Kentucky Board of Pharmacy Medication Safety Committee

Kentucky Board of Pharmacy
via teleconference at
https://us02web.zoom.us/j/81813478139?pwd=d290UFZXczhvZHpPUm40SmYwN3VWUT09
Meeting ID: 818 1347 8139 Passcode: GX79kx
Dial by your location
+1 312 626 6799 US (Chicago) +1 646 558 8656 US (New York)
Meeting ID: 818 1347 8139 Passcode: 551918

September 20, 2021
9:00 a.m.

Agenda

I. Call to Order

II. Minutes – July 12, 2021

III. Katie Johnson: How other states code event types

IV. Liz Hess: Comparison of Event Types

V. Letter of Reprimand Templates: determine who can review for language in line with Just Culture

VI. Options for assessing medication errors reported to the Board

VII. Options for medication error repository

VIII. Adjournment

KENTUCKY BOARD OF PHARMACY
125 HOLMES STREET
FRANKFORT KY 40601

MEDICATION SAFETY COMMITTEE

September 20, 2021

MINUTES

CALL TO ORDER Liz Hess called the meeting to order on September 20, 2021 at 9:03 a.m. Members present: Liz Hess; Melissa Robertson; Jessica Schmurr; Donna Drury; Amy Billimoria and Katie Johnson.

Staff: Larry Hadley, Executive Director; Eden Davis, General Counsel and Darla Sayre, Executive Staff Advisor.

Members absent: Amanda Thompson, Theresa Porter and Dreama Johnson.

MINUTES Jessica Schmurr moved to approve the minutes from the July 12, 2021 meeting. Melissa Robertson seconded, and the motion passed unanimously.

1. CATEGORIZE EVENT TYPES FOR MEDICATION ERROR

Discussion: Katie Johnson reported that she received few responses from her request to other states and the method used for event types. Of the responses the majority utilize NCC MERP with custom features specific to their needs. Liz Hess noted that it appears many facilities are not working with their Board of pharmacy. Liz Hess provided a comparison of the AHRQ Community Event Types, AHRQ Hospital Event Types, NCC MERP Event Types and proposed committee recommendations.

Actions: The committee reviewed this list with several suggested changes. The revised Event Type Recommendations will be reviewed for approval at the next meeting.

2. LETTER OF REPRIMAND TEMPLATE

Discussion: Eden Davis presented a revised letter of reprimand template after considering the feedback from the last meeting. Katie Johnson questioned if a medication error was a violation of law. Liz Hess agreed due to most mediation errors were accidental with no intent to harm. Katie Johnson requested a list of medication error violations and their resolution. Ms. Davis advised that each case must be reviewed separately and there can be no standardized discipline procedure.

Actions: Eden Davis will provide a summary of medication error violations and resolutions to be reviewed at the next meeting. Two volunteers will be named at the next meeting to draft a proposed letter of reprimand to include 'Just Culture' language.

3. MEDICATION ERROR REPORTING

Discussion: Liz Hess requested information on how medication errors are currently reported to the Board. Ms. Davis stated that medication errors are received via consumer grievance by email, fax or phone. Liz Hess inquired if there were funds in the budget to purchase software for an electronic submission. Larry Hadley stated that there are no funds allocated in the current budget for this purchase. If needed, it may be included in the future budget.

Actions: Liz Hess will meet separately with Larry Hadley and Jill Rhodes to discuss:

1. Error reporting to board
2. Medication error repository options logistics/how to carry these out?
3. Ideas for CE piece of charge, i.e. where would it be presented or available

A Doodle Poll will be sent to schedule the next meeting in November. Jessica Schmurr moved to adjourn. Katie Johnson seconded, and the motion passed unanimously.

Liz Hess adjourned the meeting at 10:34 a.m.

MEDICATION SAFETY COMMITTEE CHARGES

A. 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. January 28, 2021 – ISMP for Medication Error Prevention:

"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."