**Wednesday, September 30, 2015**

**9:00am *Welcome and introduction of new members/attendees***

***Michael Cohen, Chairman IMSN***

There were introductions from new members from latin America particularly

1. Mexico (add names later)
2. Chile (Olivero xxx)
3. Bolivia (Add name)

Mike discussed the probability of allowing access for the latin american pharmacists through a special link to IMSN

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| ***9:15*** | ***Review of minutes of 2014 meeting held in Singapore and a glance of activities for 2014-15.*** |

Follow-up on previous discussions:

1. **Discussions with INN in regards to Transuzumab**

* At least 2 death during clinical trials + several near misses
* As liaison between IMSN & INN, Etienne presented at 58th Consultation to WHO in Geneva (April 10th 2014)
* IMSN alert published on May 8th 2014
* Details of activities done available on Etienne's slides
* 58th Consultation WHO (15-16 oct 2014)
  + Informal discussion on trastuzumab emtansine
  + Other emtansine derivative on the pipeline so INN felt the reversing the terms of the 2 compounds name is not the solution
  + INN felt that the Canadian government did not provide an appropriate solution
* IMSN Letter on nomenclature of antibody-drug conjugates submitted to INN on March 23 , 2015
* During 60th Consultation WHO INN Program (April 13-15 , 2015), a "conjugate working group" established by the INN expert group seeks evidence on errors with trastuzumab emtansine:
  + Only 2 cases during trials without details
  + No published case report
  + They recognized that there are real clinical and naming issues which need to be addressed
  + It is not clear that any decisions could be made immediately on the issue of conjugated biologicals with two active substances
* Etienne discussed other dangerous combinations
* Mike presented the history of transuzumab vs. transuzumab emtansine
* David U discussed the need to develop a high-level strategy on how to address this in the future, particularly to combination products.
  + We need to keep on pushing for this plus come up with a recommendation on how to best name [Rabih-will follow-up from a Human Factors principal]

1. **Update on Biosimilars (Mike)**

FDA is coming up with recommendation to have a suffix to indicate difference between biosimilars. Example with Sandoz, they are adding Sndz

1. **Joint Commissions International Standards** **(Mike/Greg)**

JCI Standards (5th edition) require that Look-alike/Sound-alike medications be added to the list of high-alert medications. Brazil shared recent JCI visit where hospital was cited. All members agreed that this is not best practice as it dilutes the purpose of having a High-Alert list. Mike Cohen will follow-up with Jenell Mansour

1. **Update on Executive Committee (Mike)**

Benjamin + Etienne are the latest addition.

1. **Medication Safety Officers (Mike)**

Discussion done on the growing role of Medication Safety Officers. Funding being thought out to develop a White Paper on the important role of a Medication Safety Officer

1. **Withdrawal of Request to change HYDRomorphone (Mike)**

ISMP withdrew the request to change the name of HYDdromorphone due to a decrease in the number of instances where confusion between HYDRomorphone and morphine has occured. Mike believes that this is primarily due to the increase in use of the product, hence enhanced familiarity with it

1. **Update on IMSN Website (Etienne)**

* Overview of the IMSN website with emphasis on different publications available, how to join IMSN as well as the IMSN member section
* WHO INN Programme page is currently updated with the rest pending

1. **WHO Global Challenge Update (David U)**

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| ***11:30*** | ***Impact of Position Statement on Safer Labelling and Packaging (Facilitated by Beth)*** |

1. **Presentation by Beth on New Zealand Practice**
2. **Presentation by Gregory on Saudi Arabia Practice**

* Discussed the role of the National Guard in implementing the Position Statement in their practice
* Described experience with Apotex Saudi
  + Initial plan was to place additional stickers on product coming in from Canada (not approved by Apotex-Canada)
  + Company suggested a color code assigned for each therapeutic class (ie, green for cardiovascular, blue for CNS)
  + Discussed use of the NHS guide on Safe Labeling Practices
  + Encouragement provided by members for the Saudi members to share their experience with other countries

1. Discussion by Etienne on the Best/Worst Design awards done by Prescrire highlighting good and bad product design
2. David U discussed current work between ISMP Canada and Health Canada on labeling Standards
3. Group discussion around use of patient packs versus prescription bottles for dispensing medications.
   * Overall agreement that use of patient packs is safer
   * Majority of attendees utilize patient packs in their country
   * In USA, several limitations exist given that most drug companies have thousands of stores so such a change has a huge impact on storage
   * Suggestion by David U for a position statement advocating the use of patient packs

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| ***2:00 - 3:30*** | ***Presentation by members - Session 1 -*** |

1. **Presentation from Saudi Arabia (Hind)**

* Saudi Arabia presented 2 cases:
  + 50 year Anesthesia technician that died from an unintended overdose on isoflurane
  + 25 year old Staff nurse found dead in his apartment with a 1% propofol at the bedside
* Action plan following the 2nd incident included:
  + Reclassifying the Inhaled Anesthetics to category of controlled medications
  + Limiting access
* Mike discussed an editorial to be published in "Anesthesiology" journal discussing OR medication safety
* Agreement among members that there needs to be further discussion around the re-classification of such agents as controlled.

