

MSOS Member Briefing- September 2019

MSOS Member Briefings
September 2019


Moderated by: E. Robert Feroli, PharmD, FASHP

Medication
Safety



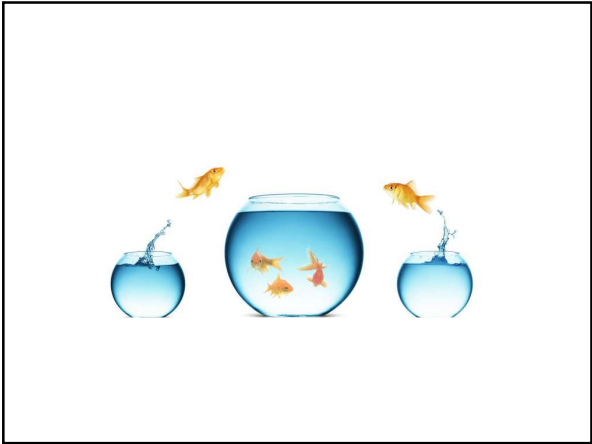


MSOS
MEDICATION SAFETY OFFICERS SOCIETY



Failure Modes in Electronic
Health Records (EHRs) That
May Lead to Medication Errors

Andrew Stivers, PharmD
Manager, Medication Use & Safety
Emory University Hospital Midtown
Atlanta GA



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"Many out-of-the-box EHRs are poorly designed for the delivery of clinical care and often do not include good documentation templates and decision-support tools for specific conditions."

- EGEMS.2014;2(1):1121





Institute for Safe Medication Practices

CHERS ABOUT CONTACT NEWS SUPPORT

Information for consumers

Consulting and Education Tools and Resources Publications and Alerts Error Reporting

GUIDELINES

Guidelines for Safe Electronic Communication of Medication Information

<https://www.ismp.org/resources/guidelines-safe-electronic-communication-medication-information>



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CHERS ABOUT CONTACT NEWS SUPPORT

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GUIDELINES

Guidelines for Safe Electronic Communication of Medication Information



Developed with input from clinicians, standard-setting agencies, professional orgs, EHR/HIT vendors

Recommendations cover inpatient as well as ambulatory/community settings

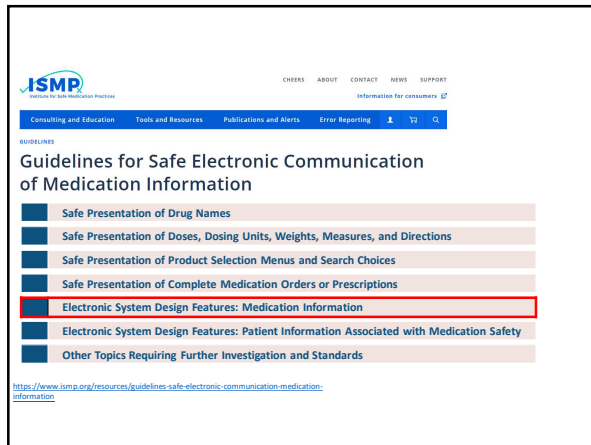
Include commonly utilized safety strategies & goal-driven recommendations

<https://www.ismp.org/resources/guidelines-safe-electronic-communication-medication-information>

