December 12, 2024 | Volume 29 ■ Issue 25

ISMP
An ECRI Affiliate

Acute Care ISMP Medication Safety Alert!®

Educating the Healthcare Community About Safe Medication Practices

Celebrating the 2024 Cheers Award Winners

This week, ISMP celebrated the 27th annual **CHEERS AWARDS**, which recognize individuals, organizations, and groups that have demonstrated extraordinary commitment to advancing the science and study of patient safety. This year's winners were honored at an awards ceremony held on December 10, 2024, at the Civic Theater in New Orleans, Louisiana. Please join us in celebrating the amazing accomplishments of this impressive group, who have helped advance vaccine safety, addressed opioid management, and has been a pioneer in the implementation of technology such as computerized prescriber order entry (CPOE) that can help reduce the risk of errors and adverse events.

CHEERS AWARDS Winners

The Quality Improvement Team at **Cook Children's Health Care System** in Fort Worth, Texas, received a **Cheers Award** for significantly reducing the number of vaccine errors within their pediatric network. The team was formed to address errors related to immunizations, especially those involving complex vaccine age eligibility and vaccine series interval timing. They collaborated with the information technology department to integrate a clinical decision support tool into the electronic health record system that alerts healthcare providers to potential errors in real time. Since it was implemented, more than 9,000 inappropriate vaccine orders have been successfully averted by following the guidance provided by the clinical alerts. A substantial decrease in error rates was noted for most vaccines, with the most pronounced decline for the hepatitis A series, which achieved an impressive 91% reduction. The team also implemented a dashboard-based monitoring system for patient safety to ensure continuous improvement and oversight.

The Perioperative Opioid Stewardship Research Program at the **Hospital for Sick Children (SickKids)** in Toronto, Canada, was honored for improving the way opioids are managed during post-surgery hospital discharge. The program aims to address overprescribing of opioids in pediatrics, minimize the volume of unnecessary opioids entering the community, and decrease the volume of unused opioids. The program team identified risks, modified practice standards, re-evaluated processes, and expanded their reach to other diagnoses. Their achievements include using technology and quality improvement methodology to safely decrease the amount of unused opioids retained by patients in the home from 83% to 17% and creating a new pathway to facilitate the return and disposal of unused opioids. They also addressed language barriers and improved access by translating all educational documents into the ten most used languages in their surgical population, allowing more families to participate.

continued on page 2 — Cheers Awards >

SAFETY briefs

HIGH-ALERT

Fluid shortage update. To address current drug shortages, Baxter received discretion from the US Food and Drug Administration (FDA) to release four lots of intravenous (IV) fluid bags manufactured at the North Cove facility prior to Hurricane Helene. A very small proportion of these products have been associated with leaks, which are currently under investigation. These lots are being released with instructions for healthcare practitioners to screen the bags for leaks before use and to sequester IV fluid bags that have any evidence of leakage. According to Baxter, any leak would most likely be presented as an obvious defect before handling, and/or would present itself as an obvious defect once pressure is applied.

Organizations should contact their local Baxter sales representative to find out if they will potentially receive impacted products, and if so, implement a process to evaluate products prior to use. If a defect is found or a leak occurs, sequester the product and report this to Baxter, FDA, and ISMP. For additional information, refer to the Baxter website: *FDA Discretion for Solution Batches*.

In addition, as a follow-up to our November 28, 2024 article, *Imported glucose injection*, the American Society for Parenteral and Enteral Nutrition (ASPEN) is providing *Clinical Considerations in the Conversion of Dextrose Injection USP to Glucose 50% Injection*, an educational resource with case studies for practitioners to better understand nuisances with the imported glucose product.

Do not confuse Neffy and Narcan nasal sprays. On August 9, 2024, the US Food and Drug Administration (FDA) approved **NEFFY** (**EPINEPH**rine), the first nasal spray for the emergency treatment of anaphylaxis (ARS Pharmaceuticals). A physician reported concerns about the potential for confusion between Neffy nasal spray and **NARCAN** (naloxone) nasal spray, which is used for opioid overdose reversal.

continued on page 2 — SAFETY briefs >

> Cheers Awards — continued from page 1

LIFETIME ACHIEVEMENT AWARD Winner

One of the highlights of the evening was the presentation of the 2024 **MICHAEL R. COHEN LIFETIME ACHIEVEMENT AWARD**. This award has recently been re-dedicated in honor of ISMP Founder and President Emeritus Michael R. Cohen and is given to individuals who have made ongoing contributions to patient safety throughout their careers. This year's honoree, ***David W. Bates, MD, MSc***, an internationally renowned safety expert, has conducted groundbreaking work evaluating the incidence and preventability of adverse drug events.

