Medication Error Reporting Meeting Minutes

Date: October 19, 2011
Time: 1:00 p.m. to 2:00 p.m.
Topic: UPMC St. Margaret Medication Error Review Committee (Draft)
Recorded by: Cynthia E. Russo

Attendees
Present:
Elizabeth Forsberg, PharmD Clinical Pharmacist
Chairperson
Ronald J. Campbell, PharmD Clinical Pharmacist
Leslie Gingo, PharmD Clinical Pharmacist
Lori Kelly, RN Performance Improvement
Blaine Lester, RT MA Regulatory Specialist
Sheree Lichtenstein, PharmD Clinical Pharmacist
Ronald J O’Neill, PharmD Director, Pharmacy
Cathy Pieper, RPh, MBA Operations Manager, Pharmacy
Janine Sharer, RN Nursing Education

Absent/Excused:
Jack Carroll Vice President (excused)
Patricia Glod, RN Informatics Nurse
Jessica Graff, RN Nursing Unit 5A
Marge Jacobs, RN Executive Director, Quality Improvement/Care Mgmt
Janice Letterle Business Systems Analyst (excused)
Heather Sakely, PharmD Clinical Pharmacist
Linda Zsolcsak, RN Nursing Unit 6A (excused)

Guest:
Scott Bragg, PharmD Pharmacy resident
Kara Plauger, PharmD Clinical Pharmacist

Minutes

I. CALL TO ORDER

The meeting was called to order at 1:00 p.m. by: Liz Forsberg, PharmD, Clinical Medication Safety Specialist, and Chairperson.

MER multidisciplinary team meets once per month to review medication incidents entered in Riskmaster™. Trends are identified and follow-ups are performed on events necessitating more information.
II. APPROVAL OF MINUTES
Findings: The last meeting was held on September 21, 2011. Minutes were approved.

III. REVIEW OF MEDICATION ERRORS AND ADVERSE DRUG REACTIONS
Findings:
A. Monthly Breakdown: Liz Forsberg, PharmD, Clinical Medication Safety Specialist, and Chairperson reported 19 events were recorded for September 21st through current. Events were distributed among event indicators as follows: (2) Adverse Reaction, (1) Dispensing, (3) Medication Duplication, (4) Medication Not Given, (3) Medication Reconciliation, (2) Other, (3) Prescribing/Order Issue, and (1) Time/Interval Issue.
B. Medication Incident Event Reports: Liz Forsberg, PharmD, Clinical Medication Safety Specialist, presented Medication reports.

**EV2011612959**: Adverse Reaction (SM6A)
Patient was found to have large reddened and purple area to right upper and lower forearm posterior side. Charge nurse was informed who then informed physician. Action: IV team restarted IV in left arm and patient was monitored.

**EV2011612088**: Adverse Reaction (SMOPS)
Patient on vancomycin 1000 mg in 200cc volume IV experienced itching scalp and red non-raised areas on face, chest, and back. IV rate was decreased resulting in no decrease in symptoms. Physician was notified. Action: Vancomycin IV was discontinued; allergy information was added to patient profile.

**EV2011613019**: Dispensing (SMPHARM)
Look-alike/sound-alike error occurred. Patient was ordered paroxetine 20 mg PO Daily. Pravastatin 20 mg was dispensed. Action: Pharmacy was notified and corrected dispensing error. Bins for these medications were double-checked.

**EV2011613796**: Medication Duplication (SM3B)
Patient was administered Solu-Medrol® (methylprednisolone sodium succinate) 80 mg IV instead of the ordered dose of 40 mg. Action: Physician and charge nurse were notified.

**EV2011612603**: Medication Duplication (SM6B)
Patient received two flu vaccinations within a 2 month timeframe. On admission initial assessment, patient was confused and not properly oriented and reported not receiving flu vaccine to admitting nurse. Computer system auto-ordered a flu vaccine based on patient’s response to admission nurse and current month being
within flu season. The patient's family informed nurse of prior patient' flu vaccine administration at PCP office after flu vaccine was administered.

