Market Trends in CSTDs PAGE S8

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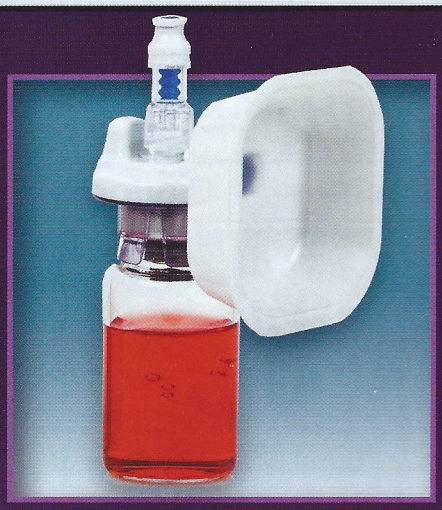
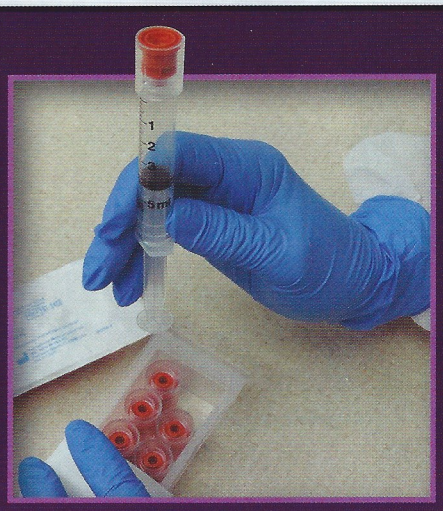
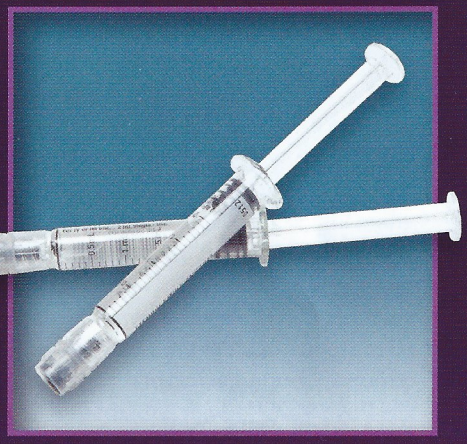
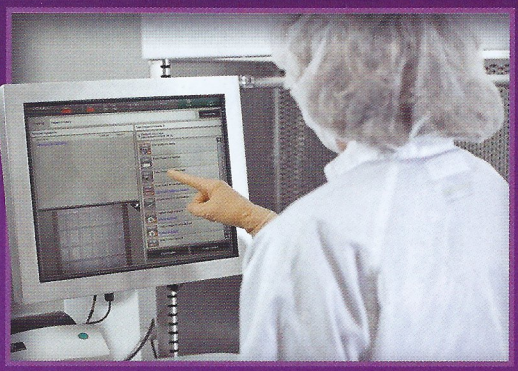
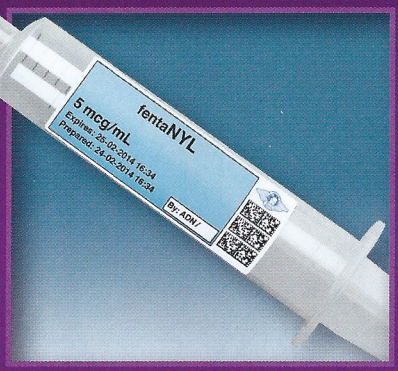


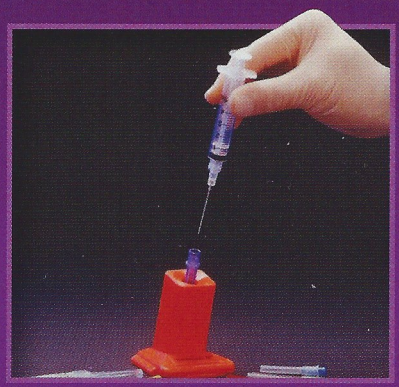




IV SAFETY







Advocating for Safe Pediatric Medication Labeling

A Q&A WITH CHRISTOPHER JERRY PAGE S2

Increase Use of Ready-to-Administer Prefilled Injectables

BY KEITH P. SHUSTER, RPh, MBA PAGE S6

Image courtesy of the Emily Jerry Foundation

Advocating for Safe Pediatric Medication Labeling

Q&A with Christopher Jerry, President & CEO The Emily Jerry Foundation

Pharmacy Purchasing & Products: **The story of your daughter Emily's death caused by a technician's compounding error is heartbreaking, and yet your resultant advocacy for patient safety is so powerful. Can you tell us how your family's tragedy has inspired your advocacy?**

