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ISMP 25 YEARS ADVANCING MEDICATION SAFETY

Acute Care ISMP Medication Safety Alert!®

Educating the Healthcare Community About Safe Medication Practices

What's in a name? Survey finds wide variety of error-prone newborn naming conventions in use today

In our April 25, 2019 newsletter (www.ismp.org/node/1520), we described unique risks associated with the newborn naming convention used in hospitals and birthing centers that have led to wrong-patient errors. Because newborn identification is a priority immediately after birth, healthcare providers typically employ a newborn naming convention that assigns a temporary, nondistinct first name (e.g., Baby Boy), plus the mother's name, to identify newborns. This results in patients with similar identifiers, including mothers and newborns with the same last names, and infants with the same nondistinct first names. Fraternal twins and higher-order multiples are at particularly high risk of misidentification errors because they have the same birthdate, gender, and last name, and they often have medical record numbers differentiated by only one number since they are created in numerical order based on the time of birth.

Other unique conditions with the newborn population can also increase the risk of wrong-patient errors. First, it is often difficult to distinguish one newborn from another based on physical appearance or gender, and they cannot participate in the identification process. Next, each newborn's electronic health record (EHR) must eventually be changed from a temporary to a permanent name after preparing official documentation for a birth certificate. Lastly, long temporary newborn names may be truncated in the EHR and on other documentation (e.g., name bracelets, labels), potentially dropping unique identifiers used to differentiate newborns from their siblings and/or mothers.

To learn more about newborn naming conventions and the challenges associated with proper identification of mothers and newborns, we conducted a survey this year between the end of April and September. During September, the National Association of Neonatal Nurses (NANN) helped recruit survey participants. The results of the survey suggest that newborn naming conventions are extraordinarily

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ECRI Institute – ISMP affiliation creates one of the largest nonprofit patient safety organizations in the world

ISMP announced last week that it has formally affiliated with ECRI Institute, of Plymouth Meeting, PA, creating one of the largest patient safety organizations (PSOs) in the world and significantly strengthening the capabilities of each organization (www.ismp.org/node/13291).The affiliation will not change the mission or vision of either organization and each will benefit from the expanded reach into new audiences and access to additional capabilities. ISMP staff will gain access to new resources, including expertise in medical device safety and human factors as well as laboratories with the capability of conducting simulations for product testing. ISMP will contribute its expertise in medication safety and voluntary practitioner reporting to ECRI Institute as part of the affiliation.

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SAFETY briefs

"Saline enema" shouldn't describe sodium phosphate enemas. A pharmacist at a children's hospital reported several near misses and nonserious errors involving sodium phosphate enema products. These products, including Fleet Saline Enema, Pure & Gentle Saline Enema, and those for use in children such as Pedia-Lax Enema, have labels that refer to them being a "saline enema" (**Figure 1**). Such labeling has contributed to clinicians confusing the products with normal saline or sodium chloride 0.9% enemas.

Figure 1. Sodium phosphate enema referred to on the label as a "saline enema."

We reported similar confusion in 2013 (Fleet Enema Saline–not just "saline." *ISMP Medication Safety Alert!,* July 25, 2013). Although the "Drug Facts" panel lists the active ingredients as monobasic sodium phosphate monohydrate 19 g and dibasic sodium phosphate 7 g, most healthcare providers would associate "saline" as a mixture of sodium chloride and water. Simply referring to the product as "saline" is confusing and does not convey the phosphate content in Fleet and similar generic sodium phosphate enema products. This is concerning because dosing in pediatric patients is much higher for a sodium chloride 0.9%

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complex, widely varied, and fraught with problems that may continue to lead to misidentification and wrong-patient errors.

Respondent Profile

ISMP sincerely thanks the 384 respondents who completed our survey. Most respondents were nurses (69%) who work in neonatal intensive care units (NICUs) (56%); integrated labor, delivery, recovery, postpartum, and newborn units (32%); and newborn nurseries (9%). We also want to thank the many prescribers, including nurse practitioners (12%); pharmacists (12%); and others (7%) (e.g., midwives, clinical instructors, administrators, interdisciplinary teams, risk/quality/safety professionals) who participated in our survey.