**EV2011614482: Medication Duplication (SMPHARM)**
Patient was administered both olmesartan and irbesartan.
*Action: Follow-up was performed.*

**EV2011609975: Medication Not Given (SM3B)**
Nitro gtt was not administered to patient. There was a change in Cardiologist and nitro drip order was overlooked.
*Action: Nurse counseled. Follow-up was performed.*

**EV2011612879: Medication Not Given (SM5B)**
Vancomycin was inadvertently discontinued and patient did not receive antibiotic for ~24 hours. Original order for vancomycin 1 gram IV Q12H was placed. Dose was adjusted to 1500 mg Q12H per pharmacokinetics protocol but order was placed with duration of one day. Patient did receive 2 doses before the order self-discontinued. Gap in care was not noticed until ~ 24 hours later.
*Action: Staff involved counseled.*

**EV2011610260: Medication Not Given (SM6A)**
Nurse identified patient 2200 and 2300 medications were not administered. Medications included Zosyn® (piperacillin/tazobactam), Heparin, and Pepcid® (famotidine).
*Action: Staff involved counseled. Nurse from that shift was notified and responded that computer system was not working. Follow-up was performed.*

**EV2011614459: Medication Not Given (SMPHARM)**
Order was placed for post-op vancomycin on 10/14/11. Infectious Diseases recommended vancomycin be continued, original order was completed on 10/15/11. Patient did not receive vancomycin on 10/16/11. On 10/17/11 vancomycin was reordered and no adverse outcomes were evident associated with the antibiotic omission.
*Action: Follow up was enacted.*

**EV2011613582: Medication Reconciliation (SM5A)**
Patient's home medication list in computer indicated patient was on losartan 25 mg PO Qday and lisinopril 5 mg PO Qday. Both medications were continued upon admission. Pharmacist questioned this combination on rounds and spoke with patient who indicated not being on lisinopril. Pharmacist contacted patient’s outpatient pharmacy to confirm that lisinopril was switched to losartan. Patient did receive three doses of the lisinopril before the error was caught.
Action: Verbal order was acquired to D/C the lisinopril.

**EV2011612217**: Medication Reconciliation (SM6B)
Plavix® (clopidogrel) was listen in the meds by history tab as “not taking” for a patient that was not on Plavix® at home. The comment did not cross over into the med rec process when physician was ordering resulting in Plavix® was ordered. The patient caught the error when the nurse attempted to administer the medication. Patient did not receive the Plavix®.

Action: Follow-up was performed.

**EV2011613905**: Medication Reconciliation (SMPHARM)
Patient was ordered glipizide 20 mg PO with breakfast, quinapril 12.5 mg Daily, and hydrochlorothiazide 25 mg Daily. Verifying pharmacist questioned the doses and checked home medication list. At home, patient was taking glipizide 2.5 mg and quinapril/HCTZ 25/12.5 mg.

Action: Physician was notified and orders were corrected before reaching the patient.

**EV2011611654**: Other (SM4A)
Two pain pills were not returned to AcuDose™ due to nurse forgot.

Action: Follow up was performed.

**EV2011609799**: Other (SM6A)
Wrong insulin was drawn up.

Action: Follow up was performed.

**EV2011613817**: Prescribing/Order Issue (SM5B)
Instead of ordering steroid taper with appropriate start and stop times, physician ordered prednisone 40 mg PO Daily, with special instructions: 40 mg PO qd x 3 days then 20 mg qd x 3 days then 10 mg qd.

Action: Pharmacist caught event during verification process and order was re-entered appropriately.

**EV2011613911**: Prescribing/Order Issue (SM6A)
Surgery resident entered orders on the wrong patient. Orders were entered for albuterol/ipratropium QID and Q2H PRN, chlorhexidine gluconate swish and spit BID, famotidine 20 mg daily, naloxone 0.1 mg As Directed/CPOE, ondansetron 4 mg IV Push Q6H PRN, and KCL 20 mEq/D5 0.9% NaCl @ 80 mL/hr.

Action: Nurse caught the error and notified pharmacy and physician resulting in orders were canceled. Incorrect medications did not reach the patient.

**EV2011614291**: Prescribing/Order issue (SMPHARM)
Ortho CRNP ordered Novolog Mix® (Insulin Aspart, Recombinant/Insulin Aspart Protamine) 70/30 instead of Novolog® Insulin Aspart insulin. The patient was on Novolog® Insulin at home with meals as well as a sliding scale with Lantus® (Insulin Glargine) Insulin at bedtime.

Action: Follow up was performed. Nurse counseled.

EV2011612044: Time/Interval Issue (SM4A)
Antibiotic dose was scheduled on the eMAR incorrectly resulting in antibiotic was administered late.
Action: Follow up was performed.

C. Medication Incident Reports:
Follow-up events reported: Liz Forsberg, PharmD, Clinical Medication Safety Specialist, and Chairperson discussed as follows:

- Last two meetings, several medication patch issues were identified. It was noted, there were zero fentanyl patch issues reported for October 2011. The committee was informed at last meeting that taping the edges ONLY of patches only is allowable, and nursing approved to reinforce this allowance.
- September meeting discussion included a patient with end stage renal dialysis on hemodialysis, and was ordered a sodium phosphate enema, which was administered, w/potential contraindication. Modification of the enema order set was being revisited.
Action: Follow-up details were not available at that time and will be reported at the next meeting.
- Sheree Lichtenstein discussed gram and milligram order modification issues.
Action: Continued review.