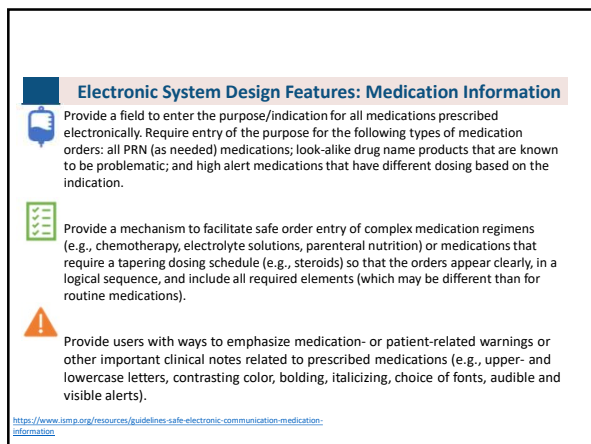
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The screenshot shows the ISMP (Institute for Safe Medication Practices) website. The header includes the ISMP logo and navigation links: CHERS, ABOUT, CONTACT, NEWS, SUPPORT. Below the header is a blue navigation bar with links: Consulting and Education, Tools and Resources, Publications and Alerts, Error Reporting, and a search icon. The main content area is titled "GUIDELINES" and "Guidelines for Safe Electronic Communication of Medication Information". Below this is a list of seven topics, each with a blue square icon: Safe Presentation of Drug Names, Safe Presentation of Doses, Dosing Units, Weights, Measures, and Directions, Safe Presentation of Product Selection Menus and Search Choices, Safe Presentation of Complete Medication Orders or Prescriptions, Electronic System Design Features: Medication Information, Electronic System Design Features: Patient Information Associated with Medication Safety, and Other Topics Requiring Further Investigation and Standards. A URL is provided at the bottom: <https://www.ismp.org/resources/guidelines-safe-electronic-communication-medication-information>.



This screenshot is identical to the one above, but the item "Electronic System Design Features: Medication Information" in the list is highlighted with a red rectangular box.



The screenshot shows a specific guideline titled "Electronic System Design Features: Medication Information". It includes three bullet points, each with an icon: a blue computer icon for the first point, a green checkmark icon for the second, and an orange warning triangle icon for the third. The first point states: "Provide a field to enter the purpose/indication for all medications prescribed electronically. Require entry of the purpose for the following types of medication orders: all PRN (as needed) medications; look-alike drug name products that are known to be problematic; and high alert medications that have different dosing based on the indication." The second point states: "Provide a mechanism to facilitate safe order entry of complex medication regimens (e.g., chemotherapy, electrolyte solutions, parenteral nutrition) or medications that require a tapering dosing schedule (e.g., steroids) so that the orders appear clearly, in a logical sequence, and include all required elements (which may be different than for routine medications)." The third point states: "Provide users with ways to emphasize medication- or patient-related warnings or other important clinical notes related to prescribed medications (e.g., upper- and lowercase letters, contrasting color, bolding, italicizing, choice of fonts, audible and visible alerts)." A URL is provided at the bottom: <https://www.ismp.org/resources/guidelines-safe-electronic-communication-medication-information>.

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Electronic System Design Features: Medication Information



Provide a field to enter the purpose/indication for all medications prescribed electronically. Require entry of the purpose for the following types of medication orders: all PRN (as needed) medications; look-alike drug name products that are known to be problematic; and high alert medications that have different dosing based on the indication.

Electronic System Design Features: Medication Information



Facility List Search - Willow, Adam Uno

Search: Browse (F4) Reference List (F5) Print

☐ Nursing visit ☐ After visit ☒ Medications ☐ Records

Name	Type	Dose	Route	Frequency	Print List
sulfadiazine oral suspension 100 mg/mL	Medication				
sulfadiazine tablet 500 mg	Medication				
sulfamethoxazole-trimethoprim (BACTRIM DS) tablet 800-16	Medication				
sulfamethoxazole-trimethoprim (BACTRIM, SEPTRA) suspen	Medication				
sulfamethoxazole-trimethoprim (BACTRIM, SEPTRA) tablet 4	Medication				
sulfasalazine (AZULFIDINE) suspension 100 mg/mL	Medication				
sulfasalazine (AZULFIDINE) tablet 500 mg	Medication				

Electronic System Design Features: Medication Information



Facility List Search - Willow, Adam Uno

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sulfasalazine (AZULFIDINE) suspension 100 mg/mL	Medication				
sulfasalazine (AZULFIDINE) tablet 500 mg	Medication				

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Electronic System Design Features: Medication Information

Facility List Search - Willow, Adam Uno

Search

Browser (14)

Reference List (75)

OK

Display List

Filter List

Name	Type	Dose	Route	Frequency	Prot List
sulfaDIAZINE oral suspension 100 mg/mL	Medication				
sulfaDIAZINE tablet 500 mg	Medication				
sulfamethoxazole-trimethoprim (BACTRIM DS) tablet 800-16	Medication				
sulfamethoxazole-trimethoprim (BACTRIM, SEPTRA) suspen	Medication				
sulfamethoxazole-trimethoprim (BACTRIM, SEPTRA) tablet 4	Medication				
sulfaSALAZine (AZULFIDINE) suspension 100 mg/mL	Medication				
sulfaSALAZine (AZULFIDINE) tablet 500 mg	Medication				