Newborn Naming Conventions Used

Singletons. Respondents reported extensive variation in the newborn naming conventions used by hospitals and birthing centers. For singletons (a single male or female newborn), respondents reported 75 different naming conventions, irrespective of the use of uppercase or lowercase letters, punctuation or other marks, or spacing between names. More than half of these 75 naming conventions were unique to a single facility. When survey respondents were asked about the naming convention used for a singleton born to "Judy Smith," the three most common were:

- Smith Girl (or Boy) Judy (25%)
- Smith BG (or BB) Judy (11%)
- Smith Baby Girl (or Boy) (8%)

Two-thirds (68%) of the naming conventions began with the mother's last name (Smith), 12% began with "Baby," and the remainder varied widely. Almost two-thirds (65%) of the naming conventions specifically designated that the patient is a newborn, with most using Baby (60%), B (15%), or NB (13%). All respondents included the mother's last name in the naming convention (one also included the father's last name).

The mother's first name was embedded by 84% of respondents, with 1 in 10 signaling that it was the mother's, not the newborn's, first name (e.g., of Judy, Judys, Judysgirl, mom Judy, mother Judy). Some respondents (29%) embedded the mother's first name in the naming convention due to the example provided in the 2018 National Patient Safety Goal (NPSG.01.01.01) by The Joint Commission (TJC). However, most respondents who embedded the mother's first name in their naming convention were already doing so before the 2018 NPSG. The 16% who did not include the mother's first name were unaware of the NPSG, had not gotten around to making the change, or felt their naming convention was safer (e.g., worried about character limitations in electronic presentations).

Only 3% of respondents did not include the newborn's gender in the naming convention (e.g., Smith Baby Judy). However, among those who did, Girl or Boy (75%) and G or B (19%) were the most commonly used expressions. Five percent of respondents reported that their naming system automatically assigns an A(a) or 1 identifier for singletons (e.g., Smith G1 Judy, Smith Girl A Judy); several commented on the confusion this causes since these designations are usually reserved for the firstborn of multiples.

Multiples. Respondents reported even more extensive variation in the newborn naming conventions used by hospitals and birthing centers for multiples (siblings of the same or different gender). Respondents reported 138 different naming conventions, irrespective of the use of uppercase or lowercase letters, punctuation or other marks, or spacing between names. Almost three-quarters of these 138

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enema (up to 6 mL/kg) and can lead to significant overdosing if a phosphate enema is administered inadvertently. Since sodium phosphate enemas are often administered in outpatient settings, monitoring may not be enough to detect adverse effects from inadvertent administration and overdose (onset of toxic effects can take up to 6 hours).

FDA and manufacturers should use the actual "active ingredient" name on the container label/principle display panel and not refer to these products as a "saline enema." Incidentally, although we have not received reports about confusion with magnesium citrate oral solution, this product is labeled "saline laxative," which also should be corrected.

HIGH-ALERT

Amino acids and lipids need light protection for young children. Fresenius Kabi made us aware of recent recommendations from the European Medicines Agency (EMA) regarding parenteral nutrition products containing amino acids or lipids used for neonates and children below 2 years of age. Parenteral nutrition products containing amino acids and/or lipids for this pediatric population should be protected from light (containers and administration sets). Such solutions exposed to light, particularly in admixtures with vitamins or trace elements, causes formation of peroxides and other degradation products. Premature neonates are especially susceptible to serious adverse effects because they are considered at high risk of oxidative stress related to multiple risk factors, including oxygen therapy, phototherapy, a weak immune system, and an inflammatory response with reduced oxidant defense.

The Fresenius Kabi communication is available at: www.ismp.org/ext/323, and the original EMA recommendations are available at: www.ismp.org/ext/324. The American Society for Parenteral and Enteral Nutrition (ASPEN) is developing a position paper on this topic, so watch for further information on its website at: www.nutritioncare.org/.

HIGH-ALERT

Danger of confusing thrombin with antithrombin. Miscommunication during a verbal order led a pharmacist to enter an order for a neonate for topical thrombin (**RECOTHROM**) when the intended drug

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naming conventions were unique to a single facility. When survey respondents were asked about the naming convention used for multiples born to "Judy Smith," the three most common were:

- Smith Girl (or Boy) A Judy and Smith Girl (or Boy) B Judy (14%)
- Smith Baby Girl (or Boy) A and Smith Baby Girl (or Boy) B (5%)
- Smith BG (or BB) A Judy and Smith BG (BB) B Judy (4%)

