San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Laguna Honda Hospital Medication Error Reduction Plan

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Background

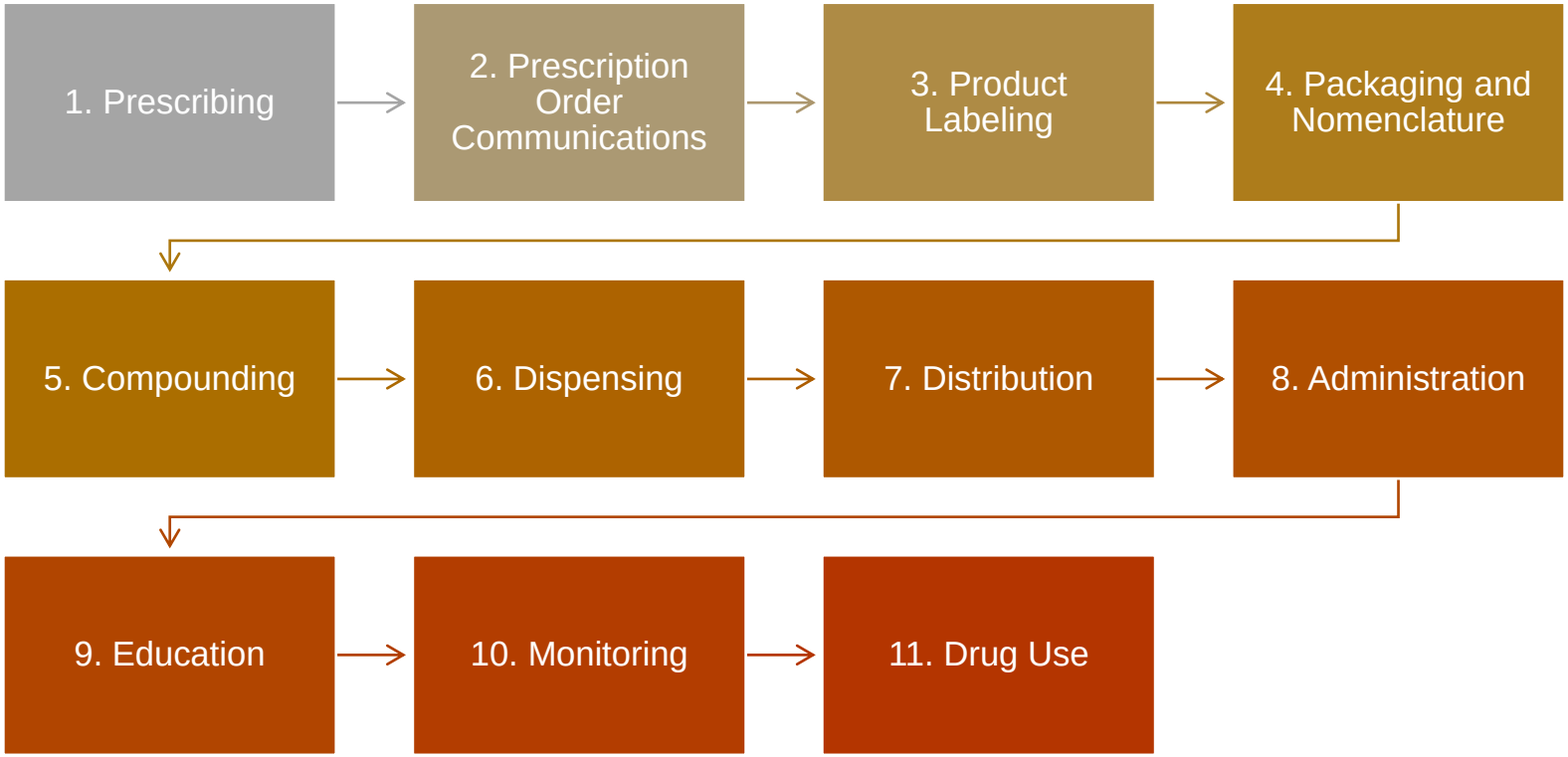
- The 1999 report, *"To Err is Human",* detailed prevalence of medical errors in healthcare and spearheaded the patient safety movement

- A Medication Error Reduction Plan (MERP) was developed in 2001
  To promote safe and effective medication use in healthcare facilities through reduction of preventable medication-related errors and adverse events

- Implementation and use of technology is required for MERP
  Electronic prescribing and access to labs
  Online drug formulary and drug information
  National Drug Code (NDC) pharmacy software and TallMAN lettering
  Automated unit dose packaging and dispensing cabinets

MERP

There are 11 “procedures and systems” that general acute care hospital facilities assess to identify weakness areas that may contribute to medication errors



Prescribing & Prescription Order Communication

- Development of order panels to minimize errors
  - Breakthrough Seizure Order Set
  - COVID Therapies Order Panels
- Participation in network wide work group to optimize Clinical Decision Support

