

**Institute for Safe Medication Practices**  
**200 Lakeside Drive, Suite 200, Horsham, PA 19044**  
[www.ismp.org](http://www.ismp.org)

**FOR IMMEDIATE RELEASE**  
November 6, 2012

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**ISMP Announces 15<sup>th</sup> Annual  
Cheers Awards Recipients**

**Horsham, Pa.**—The Institute for Safe Medication Practices (ISMP) is proud to announce its 15<sup>th</sup> Annual Cheers Awards winners. The annual awards dinner will be held on December 4, 2012, at the Mandalay Bay in Las Vegas. The Cheers Awards honor individuals, organizations, and companies that have set a standard of excellence for others to follow in the prevention of medication errors and adverse drug events; for more information, visit [www.ismp.org/Cheers/](http://www.ismp.org/Cheers/). The winners of this year's awards are:

- **forYOU Team**

*University of Missouri Health Care  
Columbia, MO*

An interdisciplinary group at the University of Missouri Health Care (MUHC) has created a unique rapid response team for addressing care of the 'second victim' after an unanticipated clinical event occurs. The 90-member forYOU Team is a network of physicians, nurses, respiratory therapists, and other allied health professionals who serve as 'lifeguards' for fellow healthcare providers traumatized by an unanticipated adverse event or medical error occurs. Team members are embedded within high-risk clinical areas and groups, such as operating rooms, ICUs, pediatrics, emergency departments, and code blue teams, and are available 24 hours of every day year-round. During the first 3 years since deployment, the forYOU Team has helped support 639 MUHC faculty, staff, and volunteers in one-on-one encounters, group briefings, or leadership mentoring sessions. Team members use an evidence-based, three-tiered model to facilitate the second victim's transition through the six stages of emotional recovery. The forYOU team has provided dozens of national and international learning opportunities, sharing its process for second victim care.

- **Peggi Guenter, PhD, RN**

*Senior Director of Clinical Practice, Advocacy, and Research Affairs  
American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.)*

Peggi Guenter is being honored for her work to ensure safety with parenteral nutrition (PN), particularly during the ongoing national drug shortages. She created a standing drug shortage committee that has resulted in faster production, approval, and dissemination of new shortage-related recommendations for IV multivitamins, electrolytes and minerals, trace elements and cysteine, fat emulsions, and amino acid products. She developed a partnership with the US Food and Drug Administration (FDA) to investigate alternative sources of products and request their importation when national shortages threatened patients' nutritional needs, and advocated for new legislation with both branches of government. Ms. Guenter also created the Sustain™ Registry: National Patient Registry for Nutrition Care, which helps measure and analyze PN outcomes and benchmark them against aggregate data, and has worked with international organizations to redesign enteral connectors to prevent potentially fatal tubing misconnections.

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- **James A. Haley Veterans' Hospital and Clinics**

*Tampa, FL*

The James A. Haley Veterans' Hospital and Clinics has developed and implemented a patient safety curriculum with an emphasis on medication safety that serves as a superlative example of applied error prevention education. The curriculum was created as part of a larger educational innovation movement supported by the VHA Office of Academic Affiliation, and is being administered to a wide variety of learners, including third and fourth year medical students at the University of South Florida Morsani College of Medicine, internal medicine residents, staff physicians, nurses, and pharmacists. During 4 week rotations, learners attend sessions on patient safety, pharmacy processes, human factors engineering, and identifying potential hazards in a patient's environment of care. They gain hands-on experience by following a medication from order entry to administration and identifying vulnerabilities for each step and possible solutions. They also participate in a human factors evaluation of a medication device and simulations representing hazards in a patient's room. The curriculum has been presented at numerous national conferences and shared with national groups within the VHA.

- **New York Hospital Queens**

*Flushing, NY*

New York Hospital Queens (NYHQ) has developed an innovative process to support the safe use of anticoagulants. The process was created by an interdisciplinary team, and includes a standard computerized practitioner order entry (CPOE) order set for warfarin, communication of international normalized ratio (INR) goals, and dosing guidance for the practitioner. A baseline INR and INR goals are required to initiate the order. The system prompts the practitioner to view previous warfarin doses administered along with pertinent INR and other history, all presented on the same screen, when placing a new order for warfarin. All warfarin orders are re-ordered daily, and the system automatically places appropriate lab, nutrition, and educational nursing orders. Pharmacists and nurses are required to document the most recent INR during order verification and administration as additional safety checks. When the NYHQ CPOE system allowed warfarin to be prescribed without an INR, there were 171 potential adverse drug events in a one-month period of time. When the CPOE system stopped prescribers from entering warfarin orders without a current INR, potential adverse events identified dropped to four per month.

