (PSM) implementation in the US healthcare system	1. Identify and validate potential PSM *barriers and facilitators* from the perspective of US patients and anticoagulation providers. 2. *Implement PSM* in five US ambulatory care sites using implementation strategies developed in partnership with the Anticoagulation Forum's Centers of Excellence program and supported by rapid-cycle research methodologies to overcome identified barriers. 3. Identify specific *factors associated with successful PSM implementation* outcomes and *quantify changes in anticoagulation therapy outcomes* such as INR control, bleeding, and thromboembolism associated with PSM implementation.

Design, implementation, dissemination and spread, and evaluation of interventions to improve patient safety.

9

9

Opportunities for AHRQ-funding: Sample active projects

Grantee	Title	Aims
Farag R18 HS 029292 University of Iowa	Assuring Medication Safety in K-12 Schools: Implementing and Evaluating the Electronic School Medication Administration Record (E-SMAR) System	1. Implement and evaluate the usability of eSMAR in a select sample of K-12 schools in the Iowa City Community School District. 2. Understand contextual factors influencing eSMAR implementation. 3. Evaluate the effectiveness of eSMAR (number of errors intercepted).

Design, implementation, dissemination and spread, and evaluation of interventions to improve patient safety.

10

10

Opportunities for AHRQ-funding: Sample active projects

Grantee	Title	Aims
Chui R18 HS 029608 The Board of Regents of the University of Wisconsin System	Engineering Resilient Community Pharmacies (ENRICH) **Patient Safety Learning Lab**	1. Identify and define community pharmacy work system design requirements for safe medication practices to enable resilient performance. 2. Design and develop MedSafeMap, a feasible and sustainable solution that facilitate safe medication practices through resilient performance. 3. Implement MedSafeMap in community pharmacies and pilot test its impact on pharmacy staff attitudes, behaviors, and performance. Refine solutions and identify challenges to adoption. Assess resilience-focused attitudes, behaviors, and performance to support chronic chare management (CCM).

Design, implementation, dissemination and spread, and evaluation of interventions to improve patient safety. Establishment of strategies to sustain patient safety improvements such as culture, incident/event reporting, measurement, monitoring, and surveillance.

11

11

Opportunities for AHRQ-funding: Sample active projects

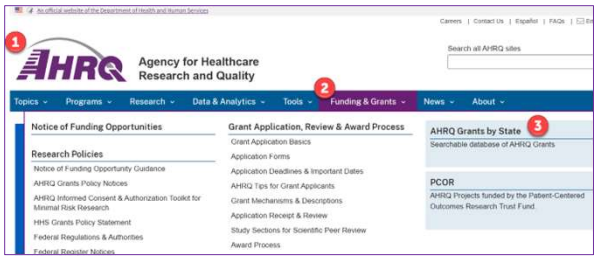
Grantee	Title	Aims
Lester R18 HS 028786 Regents of the University of Michigan	Preventing medication errors due to unsafe electronic prescription transactions with just-in-time feedback	1. Refine the design of SAVE-Rx to resolve unsafe e-prescription transactions. 2. Evaluate the implementation of SAVE-Rx for resolving unsafe e-prescription transactions. 3. Determine the effects of SAVE-Rx on medication safety outcomes. *System Approach to Verifying E-Prescriptions (SAVE-Rx): algorithm uses e-prescription transaction data to automatically identify when drug product description does not match e-prescription NDC or NDC dispensed

Design, implementation, dissemination and spread, and evaluation of interventions to improve patient safety