While most respondents (70%) used single letter identifiers (e.g., A, B, C) to distinguish between multiples, some (12%) used single numbers (e.g., 1, 2, 3). The remainder used double or triple letters (e.g., AA, BBB), Roman numerals (e.g., I, II, III), included the number sign (#) before the number, or wrote out the numbers (e.g., One, Two, Three). The position of the identifier also varied. One respondent included the identifier at the beginning of the naming convention (e.g., One Boy Judy Smith); 30% included it at the end (e.g., Smith Baby Boy A); and the remainder included it in the middle (e.g., Smith Girl A Judy). Spacing between the identifier and gender, particularly when using abbreviations, was noted to cause confusion (e.g., BA and BB [BB mistaken as baby boy]; BBA and BGB [B at end of BGB mistaken as boy, or B in BBA mistaken as twin B rather than gender]). Distinguishing identifiers (e.g., A/B, 1/2) were always used for multiples of the same gender, although a few respondents noted that the identifier may not be included with the firstborn (e.g., Smith Girl Judy [for firstborn], Smith Girl B Judy [for secondborn]). Fourteen percent of respondents used only gender to differentiate twins that were not the same gender (e.g., Smith Girl Judy and Smith Boy Judy).

Consistency. Most (95%) respondents reported that the same newborn naming convention is used for all applications displaying patient identification information. The few differences were mostly with handwritten forms of identification (e.g., bands placed on newborns at birth, crib cards, name plates). However, several respondents noted concerning differences, such as a documentation system that uses given names and a prescribing system that uses temporary names; pharmacy labels that differ from identification bracelets; variances between the two identification bands on the newborn; and variances from patient to patient.

Replacing Temporary Names with Given Names

Only 5% of respondents reported that they are aware of the newborn's given name(s) before or immediately after birth at least 95% of the time. Even when given names become available, few respondents reported changing the name mid-admission (14%) or adding the given name in quotation marks to the end of the naming convention (4%); most wait until the newborn is discharged or transferred out of the facility, or they wait at least 7 days if the newborn's length of stay exceeds a week.

The most common reason for not changing the newborn's temporary name to the given name was to prevent confusion and misidentification. For example, many respondents mentioned that changing names mid-admission and creating a second medical record for the newborn could pose a risk, particularly when prescribing medications, identifying pending diagnostic results and pre-existing blood bank information, identifying previously dispensed medications labeled with the temporary name, documenting care, billing insurance companies, and ensuring that the right infant is discharged to the right mother (in cases where the newborn is given the father's last name, which may differ from the mother's last name).

Hazards and Errors

Overall, more than half (57%) of respondents believed that wrong-patient errors could result from the newborn naming convention used in their facility. No significant difference in the perceived risk of errors was noted with respondents who reported

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was **THROMBATE III** (antithrombin III, human). Topical thrombin was dispensed to the neonatal intensive care unit (NICU), reconstituted, and administered via an extracorporeal membrane oxygenation (ECMO) circuit to the infant, who had pulmonary hypertension. Antithrombin III may be used in conjunction with ECMO for tighter control of anticoagulation and a reduction in thrombotic events (www.ismp.org/ext/321). The topical thrombin caused the circuit to clot and the patient to develop clots within her heart that were large enough to impair cardiac function. An urgent ECMO circuit change was required. The patient was later successfully decannulated from ECMO but remained in the NICU on a conventional ventilator with inhaled nitric oxide for her pulmonary hypertension.

In the above event, there was no standardized ordering process for antithrombin III with ECMO, and verbal orders were allowed instead of requiring electronic prescribing. Also, readback of the verbal order did not occur for this sound- and look-alike drug name. Also, when the drug name was searched during order entry, both thrombin and Thrombate appeared as selections, which may have added to the confusion. Packaging concerns with Recothrom may also have contributed to the error since the Recothrom kit comes with a syringe that has a Luer connector, and a nurse prepared the product in the Luer syringe at the bedside right before administration.

Our January 12, 2017, newsletter reviewed errors with topical thrombin products and provided multiple recommendations for preventing harm to patients (www.ismp.org/node/234). Among these were to always have pharmacy reconstitute and properly label topical thrombin products, and to avoid the use of a parenteral syringe (as presently contained in the Recothrom kit). These recommendations also apply to products used in the operating room or procedural areas. Before dispensing the syringe, pharmacy should place a warning label on reconstituted thrombin, making it clear the drug should only be administered topically (exception: when used via injection to treat pseudoaneurysms). As happened here, the terms thrombin and antithrombin can be confused, so take measures to differentiate them. Readback of verbal orders is a must.