EV2011607800: (SMRAD)
Vancomycin infusion began and patient developed an itching at IV site. Radiologist was made aware of the event and vancomycin infusion was stopped. Benadryl® (diphenhydramine) 50 mg IV was administered and patient was informed of the reaction to vancomycin.
Action: Allergy to vancomycin (non-rash) was added to eRecord.

EV2011609799: (SM6A)
Wrong insulin was drawn up (Novolog®). Event occurred in MEDU. Patient was on aspart SSI 9/22 and changed to Regular Insulin 9/22 PM. Event occurred 9/23 23:15.
Action: Nurse counseled.

EV2011609975: (SM3B)
Nitro Drip order from AM was overlooked.
Assessment showed Nitro gtt was ordered at 10:11 on 9/25/11. Reviewed by bedside nurse but next shift nurse found medication was not hanging. Cardiologist was
consulted and it was found that Cardiologist was changed and medication and new
Cardiologist were refused per patient’s family.
Action: Cardiologist obtained. Nitro Drip was discontinued and patient was ordered
NTG paste.

EV2011610260: (SM6A)
Omission of medications was identified by nurse.
Action: Nurse involved was notified and reported computers were not operable. Nurse
Manager and IS were notified. Nurse counseled.
EV2011610493: (SM3B)
Patient received hydromorphone 0.5 mg instead of 0.2 mg.
Assessment showed bar-code scanning procedure was not followed.
Action: Physician was notified. Nurse counseled.
EV2011610548: (SMPHARM)
Patient was ordered ceftriaxone 1 gram IV Q24H and cefazolin 1 gram IV Q8H by two
different physicians. Both orders were verified by the same pharmacist. Both
medications were administered.
Event was identified by clinical pharmacist upon patient review.
Assessment showed 19 y/o female presented to ED for evaluation of hand infection.
Order for ceftriaxone 1 gm IV Q24H was placed 9/27/11 @ 22:00 by physician #1;
order for cefazolin 1 gm IV Q8H was placed 9/27/11 @ 23:02 by physician #2. Both of
the orders were placed while the patient was in the ED. Both orders were verified
by the same pharmacist, and both antibiotics were administered. Pharmacy does not
routinely verify ED orders but the event should have been caught when verification
occurred.
Action: Pharmacist involved was counseled.
EV2011610970: (SM6B)
Patient with Heparin Drip rate adjusted incorrectly to 24.9 cc/hr instead of 12.9 cc/hr.
Charge nurse identified incorrect rate, and rate was adjusted. STAT PTT was drawn,
and physician was notified.
Action: Repeat PTTs were drawn; physician discontinued the order and ordered
enoxaparin. Nurse counseled.
EV2011611654: (SM4A)
Nurse forgot to return 2 pain medications (oxycodeinoxycodeone 5 mg IR tablets) to
medstation.
Assessment showed nurse returned the medication the next day with a nurse witness.
Pharmacy was made aware of the incident.
Action: Nurse counseled.
EV2011612044: (SM4A)
Patient was on Q8H antibiotic on 10/5/11. The 1000 mg dose was given late because the antibiotic was scheduled on the eMAR for the next dose to be given on 10/6/11 at 0630.
Action: Nurse counseled.

EV2011612088: (SMOPS)
Patient on vancomycin IV experienced scalp itching and non-raised red areas on face, chest, and back
Action: Reaction was noted by nursing staff, physician was notified, and IV was stopped.

EV2011612603: (SM6B)
Patient received two flu vaccinations. No negative outcomes were identified. Patient originally reported not receiving flu vaccine but nurse was later informed by family of prior receipt of the vaccine at PCP office, after administration.
Action: Reviewed use of DBmotion with nurse.

EV2011612879: (SM5B)
Vancomycin IV was inadvertently discontinued and patient did not receive antibiotic for ~24H.
Assessment showed dose was adjusted per PK Service weight-based dosing protocol. New dosage was accidentally entered with duration of "1 day" resulting in order self-discontinued after 1 day duration.
Action: Pharmacist counseled and event was reviewed with Pharmacy.

EV2011613019: (SMPHARM)
Patient was ordered paroxetine 20 mg PO Daily but pravastatin 20 mg was dispensed. Pharmacy was notified by nurse who identified error on medication pass. Patient did not receive incorrect medication. This was a look alike/sound alike pair; error occurred during manual fill process but could have been prevented with proper barcode dispensing procedure.
Action: Medication bins for paroxetine and pravastatin were double-checked to ensure that the two products were not mixed together in the same bin.