Electronic System Design Features: Medication Information

val

Order	Cost
valACYclovir (valTREX) Enteral -- (for HSV/VZV Only) Adults - No ID Approval Required Pediatrics - ID Approval Required in JHH Pediatrics	
valGANCiclovir (valCYTE) Enteral -- (for CMV Only) Adults - No ID Approval Required Pediatrics - ID Approval Required in JHH Pediatrics (Exemptions: GPS Transplant protocols)	

Electronic System Design Features: Medication Information

val

Order	Cost
valACYclovir (valTREX) Enteral -- (for HSV/VZV Only)	
valGANCiclovir (valCYTE) Enteral -- (for CMV Only)	

5

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Electronic System Design Features: Medication Information

Details for vancomycin (vancomycin hsp)

Details

Order Comments

Diagnoses

Order details

Dose: 1,000 mg

Route of administration: [I: IVPI]

Drug form: (Injection)

Frequency: (H: Once)

PRN: (No)

Indication

Pharmacy order priority: (Routing)

Requested start date and time: (02/24/2019 09:00)

Expiry date and time: (02/24/2019 09:00)

Infuse over:

Order for future visit

Infuse over:

PowerPlan Med

Med Order ID:

Detail values

Surgical prophylaxis

Bacteremia

Central venous system infection

Endocarditis

Enterobacterial infection

Neutropenic fever

Disseminated

Pneumonia

Sepsis

Soft tissue infection

Urinary tract infection

Other

Order Table

Order For Signature

Electronic System Design Features: Medication Information

Details for vancomycin (vancomycin hsp)

Details

Order Comments

Diagnoses

Order details

Dose: 1,000 mg

Route of administration: [I: IVPI]

Drug form: (Injection)

Frequency: (H: Once)

PRN: (No)

Indication

Pharmacy order priority: (Routing)

Requested start date and time: (02/24/2019 09:00)

Expiry date and time: (02/24/2019 09:00)

Infuse over:

Order for future visit

Infuse over:

PowerPlan Med

Med Order ID:

Detail values

Surgical prophylaxis

Bacteremia

Central venous system infection

Endocarditis

Enterobacterial infection

Neutropenic fever

Disseminated

Pneumonia

Sepsis

Soft tissue infection

Urinary tract infection

Other

Order Table

Order For Signature

Electronic System Design Features: Medication Information

Provide a field to enter the purpose/indication for all medications prescribed electronically. Require entry of the purpose for the following types of medication orders: all PRN (as needed) medications; look-alike drug name products that are known to be problematic; and high alert medications that have different dosing based on the indication.

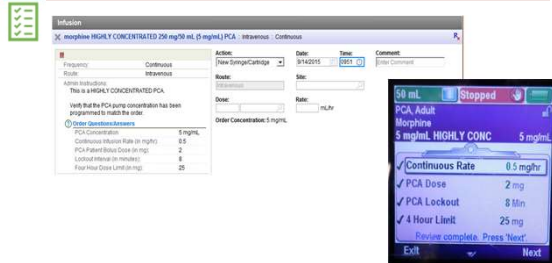
Provide a mechanism to facilitate safe order entry of complex medication regimens (e.g., chemotherapy, electrolyte solutions, parenteral nutrition) or medications that require a tapering dosing schedule (e.g., steroids) so that the orders appear clearly, in a logical sequence, and include all required elements (which may be different than for routine medications).