Christopher Jerry: That day, March 1, 2006, when multiple EEGs showed little to no brain activity, my wife and I had to make the horrible decision to take our daughter off life support. That was one of the toughest days of my life. Many people have asked me whether I was angry at the hospital and the caregivers involved. The honest answer to that question is that I skipped over the anger phase of the normal grieving process and I like to think that the reason I did so was because of the fact that all of the caregivers that came in contact with my daughter Emily, including the pharmacist that was involved, all took care of her and loved her. Her treatments to that point had actually cured her of cancer; the grapefruit-sized mass that was inside her tiny abdomen just five months prior had completely disappeared. Her treatments were to end that day.

Later that afternoon, I was loading some of Emily's personal belongings from her treatment room into the back of our SUV, which was parked on the top floor of the facility's parking lot. I was having all of these racing thoughts, terrible thoughts, because I was supposed to be taking my little girl home that day, cured of her affliction. I saw Emily's empty car seat and I thought, maybe I should take a flying leap off this parking garage. This is when the concept of the guardian angel logo first began. It was as if my daughter hit the pause button. Right at that moment, I felt that Emily was with me and she slowed down my mind. She was asking me to find out what went wrong, to determine exactly where the systems broke down and to find ways to modify those systems, and that is what I decided to do. I truly did not believe there was one single caregiver that intended to cause my daughter harm, nor did I believe those caregivers had performed their jobs in a reckless manner. I knew there had to be systems and processes that broke down that day, and these systematic flaws set these wonderful caregivers up to fail that day. I also recognized that I could not bring my daughter back, so my primary concern moving forward was to do everything I possibly could to discover the reasons behind these break downs.

Emily Jerry

After her tragic death in March 2006, The Emily Jerry Foundation was formed with a dedicated mission of saving lives by reducing preventable medication errors.

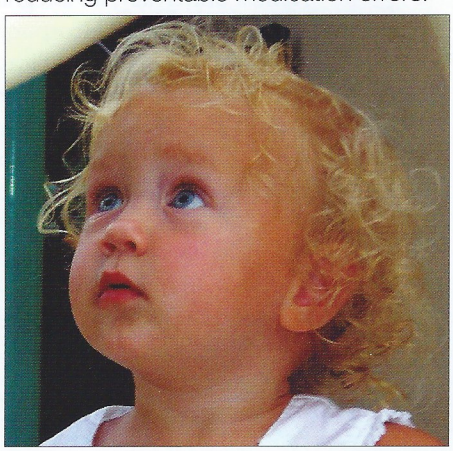


Photo courtesy of Emily Jerry Foundation

Once the hospital had performed a root cause analysis and it was determined that a pharmacy technician had made the terrible error that occurred that day, I immediately began researching the necessary qualifications to become a pharmacy technician in Ohio. What were the requirements for a position that could have made this fundamental mistake—to not know that sodium chloride could cause mortal harm—how could an error like that be made? As I began researching this, I was horrified to find that in Ohio, to become a pharmacy technician, the only requirement was a GED. There was no oversight of pharmacy technician activities by the Ohio State Board of Pharmacy. I immediately began contacting our state legislators and in January 2009, we finally were able to

FIGURE 1

Label Production in the Pharmacy

Medi-Dose was the first technology partner to integrate the Emily Angel guardian angel logo into its labeling software to help health care practitioners identify potentially hazardous medications.

