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ISMP An ECRI Affiliate

Acute Care
ISMP Medication Safety Alert!®
Educating the Healthcare Community About Safe Medication Practices

ISMP 25th Annual Cheers Awards

Walking the Red Carpet with Safety Stars

This month, ISMP celebrated the 25th anniversary of its **Cheers Awards**, which recognize individuals, organizations, and groups that have demonstrated an extraordinary commitment to advancing the science and study of patient safety. This year's winners were honored at an awards ceremony held on December 6, 2022, at Stoney's Rockin' Country in Las Vegas, NV. Another reason it was a historic event was because ISMP had the opportunity to honor its own medication safety star, President Emeritus Michael Cohen, with the **Lifetime Achievement Award**. Please join us in congratulating Mike and the rest of this impressive group of leaders, who have been true stars and developed innovative best practices and programs to advance patient safety.

Cheers Awards winners

Sharp HealthCare, based in San Diego, CA, was recognized for developing innovative solutions to reduce the risk of patient harm when infusing non-cytotoxic vesicant/irritant medications via peripheral intravenous (IV) lines. The multidisciplinary performance improvement team identified areas for improvement and developed guidelines to standardize processes to prevent and treat extravasations of these vesicant/irritant drugs and to support safe administration. They also capitalized on the use of technology by building rules, enhancing IV site change documentation, and providing tools at the point of care to ensure staff awareness of appropriate interventions during administration. The team, which consists of pharmacists, physicians, nurses, information specialists, and vascular access specialists, was able to significantly reduce the number of extravasation events after just 1 year.

Shifa International Hospital in Islamabad, Pakistan, was honored for implementing camera-assisted verification for chemotherapy admixture services with limited resources. In order to follow ISMP's ***Targeted Medication Safety Best Practices for Hospitals***, the pharmacy services team wanted to ensure that the proper ingredients and amount of each product were confirmed prior to being added to the final chemotherapy IV bag. The team put into place an affordable, workable solution that did not put additional financial strain on the hospital. With support from leadership, the project was funded for a total of approximately $915 US dollars. Shifa International Hospital's successful initiative serves as an example of what international healthcare organizations that cannot afford advanced technology such as gravimetric analysis equipment, robotic applications, and IV workflow software can accomplish to prevent errors.

George DiDomizio Award winner

The **George DiDomizio Award** was established in 2012 in memory of a late ISMP Board member who advocated for greater cooperation between the medical industry and the broader healthcare community to promote safer drug products. The award was given this year to **Vitalis**, a pharmaceutical company based in Colombia, for its dedication to designing safer labels and packages for their medications despite the fact that it is not mandatory at the regulatory level in Latin America.

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SAFETY briefs

Rotarix cap could pose a choking hazard. While we are pleased that the new ready-to-administer **ROTARIX** (rotavirus vaccine, live, oral) oral dosing applicator formulation by GSK (www.ismp.org/ext/1032) (**Figure 1**) will soon be available (the vaccine previously required reconstitution), keep in mind that the dosing applicator tip cap could present a choking hazard if used improperly. Practitioners administer the vaccine by placing the oral dosing applicator (which looks like a prefilled syringe) into the infant's mouth. But there is a protective cap on the tip of the syringe that practitioners must remove before administration. The GSK labeling emphasizes the need to remove the tip cap before administration (**Figure 2**, page 2).

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Figure 1. The new Rotarix (GSK) prefilled oral dosing applicator and tip cap.

Become an ISMP Fellow

ISMP will soon be accepting applications for our unique **Fellowship** programs that will begin in the summer of 2023. For brief descriptions of the Fellowships, candidate qualifications, brochures, and program outlines, visit: www.ismp.org/node/871. More information will be provided early in 2023!

> **Cheers Awards** — continued from page 1

After recognizing potential safety issues with their injectable medications, Vitalis reached out to several organizations, including ISMP, for guidance. As a result, new labels were designed that include several strategies: color differentiation between products and strengths, white background to improve contrast, and more legible text with vertical orientation that can easily be read by practitioners. Dangerous abbreviations have been removed and tall man (mixed case) lettering is utilized where appropriate.

These changes were incorporated into labeling on the medication packaging, ampules, and vials, and today these products are being distributed in several countries, including Colombia, Ecuador, Peru, Chile, Panama, and Costa Rica.

