Kentucky Board of Pharmacy Medication Safety Committee

Kentucky Board of Pharmacy
via teleconference at
https://us02web.zoom.us/j/88294196778?pwd=clZKWDlxNnhlalJ2LzlVNXAwOXFVUT09
Meeting ID: 882 9419 6778 Passcode: 5kaBwR
Dial by your location
+1 312 626 6799 US (Chicago) +1 646 558 8656 US (New York)
Meeting ID: 882 9419 6778 Passcode: 016236

June 9, 2021
9:00 a.m.

Agenda

I. Call to Order

II. Election of Officers

III. Discussion items:
   A. Charged July 29, 2020 – Initial Charge to advise the board on medication error matters that include:
      1. Considering application of a tool to assign harm level for medication errors that occur and are investigated by the board https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6647434/#!po=40.9091
      2. Categorize the types of errors that occur and develop a standardized remediation plan/assignment for the board to employ with a disciplinary action for a medication error
      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
         - Informal discipline
         - Letter of reprimand
         - Unethical/unprofessional conduct
         - One of the above PLUS remediation plan
         - Other
      4. Consider the idea of developing a repository database for Kentucky pharmacists to safely and anonymously report medication errors and concerns for patient welfare (no specific pharmacies or pharmacists would be reported – data collected would be categorized to type of practice setting, etc.)

- For med error review and discussion by the ad hoc committee to identify patterns of concern for our state and recommend corresponding corrective action plans / remediation support for the board to consider for the profession
- Partner with an expert organization for a state pilot? (ex. ISMP)
- Note: There are already programs available for reporting https://www.ismp.org/report-medication-error) and internal QA programs pharmacies have developed. This is not intended to supplant those programs or interfere. This is proposed as an idea to specifically look at our state's individual medication error profile and address the needs, if identified, in our state to support the profession and optimize the safety and welfare of our Commonwealth. It may also provide a safe venue for pharmacists to report errors that they feel otherwise uncomfortable with reporting and feel safety concerns exist without subjecting themselves to potential disciplinary action in the process.

B. Charged January 28, 2021 – ISMP for Medication Error Prevention:
   1. "Chris Harlow moved to direct the Medication Safety Committee consider the utilization of the ISMP Medication Safety Self-Assessment for resolution in medication error disciplinary cases. Peter Cohron seconded, and the motion passed unanimously."

IV. Adjournment

KENTUCKY BOARD OF PHARMACY
125 HOLMES STREET
FRANKFORT KY 40601

MEDICATION SAFETY COMMITTEE

JUNE 9, 2021

MINUTES

CALL TO ORDER Larry Hadley, Executive Director called the meeting to order on June 9, 2021 at 9:04 a.m. Members present: Liz Hess; Melissa Robertson; Theresa Porter; Jessica Schmurr; Donna Drury; Amanda Thompson and Katie Johnson.

Members absent: Amy Billimoria and Dreama Johnson. Staff: Larry Hadley, Executive Director; Eden Davis, General Counsel and Darla Sayre, Executive Staff Advisor.

Guests: Jill Rhodes, President of the Kentucky Board of Pharmacy; Tara Modisett, Alliance for Patient Medication Safety; Eugene O'Donnell and Mindy Smith, Tabula Rosa Healthcare; Cathy Hanna, American Pharmacy Service Corporation and Ben Mudd, Kentucky Pharmacists Association.

INTRODUCTIONS Larry Hadley requested each member present introduce themselves and provide their background information.

Liz Hess is a medication safety pharmacist at UK Healthcare. After a two year residency in Health-System Pharmacy Administration, she discovered a passion for medication safety. She was selected for the Institute for Safe Medication Practices fellowship. Her current role at UK Healthcare is investigating the medication errors reported internally to develop risk production strategies.

Melissa Robertson is the Medication Safety Manager for University of Louisville Health System. She is responsible for medication error reporting and the lead for the U of L Health Medication Safety Subcommittee of Pharmacy & Therapeutics Committee.

Jessica Schmurr is the pharmacist supervisor at Kroger Health Connect. She leads the Medication Safety Committee within her department. The committee looks at reported errors to identify the root causes and work on implementing the changes to prevent them in the future.

Donna Drury is the consumer member of the committee. She is a 30-year state government retiree. She leads local organizations including the Agency for Substance Abuse Policy and Saving Our Students. The focus of these organizations is prevention of prescription addiction and abuse through education.

Amanda Thompson is a pharmacist at Flaget Memorial Hospital in Bardstown. She is a member of their Safety Committee. She has experience in both hospital pharmacies and retail pharmacies. In 2018, she was awarded the 'Patient Safety Hero' award from the Kentucky Hospital Association.

Katie Johnson is a mediation safety pharmacist at UK Healthcare. She completed one year of residency specializing in medication safety within health-system practice settings. She is coordinator for Medication-Use Safety and Technology at UK Healthcare leading initiatives and promoting best practices for safety within medication-use processes and health information technology.