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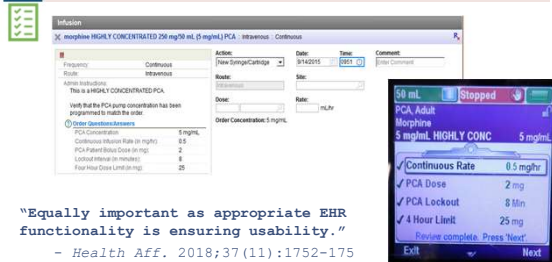
Electronic System Design Features: Medication Information

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Electronic System Design Features: Medication Information



Electronic System Design Features: Medication Information




"Equally important as appropriate EHR functionality is ensuring usability."
- Health Aff. 2018;37(11):1752-175

Electronic System Design Features: Medication Information


- Provide a field to enter the purpose/indication for all medications prescribed electronically. Require entry of the purpose for the following types of medication orders: all PRN (as needed) medications; look-alike drug name products that are known to be problematic; and high alert medications that have different dosing based on the indication.
- Provide a mechanism to facilitate safe order entry of complex medication regimens (e.g., chemotherapy, electrolyte solutions, parenteral nutrition) or medications that require a tapering dosing schedule (e.g., steroids) so that the orders appear clearly, in a logical sequence, and include all required elements (which may be different than for routine medications).
- Provide users with ways to emphasize medication- or patient-related warnings or other important clinical notes related to prescribed medications (e.g., upper- and lowercase letters, contrasting color, bolding, italicizing, choice of fonts, audible and visible alerts).

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Electronic System Design Features: Medication Information

Mouse, Mickey X									
Mouse, Mickey	CIN: 1234567890123	Admit Date: 6/21/2018	Weight (kg): 75kg	Isolation Name	G6PD: 34 mg/min	Allergies: No known	Prescription		
52 y.o. Male / 12/18/1918	Unit/Room: 4 ONC-4272	Admit Prior: Med1	Ideal WT: 73.1	Research: None					
URN: 8075309	Bed: 4272-G1	Hgt: 72" (1.829 m)	Weight Source: Actual	Pt. Class: Inpatient	Last BSA: None	Lab and Sys: None			



Electronic System Design Features: Medication Information

Mouse, Mickey X									
Mouse, Mickey	CIN: 1234567890123	Admit Date: 6/21/2018	Weight (kg): 75kg	Isolation Name	CYCLOP: 34 mg/min, Rasburicase	Allergies: No known	Prescription		
52 y.o. Male / 12/18/1918	Unit/Room: 4 ONC-4272	Admit Prior: Med1	Ideal WT: 73.1	Research: None					
URN: 8075309	Bed: 4272-G1	Hgt: 72" (1.829 m)	Weight Source: Actual	Pt. Class: Inpatient	Last BSA: None	Lab and Sys: None			



Electronic System Design Features: Medication Information



HIGH RISK MEDICATION ALERT – rasburicase

This patient has either a lab value or a documented condition indicating a G6PD deficiency. Administration of this medication is likely to result in a life-threatening reaction of acute hemolytic anemia. Careful consideration and review of the patient by the attending provider is warranted. If **determined** that the **benefit of administering the medication outweighs the risk**, please call pharmacy for additional information or to enter the order.

Close Alert and Remove Order

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Electronic System Design Features: Medication Information

Don't prescribe refills for starter packs.

HIGH ALERT

An ELIQUIS (apixaban) starter pack was prescribed for a patient who was starting treatment with this drug. The starter pack indicates that two 5 mg tablets (10 mg) continued on page 5—**SAFETY** briefs >



Electronic System Design Features: Medication Information

apixaban (Eliquis Starter Pack for... Prescribe 9/22/2019 19:34 See instructions, PO, q12hr, # 74 tab(s), 2 tabs PO q12hr

Details for apixaban (Eliquis Starter Pack for... Send To: Do Not Send: called to pharmacy (Rx)

Details Order Comments Diagnoses

Dose Route of Adm... Frequency Duration *Dispense Refill

See Instruct... See Instruct... See Instruct... 74 tab(s) 0

PRN: 2 tabs PO q12hr x 7days, then 1 tab PO q12hr

*Special Instructions as directed on package labeling

0 Missing Required Details Dx Table Sign

Electronic System Design Features: Medication Information

apixaban (Eliquis Starter Pack for... Prescribe 9/22/2019 19:34 See instructions, PO, q12hr, # 74 tab(s), 2 tabs PO q12hr

Details for apixaban (Eliquis Starter Pack for... Send To: Do Not Send: called to pharmacy (Rx)