1. **WHO Vigibase access (Etienne)**

* Vigibase is a repository of Pharmacovigilance data developed by the Uppsala Monitoring Centre (UMC) as of 1979
* Due to regulatory changes, pharmacovigilance centers can no longer refuse med error reports and can classify them using MedRA (requires subscription) which contains 4 major categories for medication errors:
  + Medication Errors
  + Medication Monitoring Errors
  + Accidental exposure to drug
  + Maladministration
* Vigiaccess is the public access to vigibase ([www.vigiaccess.org](http://www.vigiaccess.org))
  + Simple query on the drug name but difficult to refine query (only single filtering element)
* Vigilize is available free of charge to all members countries of the WHO
  + Suggesting by Etienne that IMSN members should have access to Vigilyze

1. **Workflow considerations with use of ENFit feeding tubes and associated devices (Mike)**

* ISO coming out with 5 new standards but not adapted by industry yet
* The first one is enteral feeding due to highest incidence
* New enteral syringe tip conncetor is designed to look like a female luer lock tip (vs. traditional male)
* The newly designed enteral syringe has 0.2 mL of dead space so might need to have both enteral and oral syringes
* Based on data from Childrens Hospital of Philadelphia
  + 2500 oral liquid dose per day with 1200 less than 2 mL
    - 83% dispensed from Pharmacy and 17% from unit by RN
* New prototype being designed (BD excluded)
* Plan for implementation July 2016

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| ***4:00*** | ***Network Business - Session 1 -*** |

* Discussion of membership fees
  + Permanent vs. associate network
* Position Statements
  + Need to identify which to focus on + owners

**Thursday, October 1, 2015**

**9:00am *Opioid Safety Collaborative (Beth)***

* Discussed Use of Opioids in New Zealand
* Formative collaborative which is an improvement method that relies on spread and adaptation of existing knowledge in multiple settings
* Focus on opioid due to its identification as a priority part of the Trigger tool
* Presented case of death from septicemia post opioid induced constipation
* Discussed outcome measures:
  + Collaborative effectiveness in reducing harm
  + Goal is to have an opioid bundle

**9:30am *Colombian Practice (Ismael)***

* Team thoroughly discussed role of color as a differentiator. Agreement as not primary methodology to alert/differentiate products

**10:15am *New Legal Framework in Argentine (Traceability) (Pamela)***

* Discussed event of death due to wrong medication given
* Elaborated on Global Location Number (GLN) used in Argentina as an identified
  + Must be placed in a visible area
* Discussed implementation in hospitals
  + Challenge that unit dose is not implemented across the board

**11:00-12:00 *Safer Practice with oral Chemotherapy (David U)***

* Group provided input into a guideline document from canada describing requirements (essential vs desired) for an oral CPOE system
* Agreement to develop a Position Statement on labeling of oral chemotherapy drug + role of hospital pharmacists in consolidating/supervising therapy

**12:00-12:30 *Safer use and design of vaccines (Mike)***

1. **Vaccine error reports and findings from the ISMP Vaccine Error Reporting Program (Mike)**

* Mike presented comprehensive data on the most common type of vaccines errors (TdaP and DtaP)
* Agreement that better packing and labeling required

1. **Vaccine errors in Spain (Maria Jose)**

1. **IMSN Position Statement on safer use and design of vaccines: Review and discussion for adoption (Etinenne)**

* Discussion to breakdown position statement into two: one for industry and other for healthcare providers.
* Etienne requested feedback within 2 weeks

**2:00-3:30 *Presentation from Members (Session 3)***

1. **Sub-potent dose in Pharmacy prepared prefilled syringe (Mike)**

* Issue first raised with fentanyl syringe (3 & 5 mL) where potency only 9%
* Additional feedback from BD that 10 mL also impacted
* Initial investigation linking it to the rubber stopper
* Further investigation underway by FDA and company

1. **Medication Errors in Portugal (Aida)**

* Presented Portuguese Healthcare System, universal equitable coverage
* Discussion about SINAS
* CPOE is widely spread in majority of hospitals
* Unit-dose system introduced in the 80s

**ACTION ITEMS/FOLLOW-UP**

1. Need to develop high level strategy on how to address future risks with combination monoclonal antibodies
2. Mike Cohen to follow-up with JCI on their International Standards for Medication Management (5th edition) which require the inclusion of look-alike/sound-alike as part of the high-alert medication list
3. Members are requested to provide Etienne with updates pertaining to their membership/contact information for IMSN website, along with any material that is pertinent to their country/organization
4. Rabih will work with Etienne on development of IMSN Facebook page
5. Consideration in place to test having a Whatsapp group among members
6. Preliminary review of the Vaccines Position statement. Group agreed to formatting changes which include removal of certain content along with dividing the position statement into two separate ones. First, which is the priority, addresses guidance on vaccine packaging and labelling. The second is guidance on use of vaccine for Healthcare providers
7. Group agree to draft position statement on:
   1. Recommendations for the standardized display of medication related information on electronic devices used for medication management (ie, CPOE, pumps, automated dispensing cabinets)
   2. Recommendations to dispense controlled medications and oral chemotherapy in patient packs instead of bottles
8. Additional discussion required in terms of the annual fee and provision of access to the IMSN website for non-members