KENTUCKY BOARD OF PHARMACY
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KENTUCKY BOARD OF PHARMACY

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AD HOC MEDICATION SAFETY COMMITTEE MEMBER APPLICATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Mobile Phone _____

Email _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS; ATTACH ANY REQUIRED EXPLANATION, RESUME OR CV [curriculum vitae] AND A SUMMARY OF YOUR INTEREST IN SERVING ON THIS COMMITTEE; AND DATE AND SIGN

- Have you had any criminal conviction?
  Yes _____ No _____ If yes, attach an explanation.
- Have you ever had any past disciplinary action taken against you by another licensure Board? Yes _____ No _____ If yes, attach an explanation.

_____ _____
Date Signature

Kentucky Board of Pharmacy
Medication Safety Ad Hoc Committee

Purpose:

1. To create a committee composed of pharmacists and a patient-citizen representative with expertise in medication safety.
2. To develop a peer-approved, reliable, evidence-based contemporary process for formal assessment of medication errors by the board of pharmacy through utilizing validated tools, remediation, punitive and non-punitive measures.
3. To produce a proactive medication safety plan for the board of pharmacy to reduce and prevent medication errors across the Commonwealth.

Committee Composition:

Committee will be composed of 9 members that include 7 pharmacists with expertise in medication safety and 2 patient-citizen representatives.

Background:

Punitive medication safety healthcare cultures create known barriers that are detrimental to patient safety improvement efforts. This concept applies outside the healthcare system as well. The duty of the board of pharmacy is to promote, preserve, and protect public health, safety, and welfare by and through effective control and regulation of the practice of pharmacy (see KRS 315.002, KRS 215.005). Aligning with this duty, the disciplinary action and enforcement of the laws of our profession related to medication errors would be addressed by the proposed committee.

Patient safety is a unique issue and provides an opportunity for the board of pharmacy to globally improve the overall medication safety of our Commonwealth. The reactive measure taken by the board of pharmacy to address medication errors and fulfill the duty of the board has been to apply traditional punitive disciplinary action. Other measures are encouraged to align with contemporary means of addressing medication safety that provide more support for "effective control and regulation of the practice of pharmacy." A reactive approach of applying non-punitive measures is recommended in the application of medication error board action. Additionally, proactive measures should be developed and employed by the board of pharmacy in improving overall medication safety and providing guidance to the profession. These proactive approaches should encourage new ideas and methods in patient safety when it relates to promoting best practices in medication safety in our state.

Specific board of pharmacy requests of the committee:

1. Considering adopting a formal 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)
    - Categorize the types of errors that occur and develop a ***standardized*** remediation plan/assignment for the board to employ for each type of medication error.
    - Provide assignment of ***standardized*** disciplinary action against a pharmacist or pharmacy for medication errors.
    - Provide an opinion on whether the board should assign disciplinary action against a pharmacist and pharmacy for a first offense medication error that

causes no harm v. medication errors that cause harm. For example see below bullet points.

- First time offenses that did not include gross negligence or harm could be acted upon by one or more of the following:
    - Informal discipline
    - Letter of reprimand
    - Assign no disciplinary action, punishment or fine
    - One of the above PLUS remediation plan (mandatory CE or action plan)
- Medication errors resulting in harm, 2nd time medication error occurrences or gross negligence could be acted upon by one or more of the following:
    - Unethical/unprofessional conduct
    - Informal discipline
    - Letter of reprimand
    - Assign no disciplinary action
    - One of the above PLUS remediation plan (mandatory CE or action plan)

2. Provide an annual report of the top 10 errors to the Board of Pharmacy which is provided to all registered pharmacists and pharmacies in Kentucky.
3. Create an annual 1-2 hour Board of Pharmacy Approved CE program for pharmacists to address the most common errors observed in the previous year.
4. Develop a repository database for Kentucky pharmacists. Elements of the database would include the following:
    - Pharmacists would *voluntarily* 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).
    - The repository database would be readily accessible by pharmacists on the board website. This would serve as educational tool for the profession where pharmacists may read redacted material that describes medication error events and take a proactive approach in developing safeguards for medication safety in their practice settings.
    - Medication error database review and discussion by the ad hoc committee to identify patterns of concern for our state with corresponding recommendations for corrective action plans / remediation support for the board to consider for the profession.
    - Partner with an expert organization for a state pilot for this database? (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.

Reference to KRS Statutes related to public policy – pharmacy:

315.002 Declarations of public policy -- Construction of chapter. The practice of pharmacy within the Commonwealth is declared to be a professional practice affecting the public health, safety, and welfare, and is subject to regulation and control in the public interest. It is further declared to be a matter of public interest and concern that the practice of pharmacy, as defined in this chapter, should merit and receive the confidence of the public, and only qualified persons shall be permitted to engage in the practice of pharmacy and ensure the quality of drugs and related devices distributed within the Commonwealth. This chapter shall be liberally construed to carry out these objectives and purposes. The persons entrusted through this chapter to engage in the practice of pharmacy shall be pharmacists. They shall be recognized by the Commonwealth as health care professionals, and, within their statutory scope of practice, providers of pharmacy related primary care.

315.005 Purpose of chapter. The purpose of this chapter is to promote, preserve, and protect public health, safety, and welfare by and through effective control and regulation of the practice of pharmacy; the licensure of pharmacists; the licensure, control, and regulation of all sites or persons who are required to obtain a license, certificate, or permit from the Board of Pharmacy, whether located in or outside the Commonwealth, that distribute, manufacture, or sell drugs within the Commonwealth.