



August 2002

USP Now Delivers Patient-Safety News Through Your E-Mail!

Starting this month, USP's Center for the Advancement of Patient Safety (CAPS) launches its Patient Safety CAPSLink™ Service to provide health care providers, reporters to the USP-ISMP Medication Errors Reporting Program, MedMARxSM subscribers and the larger health care community with free, up-to-date information on medication and medical safety. To introduce you to what you will receive with a subscription, we have attached to this e-mail the first set of news bulletins supplied through the CAPSLink Service.

USP's monthly CAPSLink Service will give you timely patient safety-related news from the health care industry, USP's Safe Medication Use Expert Committee as well as other USP Expert Committees, and information gleaned from USP's two medication-error reporting programs: *MedMARx* and the *Medication Errors Reporting (MER) Program*. The information will include articles and guidelines relevant to USP's patient safety activities and from organizations such as the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP), Joint Commission, Agency for Healthcare Research and Quality, American Academy of Health Services Research and Policy, American Public Health Association, American Medical Association, Centers for Medicare and Medicaid Services, and FDA.

Each month, the Patient Safety CAPSLink service will automatically provide you with a list of news bulletins with brief summaries as well as hyperlinks for additional information on selected topics. If you like the information received through this service, tell a friend, colleague, or co-worker (new subscribers see http://www.magnetmail.net/actions/USP_subscribe.cfm). You can easily withdraw from this news service at any time by following the directions at the end of each issue. We hope you will find the information provided by this service to be very useful and beneficial in your efforts to improve patient safety.

USP Patient Safety CAPSLink™

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This message has been sent to you as a service of the U.S. Pharmacopeia, Center for the Advancement of Patient Safety (CAPS). USP is a non-government organization that promotes the public health by establishing state-of-the-art standards to ensure the quality of medicines and other health care technologies. CAPS is part of one of USP's core public health programs - Patient Safety. USP's new Center for the Advancement of Patient Safety was created to encourage medication error reporting, conduct data analysis and research, develop educational programs, and propose standards, recommendations, and guidelines that ultimately improve the safety and quality of patient care.

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USP Patient Safety CAPSLink™
August, 2002

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1) NCC MERP Opposes Comparison of Medication-Error Rates

Because of differences in culture, definition, patient populations, and types of reporting and detection systems, comparisons of health care organizations' medication-error rates are "of no value," the National Coordinating Council for Medication Error Reporting and Prevention Council said in a recently approved statement. USP is a member and Secretariat of the Council. http://www.nccmerp.org/rec_020611.htm

2) American Public Health Association Annual Meeting

The 130th Annual Meeting of the American Public Health Association is scheduled for November 9-13 in Philadelphia, PA. A program on medication errors titled "Medication

error trends: Using MedMARx data to identify implications for policy, quality and practice" is scheduled for Tuesday, November 12, 2002 at 8:30 AM. In July 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented new standards directly focused on patient safety. These standards call for organizations to prioritize performance improvement initiatives. The willingness of participants in a national medication error reporting program to share information, even in the absence of federal legislation to protect such information, attests to the effectiveness of a model that supports anonymous reporting. You may see a detailed schedule for this session at http://apha.confex.com/apha/130am/techprogram/meeting_130am.htm

3) Tracking Albuterol Omissions

Missed respiratory therapy treatments are of concern to patients, health care providers, administrators, and policy makers. Missed respiratory therapy treatments (albuterol) have also been a recent focus of Joint Commission surveyors. Data collected in 2001 by MedMARx found that 35% of the sample hospitals reported at least one albuterol omission. *Emergency situation* (e.g., when the respiratory therapist has been called away from the unit to another patient care area, such as Emergency Room) was listed as a contributing factor for the omissions in 29% of the cases. MedMARx is an excellent tool for tracking missed respiratory therapy treatments. In the MedMARx program, a missed treatment is classified as a Category C error, but could be classified higher, if there is evidence of harm. A missed respiratory therapy treatment is an error of omission (Type). Causes reported to MedMARx include transcription inaccurate and handwriting unclear. MedMARx subscribers are encouraged to document actions taken that might prevent similar errors.