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changing their naming convention to comply with the example provided in TJC's NPSG (54%).

In fact, almost one-third of all respondents reported that they were aware of medication errors or close calls associated with their newborn naming convention within the past 5 years (**Table 1**). The most frequent types of reported events involved mix-ups between newborn siblings or unrelated newborns with similar or the same last names. Most of the reported events occurred during drug administration, although some involved prescribing errors in which the wrong newborn record was selected. More than 10% of respondents were also aware of mix-ups between mothers and their newborns, most of which occurred during the prescribing node.

Many respondents also commented that their newborn naming convention often resulted in long temporary names that are difficult to read or have truncated or missing information due to character limitations, particularly with hyphenated last names. In the past 5 years, 55% of respondents were aware of problems with

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Table 1. Percent of Respondents Aware of Medication Errors/Close Calls in the Last 5 Years and Examples

Percent (%)	Error Scenario	Examples
32	Newborn was prescribed, dispensed, and/or administered a medication intended for a sibling (multiple births)	■ Twin A weighed more than twin B by 40%; larger doses of ampicillin, gentamicin, and caffeine were given to twin B because the twins' weights were entered into the wrong records. ■ Twin A was misidentified as twin B due to truncated information on the identification band; twin A received a double dose of the hepatitis B vaccine.
26	Newborn was prescribed, dispensed, and/or administered a medication intended for another unrelated newborn	■ Prescriptions for an unrelated newborn with the same last name as the intended newborn were given to a mother upon discharge. ■ IV ranitidine was prescribed and administered to an unrelated newborn with the same last name; naming convention only listed the last name and gender for both newborns.
18	Mother was prescribed, dispensed, and/or administered a medication intended for her newborn(s)	■ Hepatitis B vaccine intended for the newborn was entered into mother's record and administered to the mother. ■ IV fluids intended for the newborn were entered into mother's record and partly administered to the mother.
13	Newborn prescribed, dispensed, and/or administered a medication intended for the mother	■ Tdap intended for the mother entered into the newborn's record and administered to the newborn. ■ Enoxaparin intended for the mother entered into newborn's record and administered to the newborn.
26	Other	■ Documentation errors: Birth certificate information mixed up and twins assigned wrong given names; documented on the wrong record. ■ Communication errors: Orders confused when referring to two newborns using the naming convention during rounds. ■ Twin naming confusion: Twin naming convention based on birth order was different than the in-utero naming convention based on position, causing confusion regarding which newborn had decelerations during delivery.

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HIGH-ALERT

Abbreviations to avoid. Angiotensin II (**GIAPREZA**) injection for intravenous infusion is approved for use as a vasoconstrictor to increase blood pressure in adults with septic or other distributive shock. Antithrombin III (**THROMBATE III**) is indicated for patients with hereditary antithrombin deficiency to treat and prevent thromboembolism or to prevent perioperative and peripartum thromboembolism. Angiotensin II and antithrombin III have been mixed up, particularly when the abbreviations AT II and AT III have been used to communicate these products.

One hospital told us it had recently added angiotensin II to its formulary but restricted its use for adults with septic shock in the intensive care unit. Use for any other indications required approval by the hospital's medical director. Since then, angiotensin II had been requested for use in a limited number of cardiac surgery patients while in the operating room (OR) for vasoplegic shock. On one occasion, an OR nurse called the pharmacy and urgently requested "AT two." The nurse had received a verbal order for antithrombin III but apparently miscommunicated the verbal order as "AT two" (angiotensin II). When informed the medical director would need to be contacted, the surgeon questioned whether approval of antithrombin III use was a new policy, as the drug was often available in the OR automated dispensing cabinet. Upon realization that there was a miscommunication, the correct medication, antithrombin III, was provided.

Several factors contributed to this close call: use of verbal orders, lack of indication for use available to the pharmacist, a new unfamiliar medication, use of abbreviated drug names, and the emergent nature of the order. The use of "controls" (medical director approval) for the newly introduced angiotensin II created an additional safety step that helped prevent the error.