Dr. Bates has demonstrated that information technology such as CPOE and clinical decision support can decrease the risk of serious medication errors, and CPOE has now been implemented in health systems and facilities across the United States. He has published more than 1,200 peer-reviewed papers that have been cited over 155,000 times and is among the 400 most cited biomedical researchers. His research has been referred to in Health Care Financing Administration regulations, the Medicare Patient Advisory Commission's 1999 Report to Congress, and the Institute of Medicine's report *To Err is Human*.

Dr. Bates is the Medical Director of Clinical and Quality Analysis at Mass General Brigham, and a Senior Physician at Brigham and Women's Hospital (BWH). In addition, he directs the Center for Patient Safety Research and Practice at BWH, which focuses on improving medication safety across the continuum of care and patient groups. Dr. Bates also is a professor at both Harvard Medical School and the Harvard T.H. Chan School of Public Health, and is editor of the *Journal of Patient Safety*.

He has received multiple awards, including the first John M. Eisenberg Award for excellence in patient safety research from the National Quality Forum and the Henry Christian Award for excellence in research from the American Federation for Clinical Research.

In his acceptance remarks, Dr. Bates described how he met Michael Cohen and was introduced to the work of ISMP. He talked about becoming interested in the field of medication safety, conducting an adverse drug event prevention study and later showing that CPOE can make a substantial difference. Dr. Bates also discussed his work on the impact of barcode scanning and smart infusion pumps, and shared some findings from a SafeCare study that has just been completed. The SafeCare study showed that despite all the progress that has been made, about one in four patients is harmed during a hospital admission and one in fifteen is harmed per year in the outpatient setting. Medications are the leading cause of harm in both settings. Dr. Bates went on to outline some ways that the healthcare community can work together in the future to further advance medication safety.

Thanks and Looking Forward

We would like to express our gratitude to all of the organizations and individuals who attended and/or supported this year's **CHEERS AWARDS**. Visit the Cheers Event webpage for a list of contributors and winners; you can also make a Donation to help support ISMP's lifesaving efforts.

ISMP wishes you happy holidays, and we look forward to continuing to work together on preventing errors and keeping patients safe in 2025.

The next newsletter will be published on **January 16, 2025**.

See you next year!

>SAFETY briefs

cont'd from page 1

Neffy is available by prescription only and comes in a carton containing two blister-packaged devices of **EPINEPH**rine 2 mg (2 mg/0.1 mL) (**Figure 1**). It is indicated for adults and children who weigh greater than or equal to 30 kg. Each device provides a single dose of 2 mg of **EPINEPH**rine administered into one nostril. In the absence of clinical improvement after the initial dose or if symptoms continue to get worse, after 5 minutes a second dose of Neffy may be administered into the same nostril with the second nasal spray device. Patients may need to seek emergency medical assistance for close monitoring of the anaphylactic episode and in the event further treatment is required.

Figure 1. Each single-dose Neffy nasal spray device contains 2 mg of **EPINEPH**rine. It is available in a carton containing two packaged devices.

Narcan also comes as a single-dose nasal spray. It is given for opioid overdose reversal for patients of all ages, including infants, children, and adults. If the patient does not respond, or responds and then relapses into respiratory depression, additional doses may be given every 2 to 3 minutes, using a new device for each dose, until emergency medical assistance arrives. Various brand and generic naloxone nasal sprays are available, including over-the-counter (OTC) and prescription products in several strengths (e.g., 3 mg, 4 mg, 8 mg).

Neffy and Narcan come in similar nasal spray devices, and their brand (and generic naloxone) names start with the letter "n." Neffy and Narcan nasal sprays are used for different life-threatening indications (i.e., anaphylaxis versus opioid overdose reversal), so a mix-up could lead to a delay in treatment and patient harm. Unlike the Narcan carton label which, depending on the manufacturer,

continued on page 3 — SAFETY briefs >

Child receives wrong drug due to proxy scan

A prescriber ordered an intravenous (IV) leucovorin infusion for a patient on a pediatric oncology unit. This was part of the child's chemotherapy regimen, so the hospital policy required a second nurse verification before administration. The first nurse scanned a "proxy" patient identification (ID) barcode that she printed and stored with a stack of other patient ID barcodes at the nurses' station (**Figure 1**). Then she scanned the barcode on a pharmacy-generated label attached to the leucovorin infusion. A second nurse verified the information on the leucovorin label and in the medication administration record (MAR). The nurses co-signed the documentation of administration in the MAR, using the computer at the nurses' station. The first nurse then entered a different child's room, with a similar name and age as the child who had been prescribed the leucovorin, and started the infusion. Shortly after, the nurse identified that leucovorin had not been prescribed for that child. She discontinued the infusion and notified the prescriber. Fortunately, there was no patient harm. During the event investigation, it was discovered that the unsafe process of using a proxy scan for patient ID bands was a common practice by nurses who were trying to avoid disturbing patients in the pediatric oncology unit by entering their room to scan the patient ID on their wristband.