12

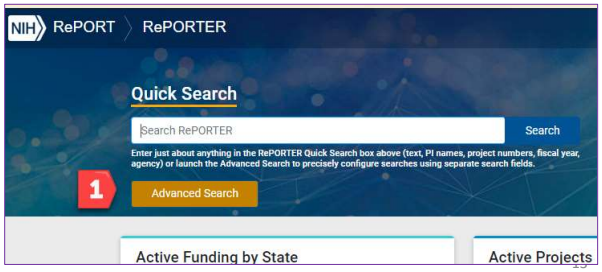
12

Opportunities for AHRQ-funding: Where to find examples



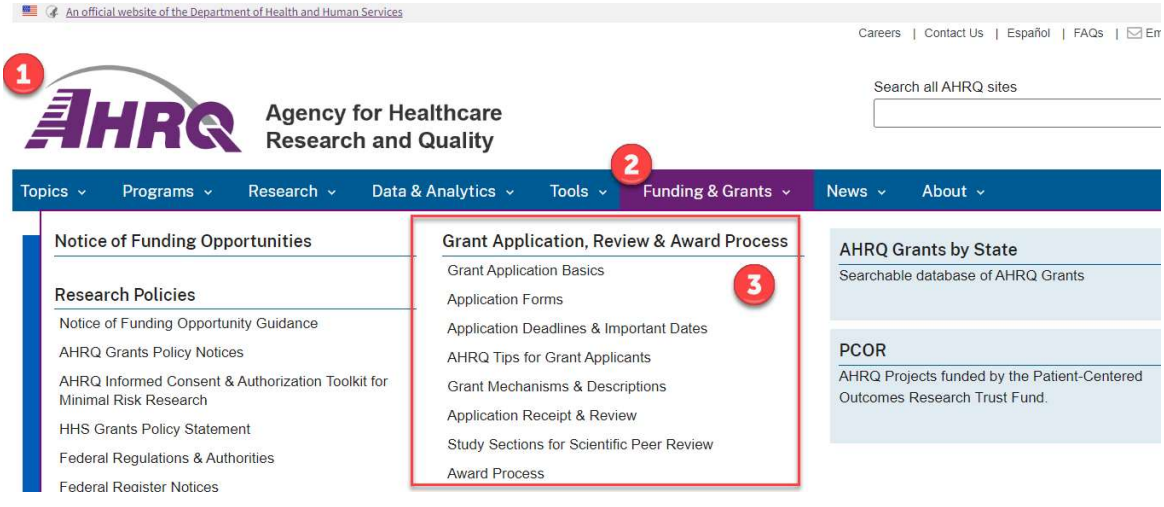
- Searchable database on AHRQ website
- Read abstracts to medication safety related projects

- NIH Reporter – use advanced search to identify medication safety research projects across agencies
- Filter for AHRQ, Investigators, Program Officers, and more!



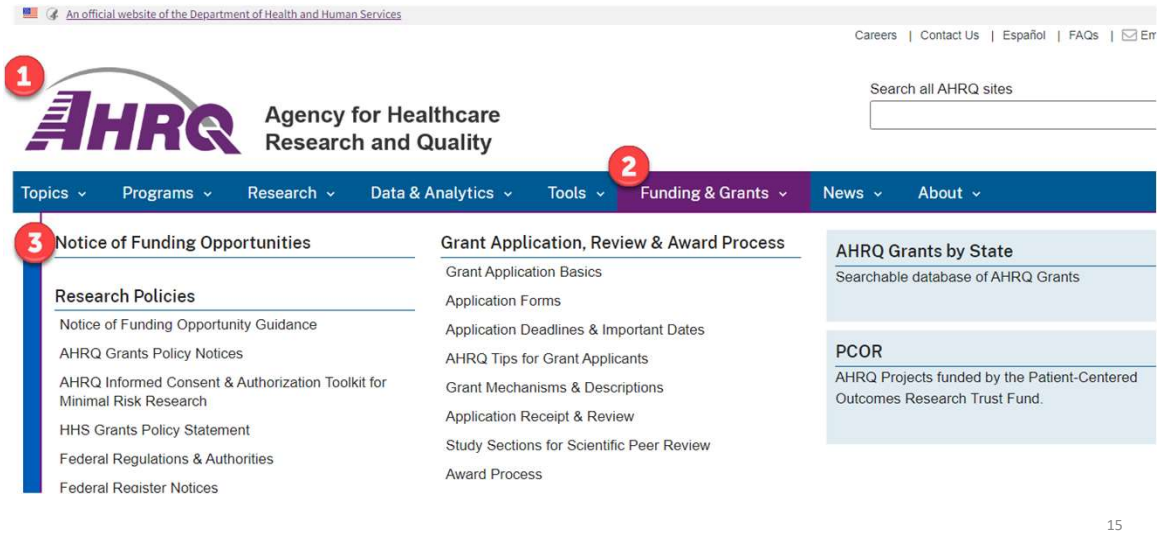
13

Opportunities for AHRQ-funding: Understanding the application process



14

Opportunities for AHRQ-funding: Program Announcements



15

Opportunities for AHRQ-funding: Selected Notice of Funding Opportunities (NoFOs)

Program Announcements: https://www.ahrq.gov/funding/fund-opps/index.html	
R18	PA 24-156: Health Services Research Demonstration and Dissemination Grants PA 23-290: Improving Diagnostic Safety in Ambulatory Care: Strategies and Interventions PA 22-048: Large Health Services Research Demonstration and Dissemination Projects for Combating Antibiotic-Resistant Bacteria (CARB) PA 21-267: Making Health Care Safer in Ambulatory Care Settings and Long-term Care Facilities PA 21-264: Large Health Services Research Demonstration and Dissemination Projects for Prevention of Healthcare-Associated Infections
R01	PA 24-154: Health Services Research Projects PA 24-093: Systems-Based Approaches to Improve Patient Safety by Improving Healthcare Worker Safety and Well-Being (Clinical Trial Optional) PA 23-291: Understanding and Improving Diagnostic Safety in Ambulatory Care: Incidence and Contributing Factors PA 22-047: Large Research Projects for Combating Antibiotic-Resistant Bacteria (CARB) PA 21-265: Large Research Projects for Prevention of Healthcare-Associated Infections
R03	PA 24-155: Small Health Services Research Grant Program
R13	PA 22-238: Conference Grant Programs
R21/R33	PA 21-164: Using Innovative Digital Healthcare Solutions to Improve Quality at the Point of Care (Clinical Trial Optional)

16

THANK YOU!