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Dose Route of Adm... Frequency Duration *Dispense Refill

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PRN: 2 tabs PO q12hr x 7days, then 1 tab PO q12hr

*Special Instructions as directed on package labeling

0 Missing Required Details Dx Table Sign

10

Electronic System Design Features: Medication Information

Discern: (1 of 1)

**Xarelto (rivaroxaban) Renewal Alert**

This patient has had a previous prescription for an Xarelto (rivaroxaban) Starter Pack on July 09, 2019 10:19:59 EDT. Do you want to order a new Starter Pack? Refilled Xarelto (rivaroxaban) Starter Packs may increase risk of bleeding and are unnecessary in most cases.

Alert Action:
☐ Cancel Xarelto Starter Pack and select an alternative prescription for continuing therapy
☐ Continue with Xarelto Starter Pack prescription

OK

- EHR safety is reliant not only on functionality but also usability
- ISMPs guidelines provide a framework for risk assessment
- Successes are reliant on strong relationships with informatics team members
- Continued advocacy efforts are needed to push EHR vendors to help embed safety principles in system design

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Medication Error Reduction Plan (MERP): A Framework for Safety Planning

Katayoon Kathy Ghomeshi, PharmD, MBA, BCPS, CPPS
Medication Safety Officer, UCSF Medical Center
Assistant Clinical Professor, UCSF School of Pharmacy

Objectives

- Describe the structure of the medication error reduction plan (MERP) program
- Describe how a MERP approach can be useful to improve medication safety

A Day in the Life

Scenario 1

You have just started a position as a Medication Safety Officer/ Professional. You are responsible for developing a safety program that demonstrates improved safety for your practice site. You have multiple stakeholders that are looking to you to lead safety improvement work across many different patient populations, clinical specialties, phases of care, etc.

Scenario 2

You have been practicing as the Medication Safety Officer at your system/hospital. You would like to develop new ideas for comprehensive safety planning across the continuum of medication-use and engage multiple disciplines in the process.

How do you accomplish this goal?

Consider using the [California MERP framework](#)

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Pop Quiz!

What is MERP?

- A. A noise my stomach makes after lunch? Only sometimes ☺
- B. Medication Error Reporting and Prevention? NCC
- C. Medication Error Reporting Program? ISMP
- D. Medication Error Reduction Plan? CDPH

YES! All of the above

NCC= National Coordinating Council for Medication Error Reporting and Prevention
ISMP= Institute for Safe Medication Practices
CDPH= California Department of Public Health

NCC MERP



Medication Error

- Any **preventable** event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.
- May be related to professional practice, health care products, procedures, and systems
- Errors may be in prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

<https://www.nccmerp.org/about-medication-errors>

California Regulatory Requirement

As a condition of licensure... every general acute care hospital... shall adopt a formal plan to eliminate or substantially reduce medication-related errors

- "medication-related error" means any **preventable** medication-related event that adversely affects a patient

MEDICATION-USE SYSTEMS AND PROCEDURES

Prescribing	Order Communication	Packaging & Nomenclature
Product Labeling	Compounding	Dispensing
Distribution	Administration	Monitoring
Education	Use	

<https://codes.fndaw.com/ca/health-and-safety/codes/hsc-sect-1339-63.html>

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If you're not in CA- choose your own

- Procurement
- Storage
- Prescribing
- Order review
- Preparing/Compounding
- Administering
- Monitoring



MERP Program Requirements

Include method to identify weaknesses in each system

Annual review of effectiveness

Modify to achieve reduction in errors

Describe technology to reduce errors

Proactively identify errors

Include multiple disciplines to analyze errors

Incorporate external error alerts

Sources of error

Internal

- Incident Reports
- Medication safety dashboards
- Quality Improvement Initiatives
- Medication-use evaluations

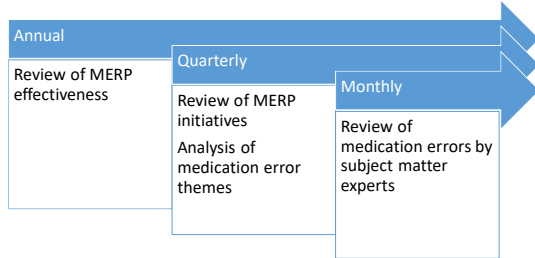
External

- NAN Alert
- TJC Sentinel Event Alert
- AHRQ Web M&M
- ISMP Acute Care Alert!
- ISMP Self-Assessments
- ISMP Best Practices

<https://www.oocmerp.org/nan-alert-archives>
https://www.jointcommission.org/sentinel_event.aspx
<https://www.ahrq.gov/mrms>
<https://www.ismp.org>

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Potential Timelines



Metrics

- What is the problem
- What is baseline (current state)
- What is goal (desired future state)
- Tactics
- Tools to consider: A3 problem solving, PDSA, DMAIC, SBAR, Spreadsheets, Word Documents



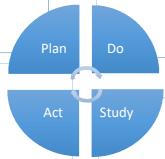
Sample Initiatives and Tools

Process	Weakness/Deficiency	Baseline Metric	Goal	Current Metric	Project Owner	Follow up
Compounding	IV compounding errors due to poor compliance with IV workflow software	37% compliance	95%	62%	Bob	Obtain new equipment for IV room; develop and implement required training material for staff; share medication error that would have been prevented

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Sample Initiatives and Tools

Administering: Post hemodialysis (HD) missed doses of antibiotic. Baseline metric- 47% of HD patients receive post HD dose. Goal 98%



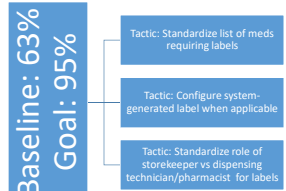
- Evaluate if med was appropriately ordered
- Evaluate when med is ordered and not given
- Medication use evaluation findings:
 - Antibiotic ordered 56% for post HD
 - RN administered 76% of time when ordered
- Providers are unaware that antibiotic is cleared by HD and there is need to re-dose
- Unclear roles for whether dose should be given by HD RN or floor RN
- Develop orderset/BPA to trigger when dose needs to be ordered
- Provide in-service on renal and HD cleared meds
- Utilize pharmacist clinical review for HD or renal patients to monitor drug therapy.
- Develop standard workflow for administering post-HD meds

BPA= Best Practice Advisory

Sample Initiatives and Tools

Product labeling:
Inconsistent practices for affixing auxiliary labels has led to med errors (eg, refrigerate sticker missing led to room temp storage, missing high alert sticker, incorrect route for the eye vs for the ear)
Metric Owner: Pharmacy Operations Manager


Baseline: 63% Goal: 95%



- Tactic: Standardize list of meds requiring labels
- Tactic: Configure system-generated label when applicable
- Tactic: Standardize role of storekeeper vs dispensing technician/pharmacist for labels

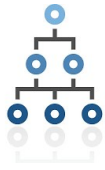
MERP Modifications

- Iterative process
- Individual project timelines may vary
- Goals may be updated



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Organizational Chart



Who can oversee this work?

- Medication Safety Committee, MERP Committee, Quality Improvement Committee, Patient Safety Committee

- Interdisciplinary- MD, RPh, RN, Administrator

- Site specific vs system level

A Few MERP Pearls

Pro/Benefit
<ul style="list-style-type: none">• Supports a culture of safety• Forces addressing many, and less obvious steps that might not get attention otherwise• Increases visibility of system issues and gains support for improvement• Not prescriptive in what you do or how you do it• Demonstrates reduction in errors/improvement in safety• Breaks up "status quo" mentality- your responsibility is to actively and continually seek weaknesses and deficiencies

Con/Challenge
<ul style="list-style-type: none">• Setting goals can be a guessing game and not all projects are metric-based• Obtaining reliable data can be onerous• Project management for multiple longitudinal initiatives requires resources and support• Some categories overlap or are not well-defined• Sometimes the weakness does not improve

In Conclusion

- MERP is a California regulatory requirement that can serve as a good model for organizing comprehensive proactive safety improvement initiatives
- MERP model looks at all steps of medication use with a multidisciplinary lens
- MERP focuses on demonstrating reduction in medication errors with metric based initiatives



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Questions?