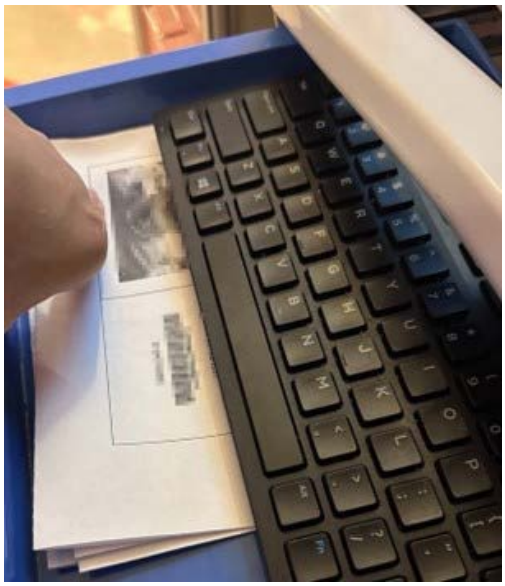

Figure 1. Printed copies of patient ID barcodes that nurses were using as a proxy scan.

Barcode medication administration (BCMA) and positive patient identification (PPID) prior to administering any medication is a crucial step to prevent errors from reaching patients. However, workarounds such as using a proxy scan (e.g., scanning a patient ID barcode that is not attached to the patient) negate the effectiveness of this technology. Regularly observe BCMA practices within your organization to help identify potential workflow issues leading to workarounds. Educate staff on when and how to report BCMA-related workflow issues, and why it is dangerous to use a proxy scan. This is an example of at-risk behavior that may stem from the culture of individual nursing units. Discuss similar concerns with nursing leadership to foster a culture of safety. Work with the informatics team to determine if it is possible to only allow for scanning of the patient ID band, and not the barcode on patient stickers/paperwork. Use internal or external published events related to incorrect BCMA utilization to educate staff to further highlight the importance of BCMA.

Special Announcements

ISMP survey on parenteral nutrition (PN)

We are conducting a short survey about PN including the usage and safety of multi-chamber bag parenteral nutrition (MCB-PN) and patient-specific compounded (i.e., custom) PN. Please take 10 minutes to complete this survey by **January 23, 2025**. We appreciate your participation!

Expanding Our Impact | ECRI acquires The Just Culture Company

ECRI is excited to welcome The Just Culture Company to its portfolio of solutions. For a limited time, we are offering special pricing on Just Culture training. To learn more about The Just Culture Company and to register for one of the programs to take advantage of the discounted pricing, click here.

>SAFETY briefs cont'd from page 2

may include warning statements such as "Use NARCAN Nasal Spray for known or suspected opioid overdose in adults and children," or "Emergency Treatment of Opioid Overdose," the Neffy label does not mention that it is for the treatment of anaphylaxis.

We have reached out to the US Food and Drug Administration (FDA) to notify them of the potential for a mix-up between Neffy and Narcan nasal sprays. If your organization includes either Narcan or Neffy nasal sprays on the formulary, ensure order sentences and discharge prescriptions include the indication. Communicate with staff about the availability of Neffy, and review the packaging, storage location, and other pertinent information. Use barcode scanning when receiving, dispensing, filling the automated dispensing cabinet (ADC), and prior to administration of any medication. Store look-alike products separately. If there is a plan to discharge a patient with a prescription for one of these nasal sprays, educate them about the indication and proper use, and to always read the medication name on the label before use. This is especially important if the patient/family will have both Neffy and Narcan nasal sprays available in their home. Educate them about the importance of storing them separately. Remind patients not to store these in cars that are subject to freezing or excessively high temperatures.

ISMP Medication *Safety Alert!* Acute Care (ISSN 1550-6312)

Report medication and vaccine errors to ISMP: Please call 1-800-FAIL-SAF(E), or visit www.ismp.org/report-medication-error. ISMP guarantees the confidentiality of information received and respects the reporters' wishes regarding the level of detail included in publications.

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ISMP
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Happy Holidays from the staff, Board of Directors, and Advisory Board at the Institute for Safe Medication Practices (ISMP). We wish you joy, health, and happiness this holiday season!

Production of this peer-reviewed newsletter would not be possible without the assistance of a reliable and talented clinical advisory board. As 2024 nears an end, we want to thank each of the following members of the advisory board for their dedication to making this newsletter a valuable medication safety resource for clinicians.

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