Thoughts?

Reach out!
Farzana.Samad@ahrq.hhs.gov

17

Simulation Medications
The Risk is "Real"

Mara Weber PharmD, BSRT
OhioHealth System, Doctors Hospital
Medication Safety Pharmacist

18

BELIEVE IN *WE*™ OhioHealth

18

OhioHealth System

Not-for-profit system of hospitals and healthcare providers based in Ohio area.

- 15 hospitals, 200+ ambulatory sites, hospice, and other health services
- Spanning 47 Ohio counties

Doctors Hospital

- 213 bed, teaching hospital
- Large Osteopathic Medicine Program

19

BELIEVE IN WE™ OhioHealth

19

Situation/Background

Healthcare simulation experiences use various types of medications and supplies.

20

BELIEVE IN WE™ OhioHealth

20

Assessment

- **Disparate simulation practices:**
  - Simulation Lab Run vs Staff Educator
  - Isolated or In-Situ (on units)
  - Expired items
  - “Demo” Items
  - Self Made Items
  - Empty Boxes

21

Assessment

- **Each of the scenarios can present different risks:**
- **These items can look realistic (actually distilled water)**
- **Expired/Deteriorated**
- **Empty boxes/vials**

- Reports from FDA & ISMP have shown these can make it into normal supply and have caused deaths

22

Assessment

From the Foundation for Safe Healthcare Simulation: 2015 Demonstration/Simulated Sodium Chloride

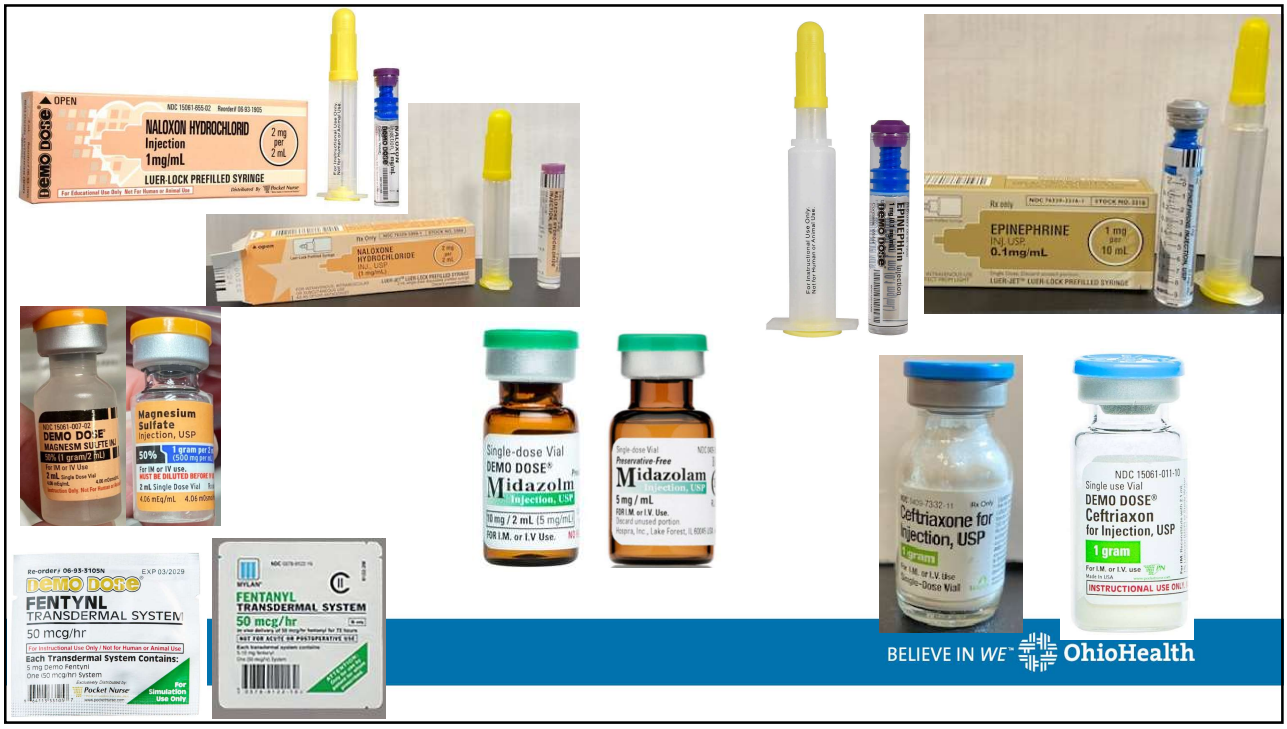
"The FDA report estimates 45 patients received this fluid intravenously, 2 became septic, requiring ICU admission. Within all the documented incidents, 2 patients died, though the direct link to the fluid administration has not been confirmed. The FDA sent out a safety alert and continues monitoring"

