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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 302 Session of 2024

INTRODUCED BY GUZMAN, BURGOS, HILL-EVANS, CEPEDA-FREYTIZ, KENYATTA, MAYES, KAZEEM, SANCHEZ, GREEN, DALEY AND POWELL, JANUARY 31, 2024

REFERRED TO COMMITTEE ON HEALTH, JANUARY 31, 2024

A RESOLUTION

1 Directing the Joint State Government Commission to conduct a
2 study of medication errors and issue a report to provide
3 recommendations on reduction of errors and improved patient
4 safety.

5 WHEREAS, According to the National Coordinating Council for
6 Medication Error Reporting and Prevention, medication errors are
7 preventable mistakes made while prescribing or issuing
8 medication to a patient; and

9 WHEREAS, Medication errors can happen at any step in the
10 process of prescribing medication, including when the medicine
11 is prescribed, when the prescribed medication is entered into
12 the computer system, when the medication is dispensed or when
13 the medication is taken by an individual; and

14 WHEREAS, Medication errors may have serious consequences such
15 as death, hospitalization, disability or birth defects; and

16 WHEREAS, Didier Epopa, a patient at Mercy Fitzgerald Hospital
17 in Darby, Delaware County, was issued the wrong medication,
18 which caused his body to seize and muscles to tighten; and

WHEREAS, The error occurred because a pharmacy technician at Mercy Fitzgerald Hospital wrongly labeled the intravenous bag containing the medicine; and

WHEREAS, A report on the medication error incident later found that the pharmacy technician was in fact not a technician, but rather a certified intern and should have been supervised; and

WHEREAS, Under current State law, pharmacists are not required to notify the Pennsylvania Board of Pharmacy about medication errors, but instead must notify the prescribing doctor of a medication error within 24 hours of the error; and

WHEREAS, Since pharmacists are not required to notify a State agency, many times this leads the hospital to only conduct an internal investigation of the error rather than involving the Department of Health; and

WHEREAS, Hospitals are required to report "serious events," which are instances that result in death or serious harm to a patient, and "incidents," which are events that could have resulted in the death or serious harm to a patient, to the Pennsylvania Patient Safety Reporting System (PA-PSRS); and

WHEREAS, According to the Pennsylvania Patient Safety Authority's 2022 Annual Report, there were 257,000 reports made, which included 247,000 reports regarding "incidents" and 10,000 reports regarding "serious events"; and

WHEREAS, The United States Food and Drug Administration (FDA) has worked to reduce medication errors by reviewing medication names, packaging, labeling and directions for all medications and required barcodes to appear on some medications for the purpose of ensuring the correct strength and type of medication; and

1 WHEREAS, The FDA also released a guidance in 2016 titled
2 "Safety Considerations for Product Design to Minimize Medication
3 Errors" to help reduce medication errors; and
4 WHEREAS, Medication errors could be further reduced with the
5 institution of adequate staff-to-patient ratios, so nurses and
6 other health care professionals are not overwhelmed with a large
7 number of patients and can provide better quality of care to
8 patients; and
9 WHEREAS, All Pennsylvanians would benefit from reduced
10 occurrences of medication errors and improved patient safety;
11 and
12 WHEREAS, The House of Representatives should craft policy
13 informed by a thorough understanding of how to reduce medication
14 errors and improve patient safety; therefore be it
15 RESOLVED, That the House of Representatives direct the Joint
16 State Government Commission to conduct a study of medication
17 errors and issue a report to provide recommendations on
18 reduction of errors and improved patient safety; and be it
19 further
20 RESOLVED, That the study include how medication errors occur
21 in different settings where patients are prescribed and
22 administered medication, including, but not limited to, acute
23 care hospitals, rehabilitation centers, senior living centers,
24 long-term care facilities and pharmacies; and be it further
25 RESOLVED, That the Joint State Government Commission appoint
26 an advisory committee to assist in this study; and be it further
27 RESOLVED, That the advisory committee be composed of the
28 following members:
29 (1) The Secretary of Health or a designee.
30 (2) One individual representing The Hospital and

Healthsystem Association of Pennsylvania.

(3) One individual representing the Pennsylvania Medical Society.

(4) One individual representing the Pennsylvania Pharmacists Association.

(5) One individual representing Pennsylvania State Nurses Association.

(6) One individual from the Pennsylvania Patient Advocacy Program within the Department of Health.

(7) One licensed pharmacist to be selected by the Joint State Government Commission.

(8) One licensed registered nurse to be selected by the Joint State Government Commission.

(9) One licensed physician to be selected by the Joint State Government Commission.

(10) Any other member identified as being helpful by the Joint State Government Commission;

and be it further

RESOLVED, That the study include policies adopted by other states to reduce medication errors; and be it further

RESOLVED, That the study include best practices supported by stakeholders such as The Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Medical Society, the Pennsylvania Pharmacists Association and the Pennsylvania State Nurses Association; and be it further

RESOLVED, That the study include a review of current Pennsylvania statute and regulations related to administration of medicine and reporting of medication errors; and be it further

RESOLVED, That the study include a review of the agency in

1 the Commonwealth with regulatory oversight of medication errors;
2 and be it further
3 RESOLVED, That the Joint State Government Commission present
4 its report to the House of Representatives no later than 18
5 months after the adoption of this resolution.