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ISMP Institute for Safe Medication Practices
An ECRI Company

Acute Care ISMP Medication Safety Alert!®

Educating the Healthcare Community About Safe Medication Practices

Sharing a Safety Mission: The 28th ISMP Cheers Awards — celebrating the winners

ISMP recently celebrated the 28th 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 9, 2025, at the House of Blues in Las Vegas. Please join us in celebrating the impressive accomplishments of this dedicated group, who have helped advance our shared safety mission through large scale smart pump integration, safe chemotherapy handling, and patient partnership.

CHEERS AWARDS Winners

AdventHealth, based in Altamonte Springs, Florida, received a **CHEERS AWARD** for its adoption of a comprehensive infusion pump management strategy across a large health system. In the past year, the AdventHealth team successfully incorporated smart pump integration with autoprogramming and autodocumentation in more than 50 hospitals throughout nine states. Prior to that, they created central governance with a multidisciplinary Smart Pump Oversight Committee, the OLTRA (One Library To Rule All) initiative to standardize AdventHealth's smart pump drug libraries, and development of a smart pump dashboard that monitors metrics for shared learning. They have continuously improved their processes, meeting national and organizational benchmarks and achieving an impressive 95% pump library compliance rate. The team's best practices have been shared on the national level, including at the 2024 IHI Patient Safety Congress, Epic XGM 2025, and a 2025 ISMP Medication Safety Officers Society briefing.

MiKaela Olsen, DNP, APRN-CNS, AOCNS, FAAN, Clinical Program Director-Oncology, Johns Hopkins Hospital and Johns Hopkins Health System, Baltimore, MD, and **AnnMarie Walton, PhD, MPH, RN, OCN, CHES, FAAN**, Dorothy L. Powell Term Chair of Nursing and Associate Professor, Duke University School of Nursing, Durham, NC, were honored for their leadership to improve the safe handling and administration of hazardous drugs for healthcare workers and caregivers. Among their many accomplishments, they co-edited the 4th edition of *Safe Handling of Hazardous Drugs* for the Oncology Nursing Society, a resource that is utilized by nurses all over the world. Drs. Olsen and Walton also each co-led the development of a Joint Position Statement on Safe Handling of Hazardous Drugs for the Oncology Nursing Society and Hematology/Oncology Pharmacy Association and have contributed to numerous other standards and guidelines.

Dr. Olsen is one of the experts developing a national Hazardous Drug Exposure Registry and has published on strategies to ensure full dose delivery of antineoplastic drugs to oncology patients. Dr. Walton conducts pivotal research on reducing healthcare workers' exposure to

continued on page 2 — Cheers Awards >

SAFETY briefs

HIGH-ALERT

U-500 regular insulin vial discontinued. We have received multiple reports that when organizations went to purchase **HUMULIN R U-500** (500 units/mL regular insulin [20 mL]) multi-dose vials, they found the product was no longer available. We met with Lilly representatives to discuss this concern, and they confirmed that the company has discontinued production of the Humu**LIN** R U-500 vials. There are currently no other 500 units/mL regular insulin vial products available in the United States. Lilly told us that the **HUMULIN R U-500 KWIKPEN** (500 units/mL regular insulin [3 mL]) pens and all presentations (vials and pens) of **HUMULIN R U-100** (100 units/mL regular insulin) will remain available in the United States.

Organizations impacted by this change should gather an interdisciplinary team and consider completing a failure mode and effects analysis (FMEA) to identify and mitigate risk. Consider alternative products on formulary, whether the organization should switch to Humu**LIN** R U-500 KwikPens, and what the workflow will be if a patient is admitted with an insulin pump and uses the 500 units/mL concentration of regular insulin. Drawing up a patient's dose from an insulin pen cartridge is not recommended, and organizations should evaluate alternative approaches (e.g., consult endocrinology, consider switching to 100 units/mL). Review impacted systems (e.g., order sets, products in the pharmacy system, discharge prescriptions), related policies and procedures, and patient teaching materials, to determine any necessary modifications.

If switching to pens, evaluate workflow and consider if it is possible to add a patient-specific label to the insulin pen device itself (not on the removable cap), so that, before administration, the nurse can scan the patient's wristband, patient-specific barcode on the pen, and the manufacturer's barcode to ensure it is the correct product for the patient.

continued on page 2 — SAFETY briefs >

> Cheers Awards — continued from page 1

hazardous drugs and was central to passage of state-based legislation to improve healthcare worker safety. They both advise health systems nationally and internationally, and their work has had a global influence on medication safety in oncology.