Product Labeling

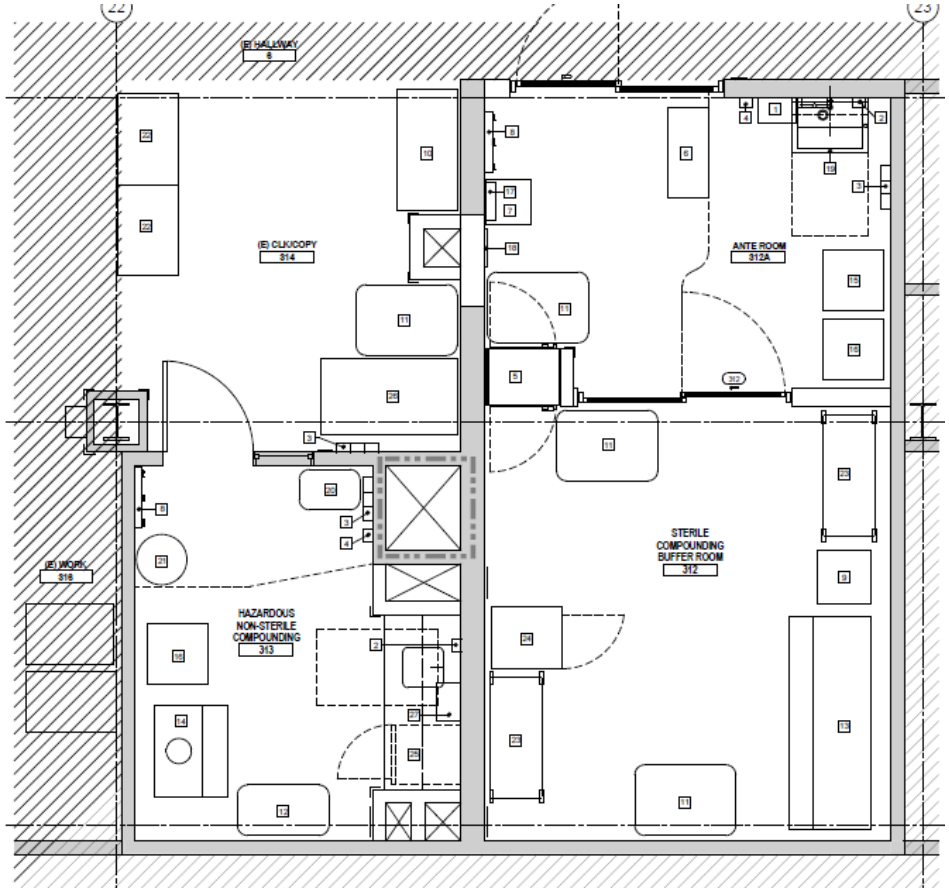
- Auto-population of expiration dating on Rx labels
  - Identify/implement OTIC auxiliary labels

Packaging and Nomenclature

- Planning for automated packager upgrade with pouch inspector

Compounding

- Capital Project for clean room upgrade underway



Dispensing

Upgrade of automated dispensing cabinets DPH wide

- LHH
- ZSFG
- JHS

- Contract negotiations ongoing
  - Recent progress in DPW portion for seismic bracing

- Current cabinets are at end of life

Distribution

- Continue to limit medication on units via ADC and 24–48-hour supply

Administration

- Upgrade of Smart Pumps
- Increased “spot” observations of medication administration
- Completed development of standardized tool for medication observations and single data repository
- Replacement of end-of-life medication carts
- Reached goal of ≥ 95% BCMA combined patient/med scanning

Monitoring

- Revised standard work for monitoring expired medication orders
- Improved investigation process for unreconciled pull of controlled substances

Drug Use

- Annual Antipsychotic Use
- Fentanyl Review

- Antimicrobial Stewardship

LHH Medication Related Committees

- Pharmacy and Therapeutics Committee
- Medication Error Reduction Subcommittee
- Drug Diversion Taskforce
- Psychotropic Drug Use Subcommittee
- Pain Subcommittee
- Diabetes Task Force
- Falls Committee
- Code Blue Committee
- Med-Nursing Combined QI
- Nutrition Subcommittee
- Product Evaluation Subcommittee
- Performance Improvement and Patient Safety
- Infection Control Committee
- SFHN Clinical Decision Support
- SFHN Rx Domain

LHH Resources for Improvement

External

- FDA Med Watch
- CDPH All Facilities Letter
- Institute for Safe Medication Practices
- Best Practices
- National Organization List Serves

Internal

- Review of adverse drug reaction data
- Review of medication error data
- Review of trigger drug reports
  - Monthly review of antidote (Narcan, D50W) use
- Medication pass observation
- Case reviews
- Omnicell audits
- CASPER reports
- Focus Groups

Future Endeavors