ROUNDTABLE ON PATIENT SAFETY
AND HOSPITAL COMPOUNDING

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Top Organizations Urge a Concerted Effort To Improve Safety in Hospital Compounding

January 22, 2018, Washington, DC – Five years after the New England Compounding Center (NECC) tragedy that brought to light safety problems stemming from the compounding of pharmaceuticals and other therapies, a white paper was released today reflecting the recommendations of major stakeholders for additional steps needed to improve patient safety relative to compounded medicines. The paper was the outcropping of a milestone dialogue where top pharmacy, healthcare provider, hospital and patient organizations assessed progress made since the 2012 NECC tragedy and the subsequent enactment of the Drug Quality and Security Act by Congress.

In spite of congressional action, heightened regulatory efforts – including recent guidance from the Food and Drug Administration (FDA) on compounding pharmacies – and industry self-policing since the NECC tragedy, the paper highlights that compounding errors continue to take place too frequently due to gaps in training, hospital resource limitations, and a lack of uniformly accepted and implemented best practices. A 2016 State of Pharmacy survey showed that more than one-third of hospitals have experienced a patient health event stemming from a compounding error since 2012.

Stakeholders from multiple disciplines sought to address these gaps at the **Roundtable on Patient Safety and Hospital Compounding,** and issued the white paper today to provide more direction to policymakers and others about what more can be done to boost hospital patient safety. Participants cited the need for a deliberate, concerted effort to address patient safety of these medicines. Among the top recommendations were:

- **Increased adoption of technologies in hospitals to prevent human errors**. Recent technological advances have the potential to minimize human error. Despite these advances, these technologies are employed in only 2 out of every 10 U.S. hospitals.
- **Increased training and support for a uniform curriculum for sterile compounding practices.** Many schools of pharmacy do not include sterile compounding as part of their core curriculum. Pharmacist technician errors can be reduced with a standard, accessible pharmacy technician curriculum that should be developed.
- **Use of commercially manufactured products and medicines, wherever available and appropriate**. Some compounding occurs even though certain therapies can be

purchased from commercial manufacturing facilities that are supervised by the Food and Drug Administration (FDA). Using commercially manufactured medications would reduce the incidence of hospital medication errors and increase capacity in hospital pharmacies.

Christopher Jerry, the father of a young girl who died from a hospital medication accident, urged policymakers and practitioners to work together to advance these and other leading practices. He noted, "Even one preventable death due to hospital medication errors is unacceptable. As a community, we must band together and take these and other simple steps to prevent these tragedies."

"This white paper reinforces our understanding of what is needed to help ensure accuracy and safety of medications before they are delivered to patients," noted Jeannell Mansur, Pharm.D., Principal Consultant at Joint Commission Resources who participated in the event. "The best way we can prevent future tragedies is to learn from the past, identify shared leading practices, and put them to work together across all relevant fields of expertise."

Another outcome of the meeting is the development of a checklist of recommended best practices for hospital compounding, which will be issued in the coming weeks.

For more information on the Roundtable on Patient Safety and Hospital Compounding, please visit www.patientsafetyroundtable.org.

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