LIFETIME ACHIEVEMENT AWARD Winner

One of the mission critical highlights of the evening was the presentation of the 2025 **MICHAEL R. COHEN LIFETIME ACHIEVEMENT AWARD**. This award is given in honor of ISMP Founder and President Emeritus Michael R. Cohen to individuals who have made ongoing contributions to patient safety throughout their careers. This year's honoree, **Martin J. Hatlie, JD**, is a pioneer who has advanced the role of patients and caregivers as essential partners in improving safety across the healthcare continuum. Hatlie has been active in the field for more than 25 years and served as the Founding Executive Director of the National Patient Safety Foundation (NPSF), helping to establish patient safety as a recognized discipline in healthcare.

He has led healthcare transformation through numerous initiatives supported by the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Patient-Centered Outcomes Research Institute (PCORI), including co-leading the development of AHRQ's *Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families* and contributing to the AHRQ Communication and Optimal Resolution (CANDOR) Toolkit. He also contributed to the Patient Safety Structural Measure implemented in the Medicare Program in 2025.

Hatlie is a cofounder of Patients for Patient Safety US (PFPS US), the United States branch of the World Health Organization's Patients for Patient Safety international network, and serves as Director for Policy and Advocacy. He is on the Board of Certified Professionals in Patient Safety and is a member of the Steering Committee overseeing the implementation of *Safer Together: A National Action Plan to Advance Patient Safety*. He serves as cochair of the Leapfrog Group's Patient and Family Engagement Expert Panel and is on advisory boards for the Institute for Healthcare Improvement, the World Health Organization, and Georgetown University's Executive Master's Program in Clinical Quality, Safety, and Leadership, among others.

In his acceptance remarks, Hatlie reflected on how patient stories helped launch the modern patient safety movement and credited ISMP for creating a national medication error reporting program for patients and families. He emphasized that learning from medication safety events, advocacy, and collaboration remain essential for future efforts to advance patient 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, and 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 2026.

The next newsletter will be published on **January 15, 2026**.
See you next year!

>SAFETY briefs

cont'd from page 1

Determine if additional strategies are needed to safeguard the 500 units/mL pens (e.g., store separately from other insulin products such as in the controlled substance safe, independent double check prior to dispensing and/or administration).

Establish a communication and staff education plan to alert all involved practitioners about the change. Educate patients using the teach-back method when there is a change in the required device for their medication taken at home. Gather feedback from staff and encourage them to report concerns and errors internally and to ISMP for shared learning.

Avoid mix-ups between immediate- and extended-release cloNIDine formulations. A pharmacist reported events where a community pharmacy improperly substituted the 100 mcg/mL **ONYDA XR** (clo**NID**ine) extended-release oral suspension for prescriptions that had previously been prepared using a 20 mcg/mL extemporaneously compounded immediate-release oral suspension. Onyda XR (Tris Pharma), approved in 2024, is a once-a-day formulation with nighttime dosing, for the treatment of attention-deficit/hyperactivity disorder (ADHD) in pediatric patients six years and older. The immediate-release tablet formulation (used to prepare the extemporaneously compounded oral suspension) is approved to treat hypertension (typically twice daily) and has been used off-label for a variety of indications, including ADHD. For ADHD, the immediate-release formulation is initially administered at bedtime, and practitioners may increase the dose in increments as tolerated until the maximum daily weight-based dose is reached by administering the drug three to four times daily (UpToDate Lexidrug. Clo**NID**ine. Updated October 17, 2025. Accessed October 20, 2025). In addition, in October 2025, Azurity announced that the US Food and Drug Administration (FDA) has approved **JAVADIN** (clo**NID**ine) (0.02 mg/mL [20 mcg/mL] immediate-release oral solution) for hypertension in adults, which should be available by the end of 2025.

According to the Onyda XR prescribing information, immediate-release clo**NID**ine hydrochloride, extended-release clo**NID**ine

continued on page 3 — >SAFETY briefs >

Do not confuse similar-looking insulin pens

We have received multiple reports about the potential for mix-ups between **KIRSTY** (insulin aspart-xjhz, biosimilar to **NOVOLOG** [insulin aspart]), and **SEMGLEE** (insulin glargine-yfgn, biosimilar to **LANTUS** [insulin glargine]) 100 units/mL insulin pens. Both pens are manufactured by Biocon Biologics. The body and cap of each pen is the same blue color, and each has a light-colored pen label (**Figure 1**). While each pen label has a colored band that corresponds to the color of the device's injection button (i.e., orange for Kirsty and purple/lavender for Semglee), the look-alike nature of the pen body and cap may lead to errors when the pens are removed from their cartons.