- **Melissa Seamonson**

*Deerfield, WI*

After the tragic death of her 2-year-old son in 2011 from an accidental drug overdose from exposure to a used fentanyl patch, Melissa Seamonson has become a tireless advocate for safe patch disposal. Blake Seamonson died after coming into contact with a used patch from his great-grandmother's nursing home. Ms. Seamonson directly approached the FDA, national patient safety organizations such as ISMP, hospitals, and long term care facilities to spur education of the healthcare community and the public at large about safe disposal of fentanyl patches. As a result of her outreach, the FDA issued a healthcare provider alert about the risks, and the National Alert Network issued a message warning that 26 children have been accidentally exposed to fentanyl patches during the past 15 years. Ten of those children died and twelve were hospitalized. Despite enormous personal pain, she also has allowed her son's case to be used as an example to bring national attention to this issue, and is currently working to start a national billboard campaign on safe medication disposal.

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- **Wesley Medical Center Committee for Safe Medication Practice**

*Wichita, KS*

The Committee for Safe Medication Practice at Wesley Medical Center has improved patient-controlled analgesia (PCA) outcomes by developing and implementing a sleep apnea risk assessment model, dosing parameters for routine and high-risk patients, robust monitoring parameters, and the consistent use of capnography to monitor respiratory status. The model helps evaluate all adult patients for apnea risk upon admission, using a modified STOP/BANG scoring system. Nurses document risk in the electronic record, allowing it to be visible for physician rounds, admission medication reconciliation, transfer orders, PCA orders, anesthesia pre-op medication records, discharge medication lists, and the pharmacy medication profile screen. In addition, smart pumps offering end-tidal carbon dioxide monitoring were put into place after online training of staff. As a result, the hospital saw a significant post-implementation decrease in severe events, code blues, and transfers to ICU related to PCA opioid use. The success of the program has been shared with other healthcare organizations in a *Respiratory Care Journal* abstract and a poster presentation at the American Association for Respiratory Care International Congress.

This year, ISMP has established the **George DiDomizio Industry Award** in memory of the late ISMP Board member who served as a steadfast advocate for medication safety within the pharmaceutical research and development community. Before his death in July 2012, George served for many years as a trusted ISMP advisor and as a leader in safety testing of drug names to avoid look-alike and sound-alike medication errors. The George DiDomizio Industry Award honors members of the pharmaceutical industry that have made important and lasting contributions to patient safety.

**Sproxil and GlaxoSmithKline** are being honored as the first recipients of the award for their joint work to prevent the spread of counterfeit medications. Sproxil collaborated with GlaxoSmithKline in 2011 on a pilot anti-counterfeiting program with the antibiotic Amplicox distributed in Nigeria. Consumers could send a scratch-off code from the medication package via a text message to a central toll-free phone number. The mobile service would then look up the code and send a verification text back indicating whether the drug is genuine, potentially fake, or stolen. A toll-free phone number was provided for consumers to call if they had questions, and the location of all counterfeit drugs was recorded. More than 480,000 patients have already sent in more than 600,000 text message verifications, and 2.5% of the messages led to a counterfeit alert. The program helped identify counterfeit Ampiclox in the Nigerian market. The company now has programs in 5 countries: Nigeria, Kenya, India, Ghana, and East Africa.

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The ISMP Lifetime Achievement Award is being presented to **James Broselow, MD**. Dr. Broselow has dedicated his life to improving medication safety in the emergency pediatrics setting. Along with Dr. Robert Luten, he developed the Broselow Tape to improve treatment of acutely ill and injured children. This color-coded tool helps determine a child's body weight from body length to provide proper emergency medication dosing and avoid errors. It is now used in nearly every adult and pediatric emergency department in the U.S., and recently has been updated to take into account the increasing incidence of childhood obesity. Dr. Broselow also has worked to develop an international standard for pediatric drug administration and created web-based mobile app versions of his dosing system that also apply to adults.

**Robert Wachter, MD**, will deliver the keynote address for the 15<sup>th</sup> annual Cheers Awards. Dr. Wachter is Professor of Medicine at the University of California, San Francisco, and is considered the academic leader of the hospitalist movement as well as a national leader in patient safety and healthcare quality. He has written two bestselling books on safety, maintains a popular blog, and edits AHRQ's patient safety online portal and journal, which receive nearly one million visitors annually. Dr. Wachter has received numerous honors, including the Joint Commission's Eisenberg Award, and has frequently appeared on national news shows to discuss patient safety and quality issues. He is past-president of the Society of Hospital Medicine and is currently the chairman of the American Board of Internal Medicine.

*Journalists who wish to attend the awards dinner should contact Renee Brehio at 704-831-8822, [rbrehio@ismp.org](mailto:rbrehio@ismp.org).*

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