As suggested in ISMP's *Guidelines for the Safe Electronic Communication of Medical Information* (www.ismp.org/node/1322), we highly recommend avoiding the use of abbreviations for drug names, referring only to the full brand and/or generic name. While antithrombin III is commonly used in the OR setting, "AT III" is likely to be unfamiliar

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expressing the full identity of newborns. Among these, almost three quarters (70%) said that this has resulted in losing a character that distinguishes multiples (e.g., "…BabyboyA" truncated as "…Babybo"), and 34% reported that this has resulted in the inability to distinguish between the mother and infant (e.g., "…Melissa Girl" truncated as "…Melissa"). NICU nurses (23%) reported fewer problems with distinguishing between the mother and infant since they do not provide care to mothers. Respondents who now embed the mother's first name in their naming convention based on the 2018 NPSG example reported more frequent problems: 84% said the increase in the length of the naming convention has resulted in losing a character that distinguishes multiples; and 48% reported the inability to distinguish between the mother and infant.

Strategies

The most frequently reported strategies used to reduce the risk of misidentifying mothers and newborns when prescribing, dispensing, and administering medications are employing barcode scanning systems, utilizing name alerts, and limiting who can change/merge newborn EHRs (**Table 2**). Other strategies reported by at least 1 in 3 respondents were limiting access to patient records to only those appropriate for the practitioner and establishing hard stops or documentation of the reason for overriding electronic alerts that may signal a potential mix-up between the mother and newborn. The least frequently reported strategies involved the use of specialized text, formatting, spacing of text, or customized screen backgrounds to distinguish newborns or enhance the display of complete information.

More than 1 in 10 respondents reported other strategies not included in our survey to prevent misidentification:

- Double banding the newborn (wrist and ankle)
- Using different automated dispensing cabinets (ADCs)/medication storage locations for mothers and newborns
- Employing independent double checks
- Requiring verification of a secondary identification number such as medical record/encounter number
- Involving the parents (when present) in the newborn identification process
- Using the proper newborn naming convention during every call, report, and encounter
- Assigning different nurses to unrelated newborns with the same last name

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Table 2. Percent of Respondents Implementing Strategies to Reduce the Risk of Misidentifying Mothers and Newborns

Strategies	Percent (%) Implementation
Employ bedside barcode scanning systems for mothers and newborns	94
Employ name alerts	87
Limit who can change/merge newborn EHRs	78
Limit access to patient records to only those appropriate for the practitioner	49
Establish hard stops or require documentation of a reason for overriding electronic alerts that may signal a potential mix-up between mother and newborn	41
Employ different formatting of text (e.g., types, cases, and/or sizes of fonts; bolding; color) to distinguish newborns (e.g., Baby **GIRL**, Baby**girl**)	23
Customize screen backgrounds (e.g., color, highlighting of newborn and age) to better distinguish between mother and newborn records	17
Increase the size, width, character spaces used for identification to enhance the display of complete information	13
Other	11

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to many who do not commonly practice in the OR setting. Angiotensin II is sometimes referred to as "AT II," but as a new medication, it is likely to be unfamiliar to staff throughout an institution. Neither of these abbreviations should be used to refer to these therapeutic agents, including in information technology databases, order sets, and protocols. Additionally, prescribers should ideally communicate orders electronically (not as a verbal order, if possible) and include the drug's indication with orders to further avoid confusion.

Confusion over antiretroviral therapy abbreviation. A patient received the wrong antiretroviral drug due to confusion with a drug name abbreviation. Like vaccine abbreviations, antiretroviral drugs have been assigned drug name abbreviations that can increase the risk of confusion (www.ismp.org/ext/306). In this case, the physician intended to prescribe **PIFELTRO** (doravirine), which is commonly abbreviated as DOR in most literature on therapies used to treat human immunodeficiency virus (HIV) infections. During order entry, the prescriber was thinking DOR but accidentally selected **DOVATO** (dolutegravir and lami**VUD**ine), which starts with DOV, as the prescribed antiviral medication.

Both drugs are taken once daily and are available in a single strength (Pifeltro 100 mg, Dovato 50 mg/300 mg). Thus, when prescribing either drug, the strength does not require selection, and the prescriber did not notice the difference between the intended 100 mg dose of Pifeltro and the 50 mg/300 mg dose of Dovato. Because both antiretroviral medications are used to treat HIV infection, the pharmacist was not able to identify the prescribing error without knowing the patient's resistance profile and specific intended therapy. As the intended drug, Pifeltro, may be paired with lami**VUD**ine, it is also unknown if the patient was already taking lami**VUD**ine, which might have led to a duplicate therapy warning since the erroneously prescribed drug, Dovato, contains lami**VUD**ine. Mix-ups are also possible between other antiretrovirals with commonly used drug name abbreviations (e.g., TAF [tenofovir alafenamide] and TDF [tenofovir disoproxil fumarate].