4) USP Introduces New MedMARx Multi-Facility Module

MedMARx has recently introduced a new multi-facility module (MFM) which was created for corporate health care systems and multi-hospital networks to analyze medication error data reported by all the facilities within their own system. The new functionality allows corporate health care systems to generate reports, charts, and graphs for an individual facility, groups of similar hospitals, or all hospitals within a system. The MFM incorporates new predefined searches developed for corporate health care systems, allowing them to generate medication error reports for their hospitals based on type of facility, bed size, error category, and action taken. Corporate health care systems also can build and save custom searches and reports. These searches, under the new MFM, can be built on error causes, location, or time frame; medication process node at which errors occurred; and type of products, staff, or patients involved.

For further information about the new MFM, call a MedMARx account manager at 1-877-MedMARx, or e-mail medmarx@usp.org For information about MedMARx, visit www.usp.org.

5) USP Supports FDA's Proposed Bar Code Regulations

USP recently announced that it supports the U.S. Food and Drug Administration's (FDA) proposal to develop regulations for bar coding on the label of all drug and biological products for human use as stated in the Dec. 3, 2001, *Federal Register*. "USP views FDA's bar coding proposal as a part of a larger medication error prevention approach," said Diane D. Cousins, vice president of USP's Center for the Advancement of Patient Safety. "And bar coding on pharmaceutical packaging will also enable health systems to leverage technology in order help prevent medication errors."

In addition to the FDA recommendations, USP also recommends that bar codes contain, at a minimum, the product's National Drug Code (NDC) number, lot number, and expiration date. The NDC number identifies the company's name, the drug's name and strength, and package size. This recommendation is contingent on FDA revisions of the current NDC system to provide greater accuracy and consistency to bar codes. For more information, visit www.usp.org/e-newsroom.

In a related story...

By October, every patient admitted to St. Lucie Medical Center in Stuart, Florida will be fitted with a barcode bracelet in an effort to minimize the potential for medication errors. <http://www.healthleaders.com/news/newspage1.php?contentid=36374>

6) Practitioners' Reporting News

View summaries of medication error reports submitted by practitioners in various healthcare settings through the USP Medication Errors Reporting (MER) Program. The latest summary posted to the Practitioners' Reporting News website is about a handwritten medication order for "Lantus" insulin that was misread as "Lente." See www.usp.org and click "Medication Error Involving Insulin Attributed to Poor Handwriting" found in the column under Headlines.

7) Congress and JCAHO Take Actions to Remedy Nursing Shortage

America's growing nursing shortage has garnered the attention of both legislators and regulators. Congress recently passed the Nurse Reinvestment Act on July 22 that includes a campaign of public service announcements to promote the nursing profession, scholarships for nursing students, and grants to hospitals and other medical facilities that offer career incentives to nurses to advance in their field. Concurrently, JCAHO recently issued an urgent call for action believing the shortage is putting patient lives in danger. Three key solutions have been proposed by a special Joint Commission Expert Roundtable report: (1) Focus on transforming the nursing workplace; (2) Bolster nursing education; and (3) Provide new federal money as an incentive for health care organizations to invest in nursing services.

<http://www.washingtonpost.com/wp-dyn/articles/A52730-2002Aug6.html>

<http://www.jcaho.org/news+room/latest+news+release/nursing+shortage.htm>

8) JCAHO Answers Questions on New National Patient-Safety Goals

JCAHO has recently posted answers to some of the most frequently asked questions regarding their new national patient-safety goals and recommendations. Starting in January 2003, organizations accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be surveyed for compliance with six patient-safety goals (National Patient Safety Goals and Recommendations). Some of the goals relate directly or indirectly to improving the safety of the medication-use process.

