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November 10, 2017

COM # 2017 - 004

Dear Pharmacy Provider:

We hope this message finds you well. Our hearts and prayers are with you as we work together to get our beloved Island back on track.

At PharmPix, we are committed to the health and wellness of our clients and beneficiaries. Our goal is to offer high quality services and valuable information that may improve patients' quality of healthcare.

Attached is a summary of important facts regarding medication errors along with relevant informational guide. Awareness of the prevalence of medical errors is a pressing matter—these errors contribute to dozens of deaths in America, year after year, even though most of them are preventable.

If you have any additional questions, you will find more information in the Institute for Safe Medication Practices (ISMP), the Agency for Healthcare Research and Quality (AHRQ), The Joint Commission (TJC), and other accredited organizations/sources. We encourage you to keep up to date with the publications made by these and other entities to assure that your practice is consistent with the most up to date information.

If you have any doubt or wish to receive more information regarding the topics noted in this communication, feel free to contact us at 787-522-5252, extension 138. You may also feel free to share information or suggestions on this matter to the address at the bottom of this communication.

Warm regards and best wishes,

PharmPix Pharmacy Department

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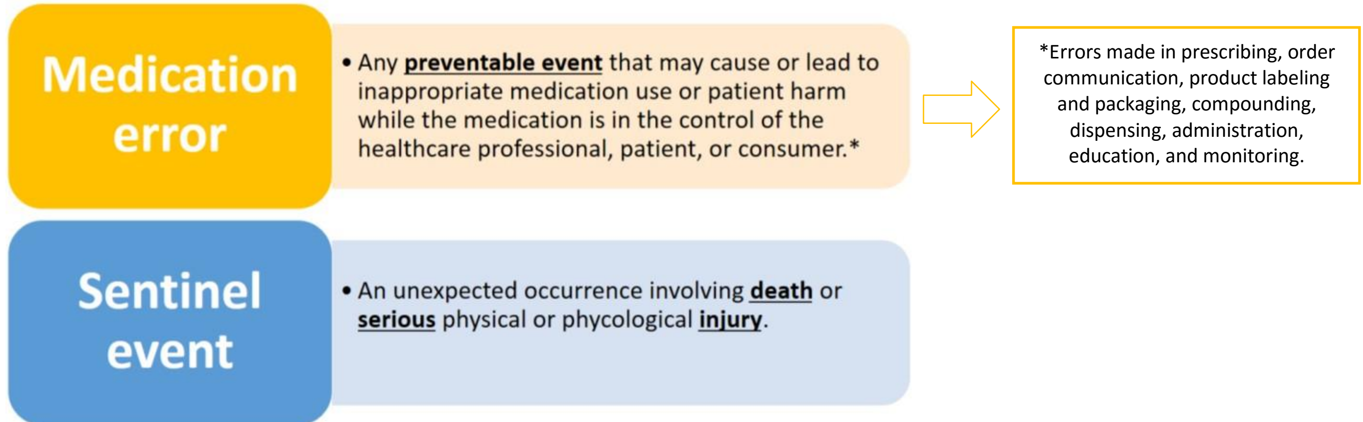
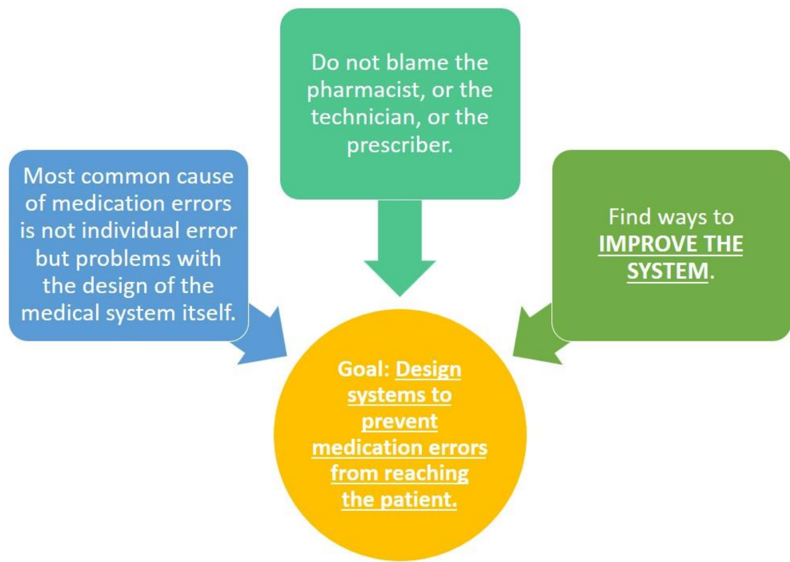
MEDICATION ERRORS