Katayoon Kathy Ghomeshi, PharmD, MBA, BCPS, CPPS
Medication Safety Officer, UCSF Medical Center
Assistant Clinical Professor, UCSF School of Pharmacy



Michael R. Cohen, RPh, MS, ScD (hon.), DPS (hon), FASHP
President, ISMP




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Matthew Grissinger, RPh, FISMP, FASCP
Director, Error Reporting Programs
Institute for Safe Medication Practices
Chair, NCC MERP


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NCCMERP
National Coordinating Council for
Medication Error Reporting and Prevention

- **Vision**
 - No patient will be harmed by a medication error.
- **Mission**
 - To maximize the safe use of medications and to increase awareness of medication errors through open communication, increased reporting and promotion of medication error prevention strategies.



NCCMERP
National Coordinating Council for
Medication Error Reporting and Prevention

Goals

- Stimulate the development and use of reporting and evaluation systems by individual health care organizations
- Stimulate reporting to a national system for review, analysis, and development of recommendations to reduce and ultimately prevent medication errors
- Examine and evaluate the causes of medication errors
- Increase awareness of medication errors and methods of prevention throughout the health care system
- Recommend strategies for system modifications, practice standards and guidelines, and changes in packaging and labeling.

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Member Organizations

- AARP
- ACCP
- AGS
- AMA
- ANA
- APhA
- ASHRM
- ASCP
- ASHP
- BeMedWise
- DOD
- DVA
- FDA
- IHI
- ISMP
- JC
- MSOS
- NASPA
- NABP
- NCSBN
- PhRMA
- SGM
- USP



About Medication Errors

What is a Medication Error?

The Council defines a "medication error" as follows:

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use."

The Council urges medication errors researchers, software developers, and institutions to use this standard definition to identify errors.

1 NNN ALERT

The National Alert Network (NAN) publishes the alerts from the National Medication Errors Reporting Program (NMERP). NAN encourages the sharing and reporting of medication errors, so that lessons learned can be used to increase the safety of the medication use system.

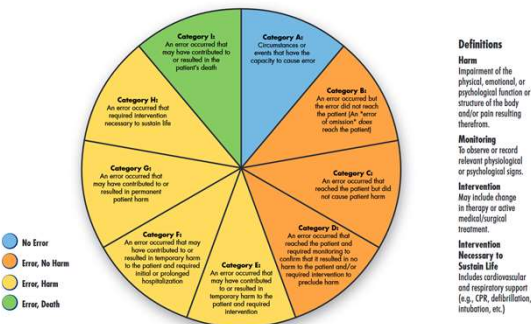
May 24, 2018
Safe handling of concentrated electrolyte products from outsourcing facilities during critical drug shortages

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POPULAR LINKS


[Definition](#)

NCC MERP Index for Categorizing Medication Errors



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NCC MERP
National Coordinating Council for
Medication Error Reporting and Prevention

Questions About NCC MERP and Medication Errors
Shawn C. Becker, M.S., B.S.N.,
Director Healthcare Quality Standards, Science and Standards Division
scb@unp.org / (301) 816-8218 tel / (301) 816-8532 fax

Contemporary View of Medication-Related Harm. A New Paradigm

Introduction

The NCC MERP has frequently been asked to help healthcare professionals distinguish among Adverse Drug Events (ADEs), Adverse Drug Reactions (ADRs) and Medication Errors. The Council notes several definitions for these terms in the literature, research reports, and by various organizations. The terms ADE and ADR have been used when patient harm has occurred as a result of a drug (see definitions). To further clarify, an ADR has been defined as harm that results from a medication dose that is "normally used in man." An ADE has been defined as harm associated with any dose of a drug, whether the dose is "normally used in man" or not. An ADR, therefore, is a subtype of an ADE (i.e., all ADRs are ADEs, but not vice versa). By definition, all ADEs are associated with patient harm, but not all ADEs are caused by an error. Significant confusion exists regarding these terms.