23

24

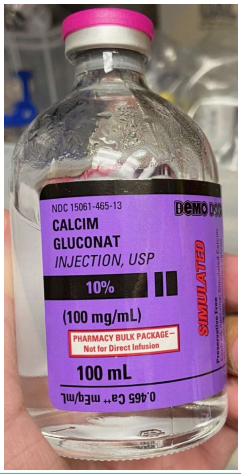
MSOS Member Briefing
March 2024

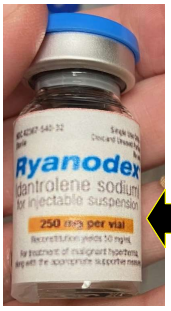
25



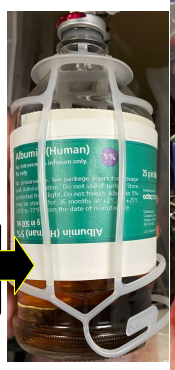
26

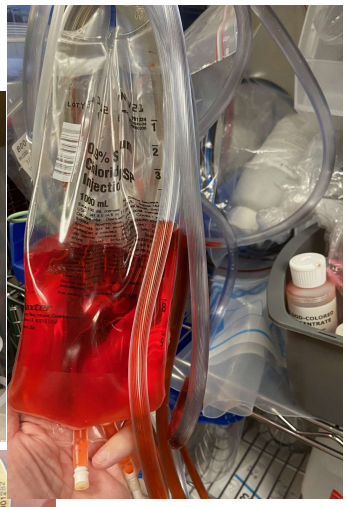
Examples:





