ISMP CHEERS AWARDS 20th Anniversary

Celebrating the Heart & Soul of Medication Safety

This month, ISMP is celebrating the 20th anniversary of the CHEERS AWARDS, which recognize extraordinary organizations, groups, and individuals who have gone above and beyond to advance medication and patient safety. This year’s winners were honored during a dinner held at B.B. King’s Blues Club in Orlando, FL, on December 5, 2017. Please join us in congratulating the following CHEERS AWARDS winners, who have created best practices, programs, and resources that are helping to prevent medication errors and are improving the quality of patient care. They truly represent the “heart and soul” of medication safety.

CHEERS AWARDS winners

The Abu Dhabi Pharmacy Conference, a joint collaborative between Abu Dhabi Health Services Company (SEHA) and the Cleveland Clinic Abu Dhabi, developed a unique video called “Ask” that is raising awareness about medication safety in the Middle East. The video, which is based on a true story about a patient who presented to an emergency department after taking methotrexate daily for several days, highlights the importance of patient and family education in preventing medication errors. It also introduces the “5 Questions to Ask about Your Medications” to help patients and caregivers start a conversation with their healthcare providers and become more knowledgeable about their medications. These questions (www.ismp.org/sc?id=3056) were initially developed through another international collaborative effort between ISMP Canada, the Canadian Patient Safety Institute, Patients for Patient Safety Canada, the Canadian Pharmacists Association, and the Canadian Society for Hospital Pharmacists.

This CHEERS AWARD is particularly noteworthy because it brings recognition to an international collaborative effort that has made an impact. The “Ask” video, which has subtitles in English, is freely available on social media and can be viewed at: www.ismp.org/sc?id=3057. A previously produced video, the “Role of Pharmacist and Technology in Medication Safety,” is also available on social media at: www.ismp.org/sc?id=3058. And now, the Cleveland Clinic Abu Dhabi just completed filming, which has subtitles in English, is freely available on social media and can be viewed at: www.ismp.org/sc?id=3058. And now, the Cleveland Clinic Abu Dhabi just completed filming, which has subtitles in English, is freely available on social media and can be viewed at: www.ismp.org/sc?id=3064.

In memory of Dennis Dunn... a frontline pharmacist who helped change the culture of safety

ISMP was very saddened to learn last week about the November 20, 2016, death of Dennis “Denny” Dunn, our friend and colleague. Denny was a pharmacist who was known by health professionals around the world for his appearance in the film, Beyond Blame (www.ismp.org/sc?id=61), which was produced by Bridge Medical around the beginning of the patient safety movement in 1998.

Denny courageously and poignantly recounted the emotional turmoil of being involved in a fatal medication error. For years, his hospital had been using premixed metroNIDAZOLE minibags, which were packaged in an overwrap. Unknown to the pharmacy, anesthesia staff ordered a trial case of mivacurium which had identical packaging. Mivacurium then found its way into the pharmacy’s storage bin. A window on the overwrap was supposed to allow staff to read the label of the drug name on the label could not be seen. According to Denny, “That assured an accident or error was going to happen. The only thing was, who was going to be the unlucky one. And that, by fate, was me.” After mivacurium was dispensed and administered instead of metroNIDAZOLE, four patients arrested. Only two survived. Denny was fired but later found his way back to the same health system, working at a different location.

Through his moving appearance in Beyond Blame, Denny’s story became integrated into the patient safety movement, leading to a better understanding of how human error is a blameless human condition often caused by system failures. Because of the incident, the manufacturer improved the packaging, and no mix-ups between the two drugs were later reported.
The Regenstrief National Center for Medical Device Informatics (REMEDI) Infusion Pump Collaborative has led the way in collecting and sharing data from smart infusion pump drug libraries to improve patient safety. REMEDI (www.ismp.org/sc?id=3060) is a vendor-neutral, evidence-based community of practice that includes pharmacists, nurses, researchers, national organizations, and pump manufacturers focused on smart pump technology and infusion therapy safety. Formed in 2009 by the Regenstrief Center for Healthcare Engineering, an interdisciplinary research center at Purdue University, REMEDI has compiled a database of more than 32 million alerts and compliance data representing almost 120 million infusions. REMEDI membership is provided at no cost to those willing to share their smart infusion pump data and knowledge, and members now include 50 health systems with more than 280 facilities in 23 states.