The Council proposes new terminology to clarify the terms and the relationships among them and encourages consistent adoption across the medication safety community (see Figure 1 for a graphical depiction with no intended meaning to size of circles):

Scenario/Case Studies

Medication error resulting in no harm
Case 1. A 35 kg child with no prior history of penicillin allergy, was prescribed 350 mg orally of amoxicillin suspension twice daily (morning and evening) for 7 days. On the seventh day, the child inadvertently received a morning dose of 500 mg instead of 250 mg. The child did not suffer any negative consequences from the error.

A preventable ADE (medication-related harm due to error)
Case 2. A 74 year old female with acute leg pain presented to the emergency department. She has a history of sleep apnea. She has no previous history of opioid use. Prescriber ordered hydromorphone 2 mg IV. Patient found unresponsive in respiratory distress with Sp O₂ at 70. Naloxone administered.

A Non-preventable ADE (medication-related harm not due to error)
Case 3. A 37 year old patient diagnosed with an infection for which amoxicillin and clavulanate potassium is a clinically reasonable choice. Patient has used amoxicillin and other antibiotics in



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Medication Error Reporting and Prevention

CONTACT US | SITE MAP

ABOUT MEDICATION ERRORS | RECOMMENDATIONS | STATEMENTS FOR CONSUMERS | FEBRUARY 20, 2018 | PHOTOS | RESOURCES | SEPTEMBER 27, 2019

Recommendations / Statements

STATEMENTS	Adopted	Revised / Reviewed
Statement Advocating for the Elimination of Prescription Time Guarantees in Community Pharmacy	Oct 31, 2013	
Statement Opposing the Criminalization of Errors in Healthcare	May 1, 2011	Jan 19, 2012
Statement on Medication Error Rates	Jun 11, 2002	Jun 24, 2008

RECOMMENDATIONS	Adopted	Revised / Reviewed
Medication / Human Errors		
Recommendations to Weigh Patients and Document Metric Weights to Ensure Accurate Medication Dosing (adopted October 25, 2018)	Oct 25, 2018	
Reducing Medication Errors Associated with At-risk Behaviors by Healthcare Professionals	Oct 22, 2013	Aug 30, 2014

MAN ALERT

The National Alert Network (NAN) publishes the alerts from the National Medication Errors Reporting Program. NAN encourages the sharing and reporting of medication errors, so that lessons learned can be used to increase the safety of the medication use system.

May 24, 2018
Safe handling of concentrated electrolyte products from outsourcing facilities during critical drug shortages

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NCC MERP Recommendations

- Recommendations to Weigh Patients and Document Metric Weights (2018)
- Reducing Medication Errors Associated with At-risk Behaviors by Healthcare Professionals (2013)
- Recommendations for Avoiding Medication Errors With Drug Samples (2008)
- Promoting the Safe Use of Suffixes in Prescription Drug Names (2007)

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NAN Alert Archive

The National Alert Network (NAN) is a coalition of members of the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP). The Institute for Safe Medication Practices (ISMP) and the American Society of Health-System Pharmacists (ASHP) publish the alerts from the National Medication Errors Reporting Program, operated by ISMP. The alerts are incident driven. The NCC MERP, ISMP and the ASHP encourage the sharing and reporting of medication errors, so that lessons learned can be used to increase the safety of the medication use system.

May 24, 2018	Safe handling of concentrated electrolyte products from outsourcing facilities during critical drug shortages
October 12, 2017	Severe hyperglycemia in patients incorrectly using insulin pens at home
September 15, 2016	Observe for possible fluid leakage when preparing parenteral syringes
June 30, 2015	Move toward full use of metric dosing: Eliminate dosage cups that measure liquids in fluid drams. Use cups that measure mL.
March 23, 2015	Biluxiver and Vazulep potential for mix-ups
February 18, 2014	Potential inaccuracy of electronically transmitted medication history information used for medication reconciliation
June 10, 2013	Important Change with Heparin Labels
April 17, 2013	Confusion regarding the generic name of the HER2-targeted drug

NAN ALERT


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- A copy of today's slides will be posted on our website
- Don't forget to mark you calendar:
 - Our next MSOS Briefings webinar will be held on Thursday, November 21, 2019.
 - **Register now:**
<https://attendee.gotowebinar.com/register/3361605469699521037>



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