Self Simulated





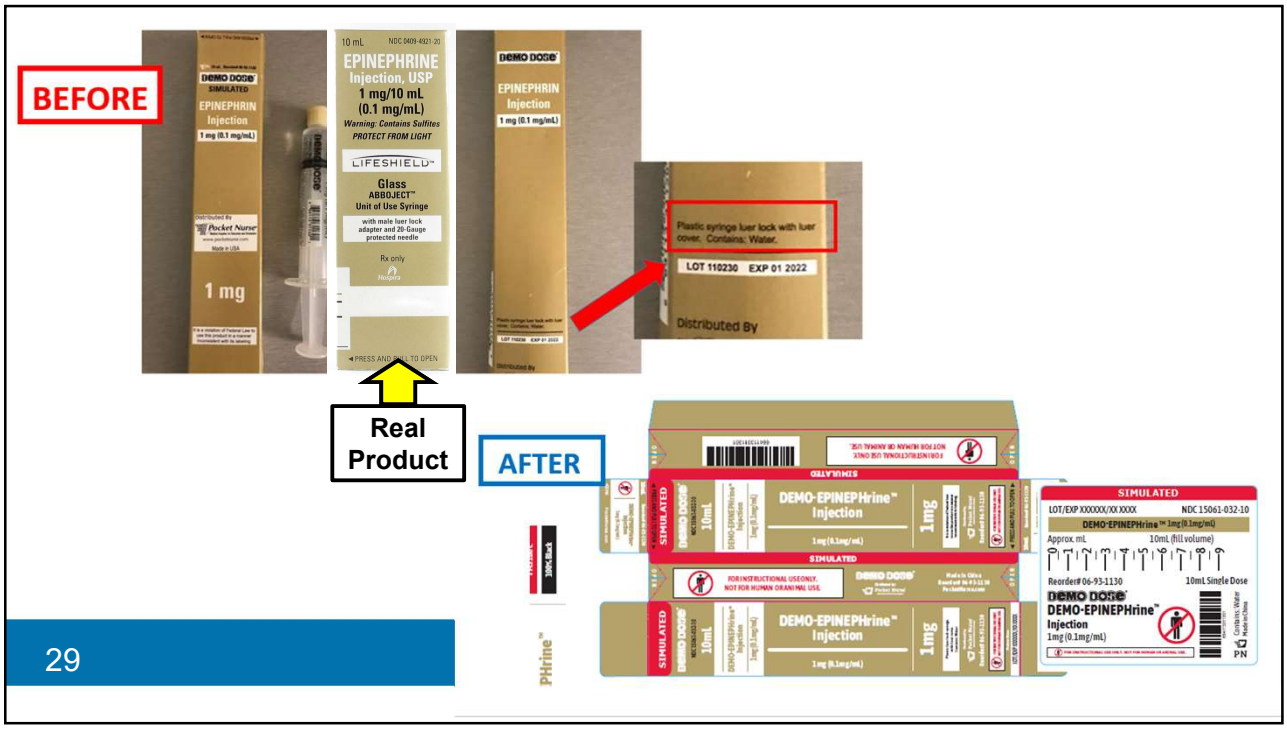
27

Partnering for Safety

A Story of Success

28

MSOS Member Briefing
March 2024

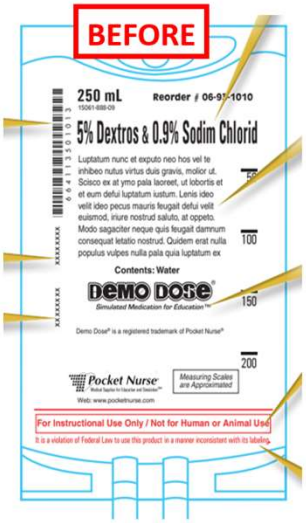


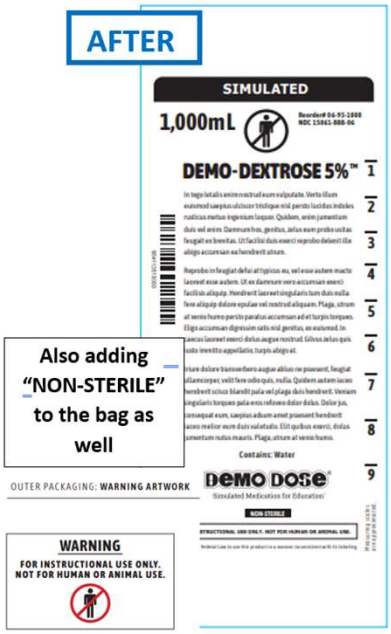
29

29

- **All shipping to have tape with "Not for human use"**
- **New terms & conditions with safety call outs**
- **Safe Simulation Information Center on website**

Safety Partner Pocket Nurse/DemoDose®!





Also adding "NON-STERILE" to the bag as well

30

30

Recommendation

- **Foundation for Healthcare Simulation Safety:** https://healthcaresimulationsafety.org/
  - First to have a **standardized approach for all simulations/simulation labs** there should not be separate processes, policies & purchasing.
  - Purchasing should **block the simulation companies from being able to be ordered in accidentally** (this is how some of the medications that have made it to patients have occurred)
  - For **ALL simulations**: A list of all items/medications that were used should be recorded during the simulation.
    - At end of event, all items/medications reconciled to assure all items used have been collected, inventoried and disposed of as needed.
    - **Implement Time Outs**

31 BELIEVE IN WE OhioHealth

31

Recommendation

- **In-Situ Simulations (i.e. on the units):**
  - -Best practice is to use real IN-DATE medications, Do not use simulated medications in these scenarios
  - -Educate staff not to fill real syringes or vials with tap water or other realistic looking solutions
- **Lab based in the hospital**:
  - - All items (real or simulated), should be clearly inventoried and labeled "Not for Human Use"
  - - Staff should be clearly educated supplies/medications used are not real/expired
  - - No items should leave the lab and could cause harm if used
- **Lab not based in the hospital:**
  - - Great environment for simulated medications
  - - Robust education that these medications are NOT real and contain only tap water
  - - No items should leave the lab and could cause harm if used

Statement for all Simulations:

"The supplies and medications in this simulation are not real, could be expired and need to be returned at the end of the event to the leader. These items could cause harm if used in real practice"

32 BELIEVE IN WE OhioHealth

32

Recommendation

Label ALL medications and supplies for simulation:

33

BELIEVE IN WE™ OhioHealth

33

BELIEVE IN WE™ OhioHealth

34

34

Patient-Centered Outpatient Pharmacy Prescription Labels

Mariam Gawdat, PharmD, MS

FDA/ISMP Safe Medication Management Fellow

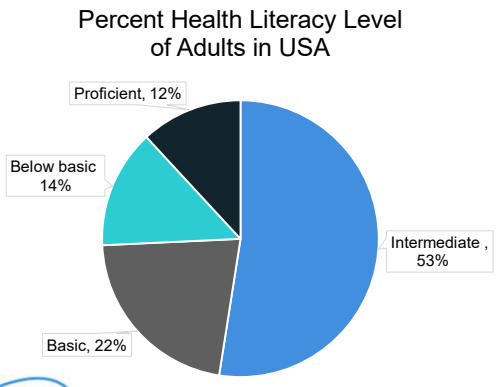
Institute for Safe Medication Practices (ISMP)
FDA Division of Medication Error Prevention & Analysis (DMEPA)

mgawdat@ismp.org; Mariam.Gawdat@FDA.HHS.edu

35

How well do patients understand label instructions?