<http://www.jcaho.org/news+room/latest+news+release/npsg.htm>

<http://www.jcaho.org/accredited+organizations/patient+safety/faq/faqs+about+national+patient+safety+goals.htm>

Final revisions of JCAHO's "medication-management standards" (to be renamed) have been delayed until at least next spring, but the standards are still on target for implementation in January 2004. JCAHO expects to finalize revisions to the hospital accreditation standards by March or April 2003 and to implement them in January 2004. The revamped hospital accreditation standards will focus on issues that directly influence the safety and quality of patient care.

9) New Adverse-Drug-Reaction Education Module is Available

A government-funded project of the Centers for Education and Research on Therapeutics at the University of Arizona has resulted in an education module titled "Preventable Adverse Drug Reactions: A Focus on Drug Interactions." This module provides a new resource for learning how to prevent adverse drug reactions.

<http://www.fda.gov/cder/drug/drugReactions/CERT%20Lecture%20Guide.pdf>

(PDF version)

<http://www.fda.gov/cder/drug/drugReactions/default.htm>

(HTML version)

10) AHRQ Inpatient Quality Indicators Software Released

AHRQ released the Inpatient Quality Indicators (IQIs), a free, downloadable tool designed to help hospitals, purchasers, and others flag potential quality-of-inpatient-care problems. The IQI software uses hospital discharge data to flag potential quality problems and can spot questionable overuse, underuse, or even misuse of certain procedures. Hospitals can use this data as a prompt to investigate quality problems and make improvements. Go to <http://www.ahrq.gov/news/press/pr2002/inptqipr.htm> to read our press release and www.ahrq.gov/data/hcup/inpatqi.htm to download AHRQ's Inpatient Quality Indicators software.

11) Overdose in Chemotherapy Leads to Hearing Loss in Boy

A 2 1/2 -year-old boy became deaf after receiving an overdose of cancer chemotherapy two months ago at the Johns Hopkins Children's Center, the state health department said yesterday. The child, who was given twice the correct dose on three successive days, was one of two pediatric cancer patients given accidental overdoses in late May, the agency said. In the other case, which involved a young girl, the dose was corrected after one treatment and before any harm was done.

[http://www.sunspot.net/news/health/bal-
te.hopkins01aug01.story?coll=bal%2Dlocal%2Dheadlines](http://www.sunspot.net/news/health/bal-
te.hopkins01aug01.story?coll=bal%2Dlocal%2Dheadlines)

12) Groups Sponsor National Health Policy Audioconference Series

A series of audioconferences on employer and health plan initiatives in healthcare quality improvement and medical error reduction is being sponsored by Health Affairs, the Alliance of Community Health Plans, the Blue Cross Blue Shield Association, the Consumer Driven Healthcare Association, the National Business Coalition on Health, the National Committee on Quality Assurance, and the Pacific Business Group on Health. The program scheduled for September 10 will deal with Employer and Health Plan Initiatives in Healthcare Quality Improvement and Medical Error Reduction.

Continuing education credit will be available. The registration fee is \$225 per site and there is no limit to the number of attendees per site. You can register online at: <http://www.HealthPolicyAudioconferences.com>

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You are currently subscribed to USP Patient Safety CAPSLink. To refer colleagues or friends to subscribe to this newsletter [click here](#). To unsubscribe click on this [link](#).

USP operates two complementary error reporting programs; the **Medication Errors Reporting Program** which operates in cooperation with the Institute for Safe Medication Practices and **MedMARx<sup>SM</sup>**. MedMARx is an Internet-accessible, anonymous medication error reporting program and quality improvement tool used to track and trend medication errors. For more information, visit [www.usp.org](http://www.usp.org)

USP does not sell or distribute e-mail addresses. Questions about USP Patient Safety CAPSLink should be sent to (CAPS@USP.ORG)

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