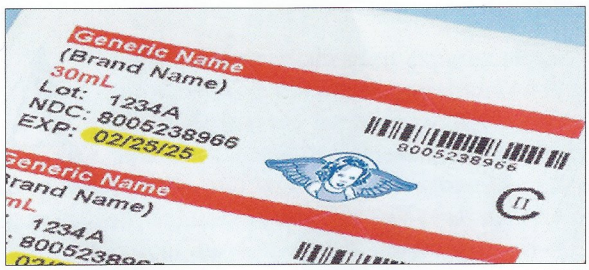


Image courtesy of MediDose/EPS

get Emily's Law passed in Ohio, which now mandates board of pharmacy oversight of pharmacy technicians. In addition, there are certification requirements and criminal background checks that must be performed. This is the kind of progress that inspired me to carry on with this work and become a full-time patient safety and caregiver advocate.

In 2009, I was able to establish the Emily Jerry Foundation with the core directive of preventing pediatric medication errors. I believe that what happened in Emily's case, as in the cases of almost every preventable medication error that occurs in the US, could have been prevented through education and the smart implementation of technology. It is through this technology, coupled with new and evolving pharmacy and medication safety practices, that we can significantly reduce, if not eliminate, the probability of human error affecting patient safety. I do not condone reckless medication practices and I do believe there should be punitive measures in place when recklessness is proven. However, rather than focusing on punishment, I want to focus on how we can improve medication use systems and make them safer so that these awful tragedies do not happen as they have, over and over again.

PP&P: **The Emily Jerry Foundation has recently teamed up with labeling technology manufacturers to produce labels intended for use with high-risk or hazardous pediatric medications. What is the intended impact of this initiative?**

Jerry: In early 2013, we started the Emily Angel Pediatric Safe Label Program. The primary focus of this program is to address the fact that when it comes to medication errors, body weight is a significant factor. An overdose of certain medications will not necessarily be overly harmful or lethal for an adult, but that same overdose given to a neonate or pediatric patient easily could be. In developing the Emily Angel label, I wanted to help incorporate a prominent, yet gentle reminder to every caregiver that comes in contact with medications that this medication is intended for a pediatric or neonate patient and to exercise caution (see **FIGURE 1**). It also is intended to be present throughout the gamut of medication use, so it will remind a technician performing compounding, packaging, or labeling to use caution. When the medication is sent up to the floor, the nursing staff performing the administration will see that guardian angel logo and will think to triple check the dosage and concentration. It is not a guarantee of accuracy, but it is a conscientious reminder for everyone who comes in contact with that medication prior to and during administration.

PP&P: **What other initiatives are you working on to increase awareness of medication safety?**

Jerry: Medi-Dose was the first technology partner to integrate the guardian angel logo into its labeling software and I am pleased to say that other technology partners, such as Condonics with their SLS (Safe Label System) are also are working to integrate this program into their technology (see **FIGURE 2**). The ongoing goal of this initiative is to enable all manufacturers of medication-labeling equipment to integrate the blue guardian angel logo onto every pediatric or neonate dose, across the board.

In addition to the labeling initiatives, we launched the Emily Jerry Foundation's Pharmacy Technician Initiative and Scorecard in 2013. This program was developed in conjunction with ASHP, whose ongoing support and assistance made the approach objective. The program resides on our foundation's website, and includes an interactive map grading each state's regulation of pharmacy technician employment. Amazingly, there are still six states in the US that have absolutely no qualifying competency requirements for their pharmacy technicians, one of them being New York with its substantial annual prescription volumes. This is a serious problem, as it is well known that pharmacy technicians compound virtually all IV medications used in US medical facilities.

To address this public safety issue, I am collaborating with individual state boards of pharmacy, even those that do not provide pharmacy technician oversight. What I found after introducing this initiative and scorecard was that many state pharmacy boards, aware of the risk, have tried for years to persuade their state legislators to pass a more comprehensive version of Emily's Law to no avail. So, I am working with the New York state pharmacy board to act as their voice in addressing their state legislators, as well as legislators in other states, on the importance of requiring pharmacy technician oversight and regulation at the state level.

Ultimately, my aim is to raise the bar for pharmacy technicians across the nation, because I am a strong proponent for

educated, competent, and well-trained pharmacy technicians. I realize that no hospital pharmacy could function properly without talented, career-oriented technicians who take their jobs seriously.

