Baum Harmon Mercy Hospital – License #28

Quarterly Waiver Report to the Iowa Board of Pharmacy

In March 2013 the Board of Pharmacy met and granted a waiver for 9.15(2). The waiver was granted provided the following: medication package barcode system continuously used and managed only by pharmacists licensed with the board, medication errors occurring at the bedside are reported to the Board and that 10% of the medications loaded independently by technicians are verified by a pharmacist.

Medications refilled or loaded by a technician during the period of time from July 1 to September 30, 2015 resulted in 466 products being filled or loaded into the automated dispensing cabinet (ADC) without pharmacist review prior to placement in the ADC.

Of the 466 products placed into the ADC by a technician without the medications being reviewed by a pharmacist prior to loading, 246 of the 466 (52.8%) medication slots filled independently were eventually pharmacist reviewed within 24 hours of being placed in the ADC.

Anomalies discovered are noted below.

Errors in the ADC:

No errors related to the ADC were noted during July 1 to September 30, 2015.

Medication Errors otherwise reported (as requested by the board):

7/19/2015	When hanging the 2200 dose of ordered antibiotic, nurse noticed that approximately 25mL was left hanging in the previous bag that had not been infused.
8/2/2015	Metronidazole (Flagyl) dose was due at midnight- the nurse was busy in ER and overlooked the time it needed to be given. Dose was given late.
8/30/2015	Noted at 0030 on 08/30/2015 that there was not a second dose scheduled for enoxaparin (Lovenox). Nurse reviewed order and saw it had been transcribed from 60mg BID to 80mg daily- time had passed for a dose and it was too close to give the next dose. Nurse checked with physician at 0625. Order was supposed to be 80mg BID. Patient missed one dose on evening of 08/29/2015.

Respectfully submitted on behalf of the Baum Harmon pharmacy,
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