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Failure Modes. Respondents provided numerous examples of conditions that still allowed errors to occur despite these strategies. For barcode scanning, several respondents commented that the task in their location does not occur in real time and is basically used *after* administration only to facilitate electronic documentation of drug administration. Several respondents noted that identification bands are often removed from newborns and attached to the crib, loose in the crib, or reattached to the wrong infant. A few others noted that errors with injectable medications have still occurred between mothers and newborns rooming together because the syringes were mixed up *after* barcode scanning occurred.

For name alerts, approximately half of the respondents who provided comments noted that only physical name alerts (e.g., on medication locations, patient lists, labels, cribs) are used, not electronic alerts within the health record. Several respondents also commented that the name alerts are not helpful outside of NICU because every mothers' and newborns' names are the same. Some noted that the name alerts are only used for unrelated patients. Finally, numerous respondents noted that limiting access to patient records could be dangerous during an emergency and does not work because, often, prescribers and nurses need to access both the mother's and newborn's records, particularly if providing care to both.

Next Steps

ISMP plans to convene an expert advisory group to review these survey findings in more detail and to make recommendations to reduce the risk of misidentification and wrong-patient errors with mothers and newborns. We have begun to gather practitioners for the expert advisory group, but if you have expertise in this area and would like to participate, send your contact information to ismpinfo@ismp.org. Look for the work of the advisory group and the resulting recommendations to be published in a 2020 newsletter.

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ECRI Institute operates the largest federally designated PSO in the country. Both ECRI Institute and ISMP became federally listed PSOs in 2008, soon after the Agency for Healthcare Research and Quality (AHRQ) began designating PSOs under rules established in the federal Patient Safety and Quality Improvement Act of 2005. Our focus remains, as always, on medication safety; operation of our voluntary practitioner and consumer reporting programs; and working with healthcare practitioners, consumers, the US Food and Drug Administration (FDA), and industry to improve patient safety.

ISMP will retain its name, websites, and editorial independence for its publications, and will continue to oversee the Medication Safety Officers Society (MSOS), as well. We will be working closely with ECRI Institute on new initiatives in the months ahead. ISMP will remain at its office in Horsham, PA, for now, but will later be joining ECRI Institute at its campus in Plymouth Meeting, PA, just 20 minutes away from our current office north of Philadelphia.

If you are not already familiar with ECRI Institute, your biomedical engineers, risk managers, and hospital leadership will likely know them well. ECRI Institute has approximately 500 employees, with locations in the US (headquarters), Dubai, London, and Malaysia. ISMP and ECRI Institute have collaborated on various activities for years, beginning in the 1990s with work on preventing infusion pump-related free-flow incidents and continuing most recently as consultants to the ECRI Institute PSO. We are two trusted, independent organizations coming together to bring a comprehensive set of unmatched patient safety capabilities that will benefit healthcare providers, patient advocates, governments, and most importantly, patients worldwide.

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This is a prime example of why drug name abbreviations should be prohibited. Check your order entry system to ensure that the given abbreviations for antiretroviral medications are not automatically populated or included in the drug name fields. Also, it is safest if drug name searches require entry of at least the first 5 letters of the actual drug name, and not an abbreviated drug name.

Special Announcements

Get intensive about medication safety

Don't miss our last ***Medication Safety Intensive*** (MSI) workshop of the year being held in **Las Vegas**, NV, on **December 6-7**! This unique opportunity will help you look at your organization through the eyes of leading safety experts. For information and to register, visit: www.ismp.org/node/127.

22nd Annual CHEERS AWARDS

Join ISMP on **December 10** at 6:00 p.m. for the 22nd Annual **CHEERS AWARDS** at **Stoney's Rockin' Country** in **Las Vegas**. The dinner will celebrate healthcare leaders who have gone all in to develop best practices and programs that prevent medication errors and protect patients. For information and to register for the **CHEERS** dinner, visit: www.ismp.org/node/938.

To subscribe: www.ismp.org/node/10

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