While the collaborative has collected an impressive amount of data, it is what they are doing with the data that is even more impressive. Members have access to their own data and other hospitals’ data, including drug library details, alert data, and compliance data. This enables users to conduct complex analyses and comparative examinations. Members that have used this data to improve infusion safety have also shared their lessons learned through regular collaborative meetings, conferences, online forums, and publications. REMEDI data has also been used to develop analytical tools for members and for research by Purdue faculty and students, which has led to several journal publications. REMEDI is raising the bar in terms of creating new ways to use informatics from smart infusion pumps to prevent errors.

The Indianapolis-based St Vincent Joshua Max Simon Primary Care Center Pharmacy Services team has created an innovative approach to pharmacist-led medical residency medication safety education. The center is an outpatient medical facility serving as the primary training site for more than 70 medical residents in 7 residency programs. After recognizing that these residency programs lacked attention and resources directed towards medication safety, the pharmacy services team began working with physician leadership in 2010 to introduce large-scale program changes, including frequent pharmacist-resident discussions, large group educational sessions, and an improved reporting process. Those initial changes led to improvements in the safety culture, medication safety practices, and error reporting, with residents now reporting a substantial proportion of medication-related events and close calls.

The pharmacy team, in collaboration with physician directors, has continued to increase resident engagement with medication safety. They have introduced an extensive medication safety orientation, a twice monthly medication safety-related email publication, and a monthly review of reported medication safety events and risks that are discussed with clinic directors and summarized for medical residents. They have also implemented half-day didactic sessions with PGY1 and PGY2 residents, during which the resident is paired with a pharmacist to review patient care and ensure patients are receiving optimal and safe medication therapy. Despite resident turnover, the program changes have allowed for consistency in messaging and resident expectations, leading to sustained safety improvements. The center’s physician directors and the pharmacy team have presented the program at respective medical residency leadership conferences in 2017. Both faculty and residents going through the program have indicated that the program’s focus on medication safety has changed their practice and extended into the communities in which the residents now serve.

The next newsletter will be published in 2018 on January 11. See you next year!
One of the highlights of the evening was the presentation of the 2017 ISMP LIFETIME ACHIEVEMENT AWARD, given in memory of ISMP’s late Trustee, David Vogel, PharmD, which honors individuals who have made ongoing contributions to medication and patient safety throughout their careers.

Bona Benjamin, BS Pharm, is a safety leader who has had a significant impact on clinical practice, accreditation issues, and regulatory standards that have advanced medication safety. She has managed national-level projects and held legislative briefings to help reduce drug shortages. She has worked closely with the US Food and Drug Administration (FDA) and the University of Utah Drug Information Service to find innovative solutions to drug shortages and ensure that clinicians receive the necessary information they need to administer alternatives safely. Her insight on drug shortages along with her ability to bring stakeholder organizations together, examine the problem, keep proceedings on target, develop recommendations, and achieve results, led ISMP to honor her and two of her colleagues in 2011 with a CHEERS AWARD.

Ms. Benjamin has also worked on a national level to improve the safety of sterile compounding. She has provided technical expertise on safe compounding practices and has worked with the Centers for Medicare and Medicaid Services to support its efforts to improve oversight of sterile compounding and develop surveyor training materials. She has served as a member of The Joint Commission (TJC) Patient Safety Advisory Group to help establish National Patient Safety Goals. She has also served as past Chair of the National Coordinating Council for Medication Error Reporting and Prevention and collaborated with ISMP to establish the National Alert Network, which communicates reports of life-threatening medication errors to the healthcare community. Ms. Benjamin has also participated on several of ISMP’s advisory boards.

Dr. Yin’s research has helped promote milliliter (mL)-only dosing directions on prescription labels. While others have suggested that parents may not be familiar with mL dosing directions and may prefer teaspoon dosing, her research has shown that parents make fewer errors when the directions for liquid medications are expressed in mL, not teaspoons or tablespoons and mL. Her work was incorporated in an American Academy of Pediatrics Policy Statement recommending mL-only dosing for orally administered liquid medications (www.ismp.org/sc?id=3061). Dr. Yin’s research has also identified that fewer errors are made when the dosing device most closely matches the volume of the actual dose. Her latest published study (Yin HS, Parker RM, Sanders LM, et al. Pictograms, units and dosing tools, and parent medication errors: a randomized study. Pediatrics. 2017;140[1]) showed that the use of a pictogram on the label helps parents visualize the exact amount to measure for each dose and reduces the frequency of errors.