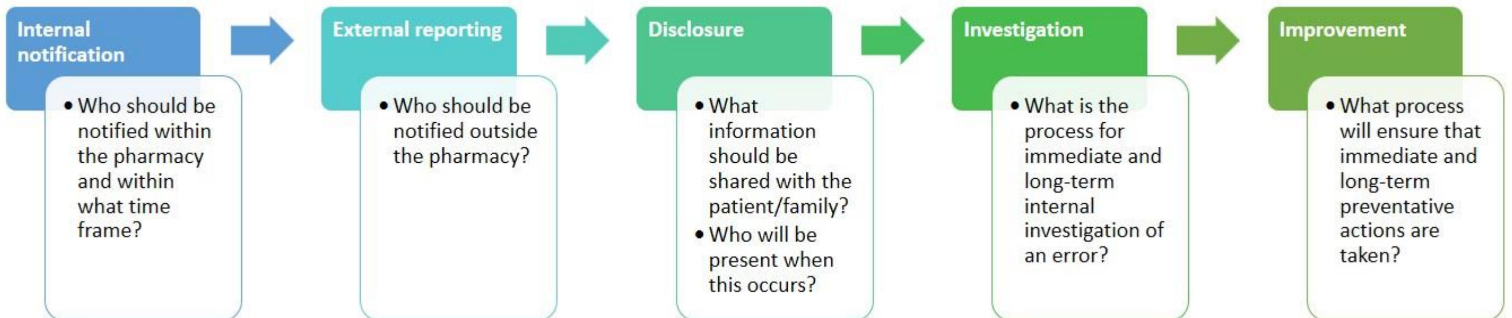


Medication errors ≠ Adverse Drug Reactions (ADRs)
ADRs are generally not avoidable.

SYSTEM-BASED CAUSES OF MEDICATION ERRORS – It is not individual error!



RESPONSE TO MEDICATION ERRORS – Have a plan!



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REPORTING – Medication errors should be reported!

Report so that changes can be made to the system to prevent similar errors in the future.

Without reporting, events may go unrecognized and will likely happen again because others will not learn from the incident.

Staff member who discover the error should immediately report to personnel involved in quality assurance.

Errors investigations need to take place quickly so that the sequence of events remains clear to those involve.

Reporting system:

- **The Institute of Safety Medication Practices (ISMP) Medication Errors Reporting Program (MERP)**

Professionals and patients should be encouraged to report medication errors in MERP. When there are many reports, manufacturers may take measures to increase safety.

Every pharmacist should make it a practice to read medication error reports and use the information to improve their practice setting.

COMMON METHODS TO REDUCE MEDICATION ERRORS

Method	Details
Avoid "Do Not Use" Abbreviations, Symbols, and Dosage Designations	• Abbreviations are unsafe and contribute to many medical errors. • Exhort physicians to try to avoid abbreviations entirely in their prescriptions. • Electronic prescribing can virtually eliminate errors associated with poor handwriting.
Tall Man Lettering	• Drugs that are easily mixed up should be labeled with tall man letters (mixing upper- and lower-case letters) to draw attention of dissimilarities. • More information is available at: http://www.ismp.org/tools/tallmanletters.pdf
High-Alert Drugs	• Drugs that bear a heightened risk of causing significant patient harm when used in error should be designated as "High-Alert". • More available at: http://www.ismp.org/tools/highalertmedicationlists.asp
Medication Therapy Management (MTM)	• Errors may be discovered during comprehensive medication review (CMR), through the process of MTM. • Patients targeted for MTM include those with multiple conditions who are taking multiple drugs.
Inclusion of Indication for Use and Proper Instructions on Prescriptions	• Exhort physicians to always include an indication for use in the prescription because this helps the pharmacist to ensure appropriate prescribing and drug selection. • The term "as directed" is not acceptable. The patient often has no idea what this means and the pharmacist cannot verify a proper dosing regimen.
Do Not Rely on Medication Packaging for Identification Purposes	• Look alike packaging can contribute to errors. • Whenever possible, separate look-alike drugs in the pharmacy. • Never rely on package to identify the right drug product.
Monitor for Drug-Food Interactions	• Check for drug-food interactions routinely.
Education	• Staff education should be provided on a regular basis. • Patients can play a vital role in preventing medication errors when they have been encouraged to ask questions and seek satisfactory answers about their medications. • Communicate to patients in their language. The written information about medications should be at a reading level that in comprehensible to the patient.

References:
Institute for Safe Medication Practices (ISMP): http://www.ismp.org/; Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov/