Description
According to The Joint Commission, high alert medications are those medications involved in a high percentage of errors and/or sentinel events, as well as medications that carry a higher risk for abuse or other adverse outcomes. High alert medications are generally recognized as more likely to be involved in medication errors and, when errors do occur, they are more likely to result in patient harm. This presentation will describe the elements of Kaiser Permanente’s comprehensive high-alert medication program and how data can be used to identify opportunities to reduce medication errors and improve patient outcomes.

Objectives
1) Describe the development and implementation of a high-alert medication program at Kaiser Permanente.
2) Discuss factors in your practice environment that can contribute to the occurrence of medication errors.
3) Demonstrate how medication error and near miss data can be used to identify opportunities for improving patient safety.
4) Describe the application of system strategies to reduce medication administration errors with IV heparin and improve patient outcomes.

Presenters
Nicholas E. Kostek, RPh, MS - is the Pharmacy Quality and Medication Safety Coordinator for Kaiser Permanente’s Northern California Region which includes 21 medical centers and 114 outpatient pharmacies serving over 3.3 million. Nick has served as co-Chair of Kaiser’s Regional Medication Safety Committee since 2008. He is the co-author of an article published in The Permanente Journal on the implementation of Kaiser’s high-alert medication program and is a chapter contributor to The Nurse’s Role in Medication Safety, Second Edition, published by Joint Commission Resources in 2012.