Severe underdosing of insulin with U-500 pen. An emergency department (ED) pharmacist was talking to a patient about his U-500 insulin dose. The patient, who had been using a U-500 insulin pen, told the pharmacist that his dose was 75 units but proceeded to show the pharmacist how he turned the dose knob on the pen to “15” to deliver each dose. The patient thought his physician had told him to dial to “15” to deliver 75 units. Prior to using the U-500 pen, the patient used a U-100 syringe to measure each dose of 75 units from a vial of U-500 insulin. Before U-500 syringes or pens were available, patients using U-500 insulin were commonly taught to use a U-100 insulin syringe and to measure their dose in “syringe units,” meaning the U-100 scale was used for dose measurement, but the actual dose was 5 times more than the measured dose. Thus, the patient had been drawing up the U-500 insulin into the U-100 syringe to the “15” units marking. The patient was then shown how to deliver the correct dose by dialing the U-500 insulin pen to 75 units.

Even with the availability of U-500 insulin pens, patient and provider confusion about the dose may still occur, especially...
CHEERS Awards keynote presentation

The keynote speaker for the 20th anniversary of the CHEERS AWARDS was Michael R. Cohen, RPh, MS, ScD (hon), DPS (hon), FASHP, the President of ISMP, who outlined the history of the awards. The inspiration for the ISMP CHEERS AWARDS originated with a January 14, 1998, article in the ISMP Medication Safety Alert! entitled “1997 Cheers and Jeers,” which described some of the great strides forward as well as a few steps back when it came to medication safety (www.ismp.org/sc?id=3062). By the end of 1998, ISMP held its first annual ISMP CHEERS AWARDS, honoring organizations such as TJC (JCAHO then), ASHP, and the Veterans Health Administration (VA); several drug companies; the Florida state board of pharmacy; and several individuals, including Dennis Dunn, a pharmacist from a VA hospital who had been involved in a fatal error that was later shared in the video, Beyond Blame. We learned recently that Dennis died last year (see page 1, right column). In 1998, we also issued “Jeers” to several agencies, manufacturers, and politicians who significantly hindered medication safety and error-prevention efforts. However, ISMP soon abandoned the “Jeers” part of the awards to demonstrate our unflagging commitment to a non-punitive and more just approach to medication safety.

In his keynote presentation, Mike also provided a unique perspective on the amazing road we have taken toward safer medication practices, chronicled some of our achievements and disappointments as a nation, and described how we can pave the way for the next stage of the medication safety journey. He recounted the evidence that many serious medication errors that have harmed patients over the past 20 years are predominantly problems of the past. He noted that patients are safer thanks to technology, clinical practice, and product improvements, including unit-dose systems, premixed products, and ready-to-administer syringes. He thanked FDA for helping to make our regulated product labeling, packaging, and drug naming the safest in the world. And he also credited an improved safety culture, where people don’t have to be afraid to talk about errors and report them. Mike reminded attendees that we sometimes have to be bold and make tough calls when necessary or risk stepping on toes when it comes to important safety issues that need to be challenged. He also called upon the healthcare community to proactively address medication safety issues, suggesting numerous areas of special focus in the future, including the safe opioid use; safety in ambulatory care, in community pharmacies, and in the home; aligning state boards with a just culture; and expansion of international efforts.

Thanks for another great year

We would like to extend a heartfelt thank you to the organizations and individuals who attended and/or supported this year’s CHEERS AWARDS dinner and helped us celebrate these extraordinary leaders and their groundbreaking achievements. Visit www.ismp.org/cheers for a list of contributors and winners, and www.ismp.org/support for ways you can help ISMP continue to play an important role in the fight against preventable medication errors. We look forward to another great year of working together to improve medication safety in 2018.

If you would like to subscribe to this newsletter, visit: www.ismp.org/sc?id=382

SAFETY briefs cont’d from page 3

when patients previously relied on a U-100 syringe to inject U-500 insulin. Dangerous underdosing with a U-500 pen should be considered in patients who exhibit severe hyperglycemia or diabetic ketoacidosis. For U-500 insulin, ISMP recommends using a U-500 insulin pen or a U-500 insulin syringe. Unfortunately, patients still use U-100 syringes with U-500 insulin, thus risking confusion.
Production of this peer reviewed newsletter would not be possible without the assistance of a reliable and talented clinical advisory board. As 2017 nears an end, we want to thank each of the following members of the advisory board for their dedication to making this newsletter a valuable medication safety resource for clinicians.

**Special Recognition…Our 2017 Acute Care ISMP Medication Safety Alert! Advisory Board**

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**HAPPY Holidays**

From the staff and trustees at the Institute for Safe Medication Practices.

We wish you joy, health, and happiness this holiday season!