One of the real highlights of the evening was the presentation of the 2022 ISMP **Lifetime Achievement Award**, which is given in memory of ISMP's late Trustee David Vogel, PharmD. The award honors individuals who have made ongoing contributions to patient safety throughout their career. This year's honoree, ***Michael R. Cohen, RPh, MS, ScD (hon), DPS (hon), FASHP***, has provided invaluable leadership and served as an unparalleled source of inspiration for so many healthcare practitioners.

Mike is the President Emeritus and co-founder of ISMP and has dedicated his long career to advocating for medication error prevention. Mike's passion for medication safety began in 1974 when he was alerted to a serious adverse event with insulin at a local hospital and immediately saw the value in sharing the story to prevent the same error from occurring again.

He founded ISMP in 1994 and launched the first of the ***ISMP Medication Safety Alert!®*** publications in 1996. Those newsletters now reach over a million health professionals in the United States and more than 30 foreign countries. Mike and his colleagues at ISMP have been instrumental in bringing about countless changes in clinical practice, public policy, and drug labeling and packaging that have impacted millions of patients and healthcare professionals in the United States and internationally.

Mike is the co-founder and longtime Chairperson of the International Medication Safety Network (IMSN), and a former member of the US Food and Drug Administration (FDA) Drug Safety and Risk Management Advisory Committee and Nonprescription Drugs Advisory Committee. He currently serves as Vice Chair of the Nomenclature and Labeling Expert Committee of USP. His many awards and honors include receiving the John M. Eisenberg Patient Safety and Quality Award from the National Quality Forum and The Joint Commission and being recognized as a MacArthur Fellow by the John D. and Catherine T. MacArthur Foundation. He also received the Harvey A. K. Whitney Award from the American Society of Health-System Pharmacists (ASHP).

Mike was the keynote speaker for the 25th annual **Cheers Awards** and reflected on the past before looking into the future. He expressed gratitude for ISMP's role in giving the United States a strong start on addressing the issues and barriers to medication safety that often hold healthcare initiatives back, and thanked ISMP staff for their dedication and determination to push forward. Mike also outlined some of the many advances that ISMP has fought for over the years, many of which have been and continue to be widely implemented by healthcare providers, regulators, accreditors, and industry:

- Developing the terminology and concept of "high-alert medications," and establishing a list with layered error-reduction strategies
- Calling infusion pumps with a dose error-reduction system (DERS) "smart pumps"

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> ***SAFETY* briefs** cont'd from page 1

However, in rare circumstances it is possible that the person administering the vaccine may not be aware of this, as has happened when capped syringes are used orally. Also, leaving the empty dosing applicator or the removed tip cap within reach (e.g., on an examination table) of a baby or child might lead to it being put in their mouth.

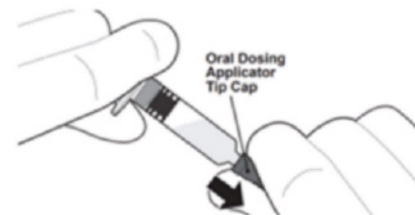

Figure 2. Remove and discard the Rotarix oral dosing applicator tip cap prior to administration.

We are unaware of any such reports with Rotarix vaccine, but one cannot be too cautious. Years ago, there were cases of asphyxiation after practitioners provided parents with parenteral syringes, which at the time had a tip cap, to measure their child's oral liquid antibiotic dose. Not all parents realized they had to remove the syringe cap before using it. The cap was often loose enough so that the person preparing the dose could draw the oral liquid into the syringe without removing it. Then, when they placed the syringe tip into their child's mouth to administer the dose of medicine, the cap fell off into the child's mouth. As a result, BD eliminated caps from all parenteral syringes. It is interesting to note that Rotarix is available in a squeezable tube in some countries, Canada being one. The manufacturer told us the decision to use the oral applicator presentation in the United States was based on healthcare provider market research, which showed a clear preference for the oral applicator rather than a squeezable tube due to ease of delivery and controlled administration.

If your organization plans to purchase this product when it becomes available in 2023, ensure practitioners and clinic/office staff are aware of this potential choking hazard.