Figure 1. Kirsty (top) and Semglee (bottom) insulin pens have a similar blue body and cap.

One of the reporters was notified that their organization, which has Semglee on formulary, would be purchasing Kirsty. So, they completed a proactive review of the labeling and packaging compared to other products used in the organization and became concerned about the potential for practitioners and patients to confuse these insulin pens. If Kirsty, a rapid-acting insulin for use at meal-time, is mistakenly administered instead of Semglee, a long-acting insulin, or if both are dispensed to patients for home use, this could lead to hypoglycemia, if Kirsty is inadvertently administered at bedtime. Although colors should not be relied upon alone, this is a great example of completing a safety analysis to proactively assess product characteristics that might cause confusion and lead to medication errors.

We have reached out to the manufacturer to notify them about this concern and recommend improved differentiation of the pen colors. When the pharmacy receives a new product or a product from a different manufacturer, conduct a review to identify potential risks with the product's design, including look-alike labeling and packaging concerns with other products in use. When problems are recognized, consider purchasing the product (or one product of a problematic pair) from a different manufacturer. Use barcode scanning when stocking, dispensing, and prior to administration. Evaluate workflow and consider if it is possible to add a patient-specific label to the insulin pen device (not the cap, which will be removed), so that before administration, the nurse can scan the patient's wristband, patient-specific barcode on the pen, and the manufacturer's barcode to ensure it is the correct patient's product. Communicate look-alike labeling and packaging concerns to staff, including any additional actions needed (e.g., use of auxiliary warning labels). Before discharge, use the teach-back method to educate patients about proper use of the pens, storing them separately, and always reading the label before use.

Welcome our new staff members

Director of Med Safety Board

Gretchen Brummel, PharmD, BCPS, joined our team as Director of Med Safety Board, an ISMP Company. Gretchen is a pharmacist and healthcare leader with expertise in safety, pediatric pharmacotherapy, digital and rural health, and disaster preparedness. She most recently served as Director of the Professional Experience Program at a college of pharmacy, leading experiential learning. Her prior roles include executive and clinical leadership at a performance improvement organization, a global information services company, and a quaternary medical center.

Medication Safety Specialist, Education

Kimberly West, MSN-Ed, RN, CHSE, joined ISMP as the Medication Safety Specialist for Education. Kimberly has worked in various hospital settings and is a Certified Healthcare Simulation Educator (CHSE). Most recently, she was an Assistant Professor of Nursing and Simulation Champion for Rasmussen University School of Nursing where she developed faculty onboarding; mentored faculty and students; was the course lead and exam coordinator; helped with curriculum design; and was involved in the building of a new simulation lab at the university.

>SAFETY briefs cont'd from page 2

hydrochloride tablets, and Onyda XR have different pharmacokinetic characteristics. Therefore, practitioners should not substitute doses of these drugs on a mg-for-mg basis as this will result in differences in exposures.

When possible, organizations should standardize to a single concentration of clo**NID**ine based on the patient population served. If changing concentrations is needed, a comprehensive proactive concentration change plan should be developed to prevent medication errors. If more than one concentration is needed, build order sets/sentences in the electronic health record (EHR) with dose range checking to guide prescribers to select the correct option based on the indication and automatically link the appropriate concentration in the pharmacy system. Use barcode scanning when preparing this medication and prior to administration. If patients will be transitioned to a different clo**NID**ine formulation, educate them about changes in dose, frequency, and concentration.

Survey on IV workflow management systems

Med Safety Board, an ISMP company, is conducting a survey on the use of intravenous workflow management systems (IVWMS) regarding the adoption, features, and medication safety concerns. We are interested in hearing from you whether IVWMS has been implemented yet or not. Please take 5 to 10 minutes to complete the survey by **January 16, 2026**. Thank you!

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Special Recognition... Our 2025 Acute Care Clinical Advisory Board

Production of this peer-reviewed newsletter would not be possible without the assistance of a reliable and talented clinical advisory board. As 2025 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.

2025 ISMP Medication Safety Alert! Acute Care Clinical Advisory Board

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!