- **National Assessment of Adult Literacy (NAAL), 2006**



- Per USP <17>, 2021
  - **46% of patients misunderstood one or more dosage instructions**
  - **Even patients with adequate literacy often misunderstand common prescription directions and auxiliary labels**
- ISMP medication error reports due to misunderstanding of pharmacy labels

US Department of Education National Center for Education Statistics, 2006. USP<17>, 2021.

36

Errors Reported to ISMP

Confusion between number of dosage units and the dosage strength

- ***Lactulose 10 g/15 mL oral solution***
  - "Take **30mL (20 g total)** by mouth 2 (two) times a day for 30 days"
- ***PrednisoLONE 15 mg/5 mL (3 mg/mL) oral solution***
  - "Take **13.3 mL (40 mg total)** by mouth daily for 10 days"
- ***Sildenafil 10 mg/mL for oral suspension***
  - Discharge paperwork: "Give **0.25 mL (2.5 mg)** by mouth every 8 hours"
  - Pharmacy label: "Give **0.25 mL** by mouth every 8 hours"
  - Accompanying manufacturer syringe dose markings: 0.5 and 2 mL
  - 7-year-old patient given **2.5 mL** every 8 hours

Sildenafil co-packaged syringe

ISMP An ECRI Affiliate

ISMP MERP, 2024.

 37

37

Errors Reported to ISMP

Confusion about injection dose units versus entire pen/syringe

- ***Kineret 100 mg/0.67 mL syringe***
  - Prescription:
    "Inject 0.102 mL (15.2239 mg) into the skin daily"
  - Pharmacy label:
    "Inject **15 mg** subcutaneously once daily"
  - Caregiver injected entire syringe for 1 year old child

ISMP An ECRI Affiliate

ISMP MERP, 2023.

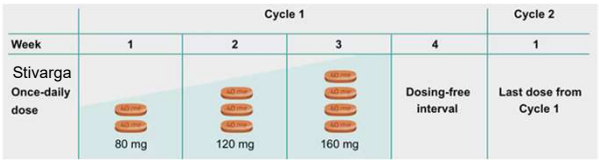
 38

38

Errors Reported to ISMP

Confusion about unique frequencies/tapering instructions

- ***Methotrexate daily instead of weekly***
  - Pharmacy label: "3 tablets every morning and 2 tablets in the evening one day a week"
    - Patient took 3 tablets every single morning and 2 tablets one evening a week.
  - Pharmacy label: "3 tablets of 2.5 mg twice daily on Thursdays"
    - Patient took 3 tablets twice daily every day
- ***PrediniSONE taper confusions***
- ***Antineoplastic regorafenib (Stivarga)***
  - Weekly tapering instructions with 1 week off *(off-label reduced initial dosing)*
  - Dispensed an unbreakable #28 count bottle
  - Patient took extra tablets on week off



ISMP MERP, 2023.

39

Errors Reported to ISMP

Wrong route error

- ***Albuterol nebulized solution***
  - Patient drank solution instead of using a nebulizer machine
    - Nebulizer machine not prescribed/not covered
    - Incomplete patient counseling; non-English speaker

ISMP MERP, 2023.

40

Pharmacy Prescription Label Standards

- Lack of universal standards for pharmacy labeling is a root cause of:
  - **Patient misunderstanding**
  - **Nonadherence**
  - **Medication errors**
- Individual Boards of Pharmacy regulations and NABP guidance on label directions are mostly generalized
- Recent guidance:
  - **USP General Chapter <17> Prescription Container Labeling (2021)**
  - **ISMP Principles for Creating Patient-Centered Outpatient Pharmacy Prescription Labels (forthcoming 2024)**

ISMP An ECRI Affiliate

USP <17>, 2021.

41

ISMP DRAFT GUIDANCE (Forthcoming 2024)

Principles for Creating Patient-Centered Outpatient Pharmacy Prescription Labels

⇒ Scope: Prescription Label Instructions

Should NOT replace pharmacist-provided patient education

Should NOT restrict professional and/or clinical judgment

ISMP An ECRI Affiliate

42

Necessary Information on Label Instructions

- Number of dosage units
- Dosage form
- Route of administration
  - **Indicate when a separate device is needed** ***(e.g., with a spacer, with a nebulizer machine)***
- Dosing frequency
- Indication (unless the patient refuses)
- Duration of use (as applicable)

ISMP An ECRI Affiliate

USP <17>, 2021. Yin HS, et al. Pediatrics, 2021;148(6):e2021054666. Oh YB, et al. J of Pharm Prac and Re. 2022;52(6):427-437.

43

Language

- Explicit, clear, simple, concise wording
- Active verbs
- Route of administration in patient-friendly terms
- Sentence case structure
- Avoid ambiguous instructions
- Avoid error-prone abbreviations, symbols, and dose designations

ISMP An ECRI Affiliate

USP <17>, 2021. Yin HS, et al. Pediatrics, 2021;148(6):e2021054666. Oh YB, et al. J of Pharm Prac and Re. 2022;52(6):427-437. IOM, *Standardizing medication labels*; the National Academies Press; 2008. NABP, Report of the Task Force on Uniform Prescription Labeling Requirement; 2008.

