

***[P-602E] Medication errors documentation, review and resolution: veterans integrated service network (VISN) approach to the Institute of Medicine (IOM) medication errors report***

***Sutherland, M. T., Creasman, G. L., Stanberry, E. A., Chung, I. K., Erk, S. D., Hammond, E. K., Jones, E. M., Schmitt, D. R., Rittmeier, A. S., Williams, S. K., Cincinnati VA Medical Center, Pharmacy Service (119), 3200 Vine St., Cincinnati, OH 45220, USA Internet: michael.sutherland@med.va.gov***

***The purpose of this presentation is to demonstrate a Veterans Integrated Service Network (VISN) model, which is consistent with the intent of the Institute of Medicine (IOM) report that appropriately addresses medication errors considerations. The Veterans Affairs Department within the State Of Ohio (VISN 10) has implemented a comprehensive medication error documentation, review, and resolution process, with links to VISN 10 Quality Improvement Program, which includes inpatient, outpatient, and Consolidated Mail Outpatient Pharmacy (CMOP) programs. Through the collaborative efforts of VISN 10's Formulary Council and Quality Improvements Committee a comprehensive standard VISN 10 Medication Distribution Quality Reporting Program form was finalized and implemented throughout VISN 10. A review of potential barriers to successful implementation will be presented. Our evaluation and application of aspects of other national medication error reporting systems will also be discussed. The comprehensive reports developed to trend and assess VISN 10's medication distribution quality reporting program will be presented along with data collected since April 1, 1999. This initiative demonstrates that a multidisciplinary team can develop and implement a realistic and meaningful medication errors program that appropriately addresses concerns expressed by the IOM and other oversight organizations.***