PP&P: **How can automated systems used in concert with proper technician training and oversight be used to improve medication safety?**

Jerry: In the years since undertaking my public advocacy, I have attended and spoken at numerous medication-related conferences, seminars, and expositions. In doing so, I have been able to interact with and tour many different pharmacies around the nation. In all that time, I found the same underlying principle: There is not a single person of sound mind in pharmacy who wants to compromise patient safety. In fact, medication errors are the worst possible scenario; it is what keeps pharmacy practitioners up at night after a busy day, the thought that a mistake may have made it through the system.

Many caregivers have shared their fear with me that they could make an error without realizing it, a risk intrinsic to simply being human. It is because of this that I believe caregiver advocacy must be part and parcel of patient safety advocacy. My aim is to support the modification of pharmacy workflow through the smart implementation of technology, which in turn will reduce the human error component and limit this intrinsic burden that rests upon compassionate caregivers. The proper implementation of automation and technology into pharmacy workflow most certainly reduces the probability of medication errors, and thereby saves lives. Take the iPhone and other smart devices that we all know and love, millions of these incredibly complex devices are manufactured with close to zero defects. It is my goal and dream to seamlessly ingrain proven process improvement methods such as the ISO Standards, Six Sigma, and 5S into pharmacy workflow. I believe these methods combined with intelligent use of automation and technology can virtually eliminate medication errors.

PP&P: **Finally, many facilities continue to promote punitive reactions when an error has been made. What is the value of creating a just environment?**

Jerry: I am proud to champion the principles of Just Culture and feel they are overdue for universal adoption in clinical pharmacy environments. In November 2012, I was certified by David Marx and The Just Culture Community (www.justculture.org) to teach Just Culture principles and urge their implementation in all of our nation's medical facilities. There is a misconception that under the Just Culture approach staff is not held responsible for their actions. Put simply, when Just Culture algorithms are applied correctly, then after conducting a root cause analysis, if an employee responsible for a specific mistake is found to have worked in a reckless manner, that person will be held accountable and punitive measures are often recommended. However, fear of punitive actions only serves to suppress error reporting and proper system remediation.

FIGURE 2

IV Syringe Label Production

Codonics has aligned with The Emily Jerry Foundation to enable the inclusion of the Emily Angel guardian angel logo on labels produced through its Safe Label System (SLS) in order to foster awareness and provide an extra reminder of potential pediatric medication risks.

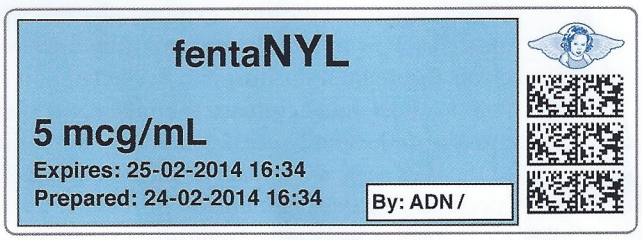


Image courtesy of Codonics

My goal is to convince upper-level health care administrators—the C-suite, trustee boards, and medical directors—in our nation's medical facilities that incorporating Just Culture principles will encourage accountability through error reporting and system failure recognition. If we are going to find solutions to correctly modify the systems and processes in our nation's medical facilities, Just Culture principles need to be truly implemented. We cannot resort to finger pointing when mistakes and errors occur, and this is one of the main reasons I publicly forgave the pharmacist who was in charge of verifying the medication that killed my daughter—I wanted to lead by example. When as a society, we respond to tragedy by placing our effort and focus on blame instead of prevention, we fight a losing battle. After the horrible tragedy that befell my family, my biggest fear was that all of the blame would be placed upon a single person, instead of the myriad system breakdowns that led to this terrible end. This mind set immediately instills a false sense of security; that by "catching the perpetrator," we have somehow solved the problem. This could not be further from the truth. The onus cannot be placed on individual caregivers, especially when a root cause analysis clearly indicates multiple system failures. It is with these ideals in mind that we must seek a just culture in health care. It must be universal. ■

Christopher Jerry is the president and CEO of The Emily Jerry Foundation. He is Emily Jerry's father. He can be reached through the foundation's website: emilyjerryfoundation.org