44

Dosage Expression

- Use digits instead of words, except for portions of tablets

Recommended	Not Recommended
– "Take 2 tablets by mouth in the morning and 2 tablets in the evening"	– Take two tablets by mouth twice daily
– "Take half a tablet in the evening" – "Take one and a half tablet in the evening"	– "Take ½ tablet in the evening" – "Take 1.5 tablet in the evening"

- Decimals for portions of liquid
  - **Use leading zeros (e.g., 0.5 mL, never .5 mL)**
  - **Do not use trailing zeros (e.g., 5 mL, never 5.0 mL)**
- Clearly separate the number of dosage units from administration times

ISMP An ECRI Affiliate

USP <17>, 2021. Yin HS, et al. Pediatrics, 2021;148(6):e2021054666. IOM, *Standardizing medication labels*; the National Academies Press; 2008. Tan YW, et al. Explor Res Clin Soc Pharm; 2021;4:100087. Bailey SC, et al. BMJ Open; 2014;4(1):e003699. ISMP List of Error-Prone Abbreviations, , Symbols, and Dose Designations; 2021.

45

Unit of Measure

- Use metric units (e.g., mL) for oral liquids

- Express instructions with number of dosage units
  - **As used by the patient to measure and/or administer the dose**
  - **Match the dose marking(s) on the drug device/measuring device**

- Do not combine
  - **Dosage strength and number of units**
  - **Multiple units of measure**

Recommended	Not Recommended
– "Take 4 mL …"	– Take 2 mg (4 mL)…"
– "Take 2 tablets …"	– "Take 2 tablets (4 mg) …"

ISMP An ECRI Affiliate

ISMP Targeted Medication Safety Best Practices for Community Pharmacy; 2023. *ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations*; 2021. Yin HS, et al. Pediatrics; 2021;148(6):e2021054666.

46

Time Periods and Frequency

- Use the Universal Medication Schedule (UMS) with the specific standardized time periods (i.e., morning, noon, evening, bedtime)

- Avoid
  - **Times per day (e.g., twice a day)**
  - **Hourly (e.g., every 12 hours)**
  - **Precise hour of the day (e.g., 8 AM)**

Recommended	Not Recommended
– "Take 1 tablet by mouth in the morning and 1 tablet at bedtime"	– Take 1 tablet by mouth twice daily" – Take 1 tablet by mouth every 12 hours" – Take 1 tablet by mouth at 8 AM and 8 PM"

- May add mealtime anchors (e.g., with lunch, at dinner) as applicable

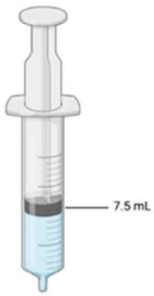
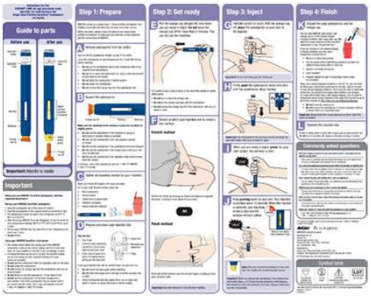
ISMP An ECRI Affiliate

IOM, *Standardizing medication labels*; the National Academies Press; 2008. Tan YW, et al. *Explor Res Clin Soc Pharm*; 2021;4:100087. California BOP. Lawbook for Pharmacy. 2024. Sharko M, et al. *Patient Educ Couns*. 2022;105(7):1888-1903.

47

Consider Supplemental Resources

- Visualization tools

Dose Measurement	Dosing Schedule	Injection Administration Technique
Take 7.5 mL 	Time Interval Visualization  Compliance Package  Dosing Calendar 	Manufacturer's Instruction For Use 

ISMP An ECRI Affiliate

Sharko M, et al. *Patient Educ Couns*. 2022;105(7):1888-1903.

48

Key Takeaways

- Instructions on prescription labels need to be patient-centric to avoid medication errors.
- Generally, "less is more" when it comes to the language used to describe how patients should take their medications.
- Medication safety leaders should review the current state of medication instructions on discharge instructions and prescriptions, with the goal of standardizing to directions that are less likely to result in an error.
- Medication safety leaders should share these safe practice recommendations with prescribers, outpatient pharmacy staff, as well as practitioners who provide discharge education to patients.

ISMP An ECRI Affiliate

49

Acknowledgement

- **Michael Gaunt, PharmD**
- **Matthew Grissinger, RPh, FISMP, FASCP**
- **Christina Michalek, BS, RPh, FASHP**
- **Jennifer Young, PharmD, BCPS, CSP**

ISMP An ECRI Affiliate

50

Questions?

