

Kentucky Board of Pharmacy Medication Safety Committee

Kentucky Board of Pharmacy
via teleconference at

<https://us02web.zoom.us/j/85982194547?pwd=enpoK1J0QWxoRy83NGo1cmM0UGFldz09>

Meeting ID: 859 8219 4547

Passcode: 7m40Kz

Dial by your location

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Meeting ID: 859 8219 4547

Passcode: 494631

July 12, 2021

10:00 a.m.

Agenda

- I. Call to Order
- II. Minutes – June 9, 2021
- III. Sample of cases of medication errors report to board
 - Discussion
- IV. NYTimes articles
 - Discussion
- V. Determine Harm Score for Medication error
 1. Members of the committee to provide information on what they use
 2. Determine what this committee will use
- VI. Categorize Event Types
 1. Discuss what event type taxonomy members of the committee use
 2. Determine what the committee will use
 3. Determine if the committee will add any ad-hoc event types
- VII. Medication Error Reporting
 - Members of the committee to provide information on what they use
- VIII. ISMP Self Assessment for community/ambulatory pharmacy
 - Discussion

- IX. Plan for what needs to be reviewed/discussed in order to have a productive discussion on charge 3 “Provide an opinion on the disciplinary action recommended for first time medication error offense that causes no harm v. medication errors that cause harm”
- X. Adjournment

**KENTUCKY BOARD OF PHARMACY
125 HOLMES STREET
FRANKFORT KY 40601**

MEDICATION SAFETY COMMITTEE

JULY 12, 2021

MINUTES

- 1. CALL TO ORDER** Liz Hess called the meeting to order on July 12, 2021 at 10:05 a.m.
Members present: Liz Hess; Melissa Robertson; Jessica Schmurr; Donna Drury; Amanda Thompson and Katie Johnson.

Members absent: Amy Billimoria, Theresa Porter and Dreama Johnson. Staff: Larry Hadley, Executive Director; Eden Davis, General Counsel and Melissa Hall, Administrative Specialist III.
- 2. MINUTES** Jessica Schmurr moved to approve the minutes from the June 8, 2021 meeting. Melissa Robertson seconded, and the motion passed unanimously.
- 3. MEDICATION ERROR CASE HISTORY WITH SAMPLE CASES**

Discussion: The committee reviewed the medication error case history and sample cases provided by Eden Davis as requested at the June 8th meeting. Katie Johnson questioned the term ‘Letter of Reprimand’. Ms. Davis informed the committee that a Letter of Reprimand acknowledged sufficient evidence of a violation of law, but no disciplinary action was taken. A Letter of Reprimand is not reported to NABP or available to the public. Amanda Thompson stated that errors frequently occur that are not self-reported to the Board due to fear of discipline. Consumer complaints are often used retaliatory tool toward pharmacies and pharmacy staff. Shelly from Kroger stated that they focus on the stores that have few reports of errors. Liz Hess agreed and stated that pharmacies self-reporting are actively working to reduce the errors. Those that do not self-report may indicate a lack of concern on medication errors. Katie Johnson stated that the language in the Letter of Reprimand was harsh and did not contain any helpful information to reduce medication errors.

Actions: Liz Hess suggested templates for the Letter of Reprimand to be reviewed at the next meeting. Board staff will draft these templates.
- 4. NY TIMES ARTICLE** Liz Hess summarized the article in which several pharmacy staff across the nation were hesitant to self-report errors for fear of disciplinary actions rather than steps to prevent the error in the future.

5. HARM SCORE FOR MEDICATION ERROR

Discussion: The committee discussed the taxonomy used by their pharmacy to assign harm levels to medication error reports. Donna Drury stated that one method would be best to determine harm score. The use of one method would eliminate multiple interpretations of terminology.

Actions: Liz Hess moved to recommend the use of the National Coordinating Council Medication Error Reporting and Prevention (NCC MERP) for determining the harm score for medication errors. Melissa Robertson seconded, and the motion passed unanimously.

6. CATEGORIZE EVENT TYPES FOR MEDICATION ERROR

Discussion: The committee discussed the taxonomies used by their pharmacy to code medication errors, event types, e.g. wrong drug, wrong patient. The two commonly used were NCC MERP and ARHQ Event types.

Actions: Liz Hess moved to develop a hybrid of the two programs to allow use in retail settings and hospital settings. Jessica Schmurr seconded, and the motion passed unanimously. Katie Johnson inquired about the methods used in other states. She will provide that information for review at the next meeting. Liz Hess will provide a combination of the AHRQ Community Event Types and the NCC MERP Event types for the committee to review and determine which to use.

7. MEDICATION ERROR REPORTING The committee discussed the software program used by their pharmacies to report medication errors. Datix Safety Intelligence, RL Solutions and IRIS [Incident Reporting Information System] are utilized by the members. The ISMP Reporting system is supported by their company and does not use any of the software used by committee members. Jill Rhodes stated there will be no Board funds to support purchase of software.

8. ISMP SELF ASSESSMENT FOR COMMUNITY/AMBULATORY PHARMACY The committee reviewed the ISMP Medication Safety Self-Assessment for Community/Ambulatory pharmacy. This self-assessment is currently recommended to pharmacies with reported medication errors; however, it was noted that all pharmacies could benefit from the self-assessment.

A Doodle Poll will be sent to schedule the August meeting, which will be virtual. Liz Hess moved to adjourn. Jessica Schmurr seconded, and the motion passed unanimously.

Liz Hess adjourned the meeting at 11:22 a.m.