California Department of Public Health
Center for Health Care Quality
Licensing & Certification Program

The following documents and data are being requested to conduct the Medication Error Reduction Plan (MERP) survey. Please have available items one through three as soon as possible.

1. Policies and procedures related to:
   - Medication errors (e.g., reporting and analysis)
   - Medication administration (including medication administration times)
   - Emergency medication use (crash carts, malignant hyperthermia carts, etc.)
   - Automated dispensing cabinets (ADCs) including overrides and discrepancies
   - Drug storage (refrigerators, warmers, unit stock, etc.)
   - High risk medication use (fentanyl patches, insulin, droperidol, propofol, etc.)
   - Patient Controlled analgesia (PCA) use and pain management.
2. The current MERP and evidence of annual reviews since the previous MERP survey.
3. List of patients that have received any of the following medications within the last 30 days: PCA delivered drugs, transdermal fentanyl, droperidol, insulin drip, heparin drip, rescue (reversal) agents naloxone, D50W, and protamine.
4. Medication error summary reports and trends analysis since the last MERP survey.
5. Multidisciplinary MERP committee meeting minutes, Pharmacy and Therapeutics (P&T) Committee meeting minutes, Medical Executive Committee (MEC) meeting minutes and Quality Assurance (QA) Committee meeting minutes since the last MERP survey.
6. Preprinted or computer order sets for titrating medications (insulin, heparin, etc.).
7. All events since the last MERP survey, resulting in any patient death or serious disability directly related to a contaminated drug, device, or biologic; use or function of a device other than is intended (where “device” refers to equipment associated with medication delivery); medication error or hypoglycemia (see H&SC 1279.1 [b][2][A],[b][2][B],[b][4][A], and [b][4][D].