51

ISMP Update
MSOS Briefing March 2024

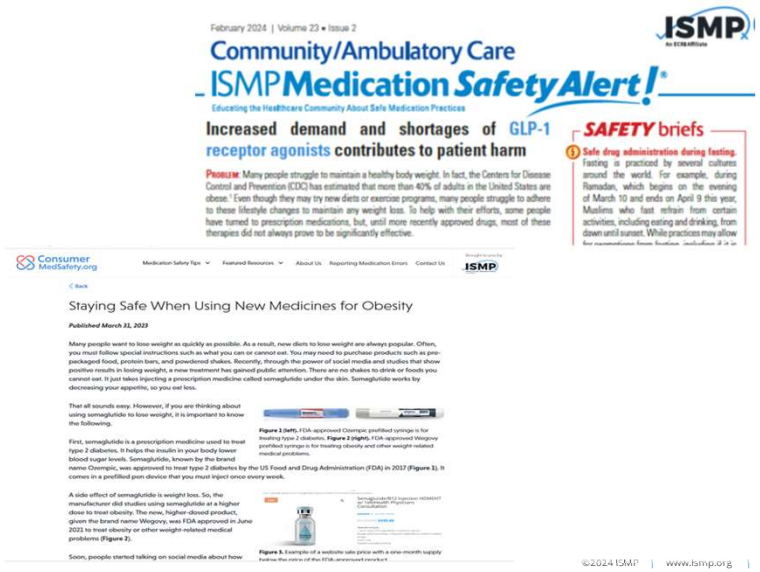
Rita K. Jew, PharmD, MBA, BCPPS, FASHP
President
Institute for Safe Medication Practices

52

Patient Harm from Compounded GLP-1 Agonists

SAFETY briefs

Accidental overdoses and adverse effects from compounded GLP-1 agonists. Glucagon-like peptide-1 (GLP-1) receptor agonists (e.g., **OZEMPIC** [semaglutide], **VICTOZA** [liraglutide]) were originally approved to treat patients with type 2 diabetes by improving glycemic control, along with diet and exercise. They are available primarily in prefilled pen devices. After clinicians and researchers observed that these medications also helped patients lose weight, manufacturers developed specific products (e.g., **WEGOVY** [semaglutide], **SAXENDA** [liraglutide]) indicated for chronic weight management.


February 2024 | Volume 23 • Issue 2

Community/Ambulatory Care

ISMP Medication Safety Alert!

Increased demand and shortages of GLP-1 receptor agonists contributes to patient harm

SAFETY briefs

Safe drug administration during fasting.

Consumer MedSafety.org

Staying Safe When Using New Medicines for Obesity

Published March 31, 2023

53

Top 10 Health Technology Hazards for 2024

- Sterile drug compounding without the use of technological safeguard increases the risk of medication errors (see ***Guidelines for Sterile Compounding and the Safe Use of Sterile Compounding Technology***)
- Infusion pump damage remains a medication safety concern (see ***Guidelines for Optimizing Safe Implementation and Use of Smart Infusion Pumps***)

54

Top 10 Patient Safety Concerns 2024

- Lack of proper escalation process for BCMA scanning failures
- Misuse of parenteral syringes to administer oral liquid medications
- Drug, supply, and equipment shortages continue to compromise patient care

ISMP An ECRI Affiliate

55

BPS New Specialty Request: Medication Safety

- New specialty request to BPS Board
- Role delineation study/Job analysis through a task force
- Call for petition
- Request from MSOS members
  - **SME who could participate in initial role delineation/job analysis task force**

ISMP An ECRI Affiliate

56

Survey on New Best Practices

- Brief survey for baseline measurement of the current level of implementation of the new Best Practices for hospitals
- Deadline: April 19, 2024
- Survey link https://surveys.ismp.org/s3/ISMP-Survey-on-the-Three-NEW-2024-2025-Targeted-Medication-Safety-Best-Practices-for-Hospitals

57

Upcoming Educational Programs

- Webinar on "Leveraging IV Robotics to Optimize Sterile Compounding Practices to Improve Safety"
  - **April 10th, 2024**
- *ISMP 2024: Forward Facing Strategies for the Future of Medication Safety*
  - **June 9th (ASHP Pharmacy Futures)**
- Facilitating *Train the Trainer: Peer Support Workshop for Second Victim Program Implementation*
  - **June 12th (ASHP Pharmacy Futures)**
- Medication Safety Intensive Workshops
  - **May 16 & 17**
  - **Aug 8 & 9**
  - **Oct 3 & 4**
  - **Dec 5 & 6**
- Medication Safety Intensive Workshops for Community & Specialty Pharmacies
  - **Apr 12 & 19**
  - **Sep 20 & 27**

58

Questions?

- A copy of today's slides will be posted on our website.
  - Next MSOS Briefing date – May 23rd, 2024.

MSOS
MEDICATION SAFETY OFFICERS SOCIETY

59