CHARGE TO COMMITTEE Jill Rhodes gave a brief overview of the expectation of the committee and the charge given by the Board. The committee is to look at 'just culture' [a concept related to systems thinking which emphasizes that mistakes are generally a product of faulty organizational cultures, rather than solely brought about by the person or persons directly involved] and how it relates to the Board. The committee is to provide recommendations to the Board on:

- How we evaluate medication errors that are investigated by the inspection staff and come before the Board for discipline.
- What tools could be used to categorize the medication errors identifying common errors and implementing corrective action methods/education to prevent them in the future.
- Development of potential disciplinary actions or corrective measures for resolution of medication error cases.
- A database to safely report medication errors for review by the Board or committee to be used in categorization and resolution
- Review partnership with other organizations to implement their recommendations

Mr. Hadley proposed the committee set a time limit of one year to provide these recommendations to the Board. If additional time is required, the Board can provide an extension upon request.

ELECTION OF OFFICERS Liz Hess self-nominated to be Chairperson. The vote was unanimous. Donna Drury nominated Jessica Schmurr for Vice-Chairperson. The vote was unanimous.

DISCUSSION The committee reviewed the charge from the Board.

A. Charged July 29, 2020 – Initial Charge to advise the board on medication error matters that include:
    1. Considering application of a tool to assign harm level for medication errors that occur and are investigated by the Board.
    Discussion: Liz Hess advised that National Coordinating Council Medication Error Reporting and Prevention (NCC MERP) is used at University of Kentucky Healthcare.

Melissa Robertson stated that NCC MERP is also utilized at the University of Louisville.

Actions: Liz Hess requested the following from each member to be reviewed at the next meeting:

- What taxonomy, if any, is used by your pharmacy to assign harm levels to medication error reports, e.g. National Coordinating Council Medication Error Reporting and Prevention (NCC MERP)?

2. Categorize the types of errors that occur and develop a standardized remediation plan/assignment for the board to employ with a disciplinary action for a medication error.

   Discussion: Liz Hess stated that NCC MERP has this list available. Some agencies have made modifications of the list to better identify their needs.

   Actions: Liz Hess requested the following from each member to be reviewed at the next meeting:

   - What software program, if any, is used by your pharmacy to track medication errors, e,g, Datix?

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
   - Informal discipline
   - Letter of reprimand
   - Unethical/unprofessional conduct
   - One of the above PLUS remediation plan
   - Other

   Discussion: Eden Davis gave a summary of the case disciplinary process for medication errors. Medication errors are reported to the Board from multiple sources: consumers, pharmacists, insurance, etc. Prior to February 2021, the standard resolution for a medication error resulted in an adverse action taken against healthcare professionals which is reportable to the National Association of Boards of Pharmacy [NABP]. An adverse action is an action taken by the Board of Pharmacy that gets reported to NABP and the NPDB. This includes all Agreed Orders. The Board is currently utilizing a letter of reprimand, a non-adverse action. A non-adverse action is an action taken by the Board of pharmacy that does not get reported to NABP/the NPDB. This includes letters of reprimand and letters of concern. “Letter of reprimand" means a letter admonishing a licensee, permit holder or registrant for violating pharmacy law, but notifying the licensee, permit holder or registrant that in consideration of mitigating evidence, the board has determined that disciplinary action is not appropriate. A letter of reprimand is not considered to be an adverse action and is not reportable to NABP. The letter of reprimand discoverable with an open records request. It was noted by the committee that the

term ‘reprimand’ has a negative connotation for the lay person, even if not considered disciplinary.

Actions: Liz Hess proposed a review of two New York Times articles at the next meeting and requested Ms. Davis provide a sampling of cases involving medication errors reported to the Board.

4. Consider the idea of developing a repository database for Kentucky pharmacists to safely and anonymously report medication errors and concerns for patient welfare (no specific pharmacies or pharmacists would be reported – data collected would be categorized to type of practice setting, etc.)

   Discussion: The committee discussed the development of a repository database for pharmacists to report medication errors safely and anonymously for review. Liz Hess stated this was possible using ISMP or RL Solutions. Jill Rhodes suggested utilizing the inspection staff in the review process. The committee agreed that this reporting tool should be simple and easy to use avoiding duplication of other reporting methods.

   Actions: Liz Hess requested the following from each member to be reviewed at the next meeting:

   - What software program, if any, is used by your pharmacy to report medication errors?

B. Charged January 28, 2021 – ISMP for Medication Error Prevention: Direct the Medication Safety Committee consider the utilization of the ISMP Medication Safety Self-Assessment for resolution in medication error disciplinary cases.

   Discussion: The utilization of the ISMP Medication Safety Self Assessment for Community/Ambulatory pharmacy as part of the resolution of disciplinary cases for medication errors was discussed. This self-assessment is intended to review risk points within the medication-use process, in order to identify opportunities to prevent medication errors.

   Actions: Liz Hess will provide a copy of the self-assessment at the next meeting.

A Doodle Poll will be sent to schedule the July meeting, which will be virtual. Jessica Schmurr moved to adjourn. Melissa Robertson seconded, and the motion passed unanimously.

Liz Hess adjourned the meeting at 10:46 a.m.