EV2011613796: (SM3B)
Patient was administered Solu-Medrol® 80 mg instead of 40 mg.
Assessment showed the 40 mg dose resulted in eRecord cautioning alert of inappropriate dose, and 80 mg dose was needed. Nurse obtained an additional 40 mg dose and scanned it, as system indicated and per triggered alert. Patient did have frequent dose changes over several days,
Action: Physician/eRecord both notified.

EV2011614148:
Patient had admitting diagnosis of acetaminophen toxicity. Patient was prescribed, via telephone, oxycodone 5 mg PO Q6H PRN for pain. Verbal order was entered into computer charting as acetaminophen 325 mg/oxycodone 5 mg PO Q6H for pain. Patient received one tablet of acetaminophen 325 mg/oxycodone 5 mg

Action: Nurse notified physician. Acetaminophen level was obtained; no patient adverse events were shown.

EV2011614482: (SMPHARM)
Patient reported duplicate Angiotensin II agents in medication history. Olmesartan and irbesartan; both prescribed and administered.
Event was identified by pharmacist upon checking manual medication fill in the evening.
Assessment showed both olmesartan and irbesartan were present on admission medication reconciliation list with recent administration times (time/date last dose taken prior to admission). Both medications were listed on PCPs medication list in progress notes with comment noting stable hypertension. Patient did not experience hypotension during the co-administration of these two medications.

Action: order for irbesartan was discontinued.

IV. Nursing Update
- Nursing Patient Safety Event: Little Room of Horrors – reminder was provided: Mon-Tues 0700-1700 in the Nursing Education Classroom.
  It was noted event will be an interactive walk-through event identifying safety issues.
  - High concentrated vancomycin is included in the events being displayed.
  - Mislabelling
  - Scenarios of various types where participant will attempt to identify inappropriateness.
- Concerns with fentanyl IV bolus administration and absence of documentation area. Areas do populate for bolus doses of hydromorphone and morphine but not fentanyl bolus. It was noted physicians do order fentanyl boluses; fentanyl IV guidelines represent a continuous order.

VI. IS Update
- Humalog® (insulin lispro) one time order set developed.
- Non-appropriate interchanges for combination drugs have been occurring.
  Therapeutic tab in eRecord accesses various choices with some non-relevant choices. Example will be sent to nursing for further investigation.

VII. Medication Safety Alert:
• ISMP Medication Error Report Analysis
  ○ Barcode scanning
  ○ Dosing confusion with colistimethate for injection
  ○ Mix-ups between risperidone and ropinirole.

IX. AdHoc Discussion
• New Anticoagulation Medications
  New education tactics include Journal Club for nursing, RPh Unit Target, E-mail, screensaver examples, Safety Fair.
  The committee was asked to recommend education ideas.
  ○ Xarelto® (rivaroxaban): XARELTO is a factor Xa inhibitor indicated for the prophylaxis of deep vein thrombosis (DVT) which may lead to pulmonary embolism (PE) in patients undergoing knee or hip replacement surgery. (2)
  ○ Brilinta® (ticagrelor): FDA approved for reduction of the rate of thrombotic cardiovascular events in patients with acute coronary syndrome (ACS), including unstable angina, non-ST evaluation myocardial infarction (NSTEMI) and ST evaluation myocardial infarction (STEMI). (1)
  ○ Pradaxa® (dabigatran) PRADAXA is a direct thrombin inhibitor indicated to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation (3)

Action Items

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<tr>
<th>Action</th>
<th>Assignee</th>
<th>Deadline</th>
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<tbody>
<tr>
<td>Review of medication errors and adverse events.</td>
<td>MER Committee</td>
<td>Ongoing</td>
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<tr>
<td>Fentanyl bolus documentation area follow-up/changes</td>
<td>Ron Campbell; Sheree Lichtenstein, Janice Letterle</td>
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<tr>
<td>New Anticoagulation Medications; Planning education.</td>
<td>Sheree Lichtenstein; Liz Forsberg</td>
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<tr>
<td>Therapeutic Interchange tab and combination medication choices. Send nursing example screen prints.</td>
<td>Sheree Lichtenstein</td>
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Next meeting: UPMC. St. Margaret Conference Room 1&2, November 16, 2011, 1:00 p.m.

(AV equipment)

ADJOURNMENT
Meeting was adjourned at 2:00 PM.
Respectfully submitted,

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Liz Forsberg, PharmD, Clinical Medication Safety Specialist, and Chairperson.

References
2. PHYSICIANS’ DESK REFERENCE: PDR - Xarelto Tablets. (Janssen)
3. PHYSICIANS’ DESK REFERENCE: PDR - Pradaxa Capsules(Boehringer Ingelheim)