Etoposide vial found in DOXOrubicin carton. Possible packaging errors are among the many reports we receive through the ***ISMP National Medication Errors Reporting Program*** (ISMP MERP). For example, we recently received a report

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The next newsletter will be published on **January 12, 2023**. ***See you next year!***

> **CHEERS AWARDS** — continued from page 2

- Furthering the development and utilization of tall man (mixed case) lettering to decrease drug name mix-ups
- Publishing the first scholarly article on free-flow protection for infusion pumps
- Helping to get medication barcoding widely adopted
- Creating vital resources such as a list of look-alike/sound-alike drugs
- Maintaining a list of error-prone abbreviations that should never be used
- Advocating for vin**CRIS**tine to be dispensed and administered via a minibag instead of a syringe to prevent fatal wrong route errors
- Promoting the adoption of ENFit devices to prevent tubing misconnections
- Encouraging large scale changes like the adoption of the metric system for over-the-counter (OTC) and pediatric drug dosing instead of household measures, including the use of mL to avoid confusion between teaspoon and tablespoon
- Starting the ***ISMP National Vaccine Errors Reporting Program*** (ISMP VERP) and warning about errors with two component vaccines
- Founding the Medication Safety Officers Society (MSOS)
- Improving packaging and labeling of pharmaceuticals, including advocating for expiration date standards and the adoption of premixed solutions, and ready-to-administer and ready-to-use products
- Initiating summits, guidelines, self-assessments, and other tools to help organizations improve patient safety

He also touched on ISMP's work to help elevate medication safety internationally, including development of successful ISMP affiliates in Brazil, Canada, and Spain and co-founding the International Medication Safety Network (IMSN). Mike emphasized that the world needs ISMP, and we need our supporters to continue our lifesaving work. He called on the entire healthcare community to continue helping ISMP to ensure that the powerful lessons learned from error reports are heard around the globe.

After reflecting on the lifesaving work that has been accomplished, Mike noted there is still much to be done. This includes working with State Boards to expand the concepts in ISMP's ***Targeted Medication Safety Best Practices for Hospitals***, into community pharmacy settings. As for the industry, he made a call to action that "we need your help" as both a source of funding for educational programs and to continue to make products safer. Mike aims to draw national attention to medication safety problems, offer healthcare providers new ways of looking at problems, and inspire change.

Thanks and looking forward

We would like to express our gratitude to all the organizations and individuals who attended and/or supported this year's **CHEERS AWARDS**. For a list of contributors and winners, please visit: www.ismp.org/node/34185, and for ways you can join us in creating a brighter future for medication safety, please visit: www.ismp.org/support.

ISMP wishes you a happy, safe, and peaceful holiday season, and we look forward to continuing to work together on preventing errors and keeping patients safe in 2023.

> ***SAFETY* briefs** cont'd from page 2

about a potential packaging error involving certain chemotherapy products. While the outer carton identified the vial inside as **DOXO**rubicin 20 mg/10 mL, the vial contained in the carton was labeled etoposide 100 mg/5 mL. The reporting organization does not typically purchase this strength of etoposide. Although the cartons are not individually sealed, the pharmacist noted that the carton appeared to be unopened. So, it was uncertain if the package was tampered with, if the mistake was due to a manufacturer packaging problem, or if someone on staff repackaged the product incorrectly. The manufacturer has completed an investigation of this situation and did not find any evidence that an error happened at their end.

Strange things like this do happen! Readers may recall an incident we described in our February 11, 2021, newsletter (www.ismp.org/node/22779) involving Meitheal Pharmaceuticals cartons that were labeled as cisatracurium 10 mg/5 mL but contained vials labeled as phenylephrine 100 mg/10 mL. Since the vial caps had "Warning: Paralyzing Agent," a suspicious pharmacist followed up and learned the vials were indeed mislabeled and contained cisatracurium! It should go without saying that labels must be read when removing a vial from an external carton.

Employment opportunity

ISMP is seeking a full-time pharmacist with at least 5 years of experience in the community and specialty pharmacy practice settings. In addition, 3 years of experience managing performance improvement projects and in writing articles and proposals are required. This ***Medication Safety Specialist*** position will support our membership services initiative. For more information and to apply for the position, please visit: www.ismp.org/node/20395.

If you would like to subscribe to this newsletter, visit: www.ismp.org/node/10

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Report medication and vaccine errors to ISMP: Please call 1-800-FAIL-SAF(E), or visit www.ismp.org/report-medication-error. ISMP guarantees the confidentiality of information received and respects the reporters' wishes regarding the level of detail included in publications.

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Happy Holidays...from the staff, Board of Directors, and Advisory Board at the Institute for Safe Medication Practices (ISMP). We wish you joy, health, and happiness this holiday season!

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2022 ISMP Medication Safety Alert!®

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Production of this peer-reviewed newsletter would not be possible without the assistance of a reliable and talented Clinical Advisory Board. As 2022 nears an end, we want to thank each of the following members of the Clinical Advisory Board for their dedication to making this newsletter a valuable medication safety resource for clinicians.

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