**MNSA Medication Safety Meeting Feb 2nd**

**(88 people in attendance)**

**Attended**: Julia, Rachel, Stephanie, Teresa, Jackie, Sam, Emily, Doctor Moore, Doctor Emeghebo, Professor Mullarkey

**Excused**: Phil, Katelyn

**News**:

* Ronald McDonald House Feb 6th 9:30am
* EKG Class 2/16
* Book Fair 2/23-2/24
* Gear Sale 2/22-2/24
  + - * Monday: 10-5
      * Tuesday 1-5
      * Wed 1-6

**Speaker Brain Malone**

* Medication Safety
* How to properly identify medication errors
  + Key identifiers
    - Name, Date of birth, asking past history if questioning medication
* Monitoring of the drug, which is done by proper
* 60% percent of medication errors are due to poor communication
* Swiss cheese theory
  + - Doctor writes an order
    - Technical/Individual error
    - Undesired outcomes
* Reasons for mistakes
  + - Distraction
    - High volume
    - High activity
    - Multiple individuals involved in care
* No harm if medication error is reported
  + - Committee meets and sees how the issue could be resolved/avoided.
* Everyday there are over 1200 medications being given at Winthrop
  + - In 3 months there were only 98 reported errors of 1million at Winthrop
      * 34 were mis-prescribed dose
      * The rest were transcription error
      * 40 did not hurt the patient at all
        + Missed dose, wrong dose, etc
* Joint Commission
  + They create medication safety goals, if a hospital has multiple errors they get accredited
  + Government regulations
* High Risk drugs
  + Drugs that have high potential for abuse
    - Insulin
    - Heparin and Anticoagulants
    - Anti- neoplastics
    - Opioids
    - Propofol
    - Benzodiazepines
* Look a like-sound alike meds
  + They might look similar but they DO NOT act the same
  + Tall Man lettering
* Reconciliation Medication
  + Needed the complete list of Medication taken at home (home list)
  + To make sure the right dose and right medications are given
* Telephone orders
  + Rarely allowed, one time orders only, or in a code
* Some abbreviations are unacceptable
  + Causing medication errors
    - U (for unit)
    - U.D, Q.I.D, Q.O.D
    - Trailing Zeros
* Medication Management
  + Computer system that double checks common errors
* Goals
  + Reduction of Floor stock
* Bar Code Medication administration
  + Proven to reduce errors
  + Provide valuable near misses
  + Provided an automated accuracy of medication
  + Shows the missed dose
* Alaris Smart Drip
  + Prevents infusion errors of high risk medications
  + If error is present, medication will not administer
* What are ADR?
  + Adverse drug reaction
    - Unintended, unexpected reaction to a medication
      * S&S: Trouble breathing, hypotension, hypoglycemia
      * Should be reported

There is a hotline regarding ADR

Prevents effects of drugs

* Medication addictions
  + Prevented now by inspections
  + Divergent is a program offered to help health care professionals who are addicts
* In 2014, 51 deaths are reported for Heroin Deaths
  + Running rapid now because perception drugs are hard to come by.