Meet Matt, Mister Medication Safety

By Sonja Sherritze, Editor, P&T

Matthew Grissinger’s column on medication errors first appeared in P&T nearly three years ago (May 2001) and soon became the second most widely read department in the journal, according to a readership survey. Perhaps it was a combination of good timing and Matt’s straightforward communication style; in any case, there has been no shortage of errors and near-misses for him to write about.

I asked Matt about his work with the Institute for Safe Medication Practices (ISMP).

“I’ve always been interested in science,” he says, “since long before I got my degree in pharmacy. But,” he adds, joking, “of course, the reality is you learn all this stuff and you work in the pharmacy world and you don’t use any of it.”

A graduate of the Philadelphia College of Pharmacy and Science (now called the University of the Sciences in Philadelphia) in Pennsylvania, Matt has been a medication safety analyst at ISMP since 2000. He works closely with health care practitioners and institutions, regulatory agencies, specialty organizations, and the pharmaceutical industry to educate professionals about medication errors and their prevention. He provides an independent review of errors that have been voluntarily submitted by practitioners to a national Medication Errors Reporting Program (MERP) that is operated by the United States Pharmacopoeia (USP) and that uses a technique known as Failure Mode and Effects Analysis (FMEA) to uncover potential problems arising from look-alike names and labels, sound-alike names, and other nomenclature issues when reviewing potential proprietary names for drug manufacturers. He speaks about current topics in medication safety for health care organizations in acute-care and long-term care facilities, community pharmacies, and managed care pharmacies.

“I’m lucky because at ISMP, the vast majority of people have a hospital background—whether they’re nurses, physicians, or pharmacists—but I was the first one here to have a little bit more of a diverse background,” he says.

Matt started in the long-term care pharmacy arena and has worked as a pharmacy manager or consultant pharmacist in various settings.

“That helps me to get out and give presentations to a wide variety of health care practitioners,” he says, “from hospital groups to community pharmacy, home infusion, managed care, long-term care. And the topics range from basic principles that we believe in at ISMP about what causes medication errors to more specific things like Joint Commission issues, and their standards, and technology issues, like with bar-coding or computerized physician order entry. I like the variety here.”

Matt is a logical choice to speak about the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), where he worked, from 1998 to 2000, before joining ISMP. As a home care and long-term care surveyor, he provided general evaluation, education, and consultation consistent with applicable JCAHO standards, policies, and protocols, and he determined the degree of compliance with applicable standards. Although Matt liked his work with the organization very much, he left in 2000, when many home care companies were closing as a result of cuts in Medicare coverage and “massive” layoffs of home health care surveyors.

Since he started at ISMP, Matt has seen a significant increase in error reports, in part because of a greater awareness about what the ISMP does and because people are less afraid of the repercussions of notifying the organization. One report that stands out in his mind, however, did not come to ISMP but was sent to the FDA. It involved a Duragesic® (fentanyl) transdermal patch—a pain medication that is worn for three days.

“The report had only three sentences in it,” he says. “A 67-year-old woman was at home and was wearing one of these patches. But somehow it fell off onto the floor, and a three-year-old child sat on it and eventually died. It seems like a pretty innocuous thing, a little patch. But people don’t realize how dangerous these patches can be if they’re not handled properly. And things like that affect you—anytime there’s a death involved. It doesn’t matter who it is, and you don’t get used to [these things]. Just because I’ve seen a lot of [these events] doesn’t mean I feel any better about the next one.”

Matt is encouraged by the increase in error reports, though, and by the fact that health care practitioners often submit detailed descriptions of their experiences.

“Every week you learn something totally new and different that can lead to an error that people never think of. And even with all the new technology—that leads to new problems. As long as human beings are involved, there are going to be issues.”

Matt also appreciates the feedback he has received from readers.

“We get letters in response to our newsletter and from P&T readers saying ‘thanks for what you’ve written . . . we didn’t even know we had this problem.’ The contributing factors can be endless.”

Matt acknowledges that ISMP still has a long way to go before all health care practitioners are aware of the scope of the problem.

“We’re still in the battle of getting information out there,” he says, “especially to other health care organizations besides hospitals. Just when you think people know who you are, you find out many more people don’t know who you are. People don’t learn about this in college either, although that’s starting to change. Some pharmacy schools out there are offering classes on medication safety. We’re getting there.”

A native of south central Pennsylvania (“the middle of nowhere,” as he says), Matt is an avid fan of Philadelphia and its sports teams, particularly the Phillies and the Eagles. His other full-time job, which he shares with his wife Jackie, is being a parent to their eight-year-old daughter, Alexa.