Protect Yourself from Medication Errors

Safe Medicine

The Institute for Safe Medication Practices

Premier Issue www.ismp.org

Welcome to *Safe Medicine!*

Welcome to the first issue of ***Safe Medicine***, a newsletter from the Institute for Safe Medication Practices (ISMP). You may be unfamiliar with our organization. However, we're well known among healthcare professionals as the nation's only nonprofit organization of pharmacists, nurses and doctors devoted entirely to safe medication use. We are independently funded and do not accept advertising.

Preventing medication errors isn't a job just for health professionals any longer. Today, as consumers, you play a vital role in helping to prevent errors by taking more responsibility for your own healthcare and safety. And you can take a more active role in preventing medication errors once you know how and why errors occur.

During the coming months we'll share with you some of the things we've learned about protecting consumers from errors. We'll tell you about medication errors that doctors, pharmacists, and nurses have reported to us voluntarily. Using this information, we'll show you how to avoid making similar mistakes. And, because there's a growing interest in using herbal products, we'll bring you stories on how to use them safely. You'll also have the chance to ask us questions about how to prevent mistakes with your medications.

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Occasionally, we'll offer you an opportunity to participate in a survey so we can learn more about you and your medication safety concerns.

The ISMP ***Safe Medicine*** newsletter is sure to provide you with the knowledge you need to help prevent medication errors. Each issue carries valuable information that will make you a better-informed medical consumer.

Michael R. Cohen, RPh, MS, ScD
President, ISMP

To learn more about ISMP, visit our website at **www.ismp.org.**

Double Trouble

Look-alike drug names

Double, double toil and trouble! William Shakespeare wasn't writing about drug names but he sure had the right idea! Today, many medications have names that look or sound like other medications. So mixups are possible.

For example, Lamisil (terbinafine), used to treat nail infections, has been mixed-up with Lamictal (lamotrigine), used to treat epilepsy. Zyrtec (cetirizine), used to treat allergies, has been mixed up with Zyprexa (olanzapine), used to treat mental conditions.

Why the mix-ups? Poorly written prescriptions are one reason. But it's also due to confirmation bias. This happens because people tend to see what they expect to see. For example, have you ever bought Pepsi when you intended to buy Diet Pepsi? If you have, you've experienced confirmation bias.

Many look-alike and sound-alike drugs are used to treat different conditions. So, have your doctor write your condition on the prescription. This alerts your pharmacist to your condition and serves as a check to make sure the correct drug was prescribed.

60 second safety tips

■ **Don't throw away the carton or outer wrapper that held your medication.** If you do, you may discover that you no longer have information on the strength of the medication or instructions on how to take it. The label on *over-the-counter* medications also may not list all the drugs in combination products that treat conditions such as colds and the flu. Likewise, if your *prescription* medication is dispensed in an outer carton, the pharmacist is likely to put the label with the directions on the carton itself, not on the medication container. This often happens if the medication comes in a tube or a small bottle like eye drops.

■ **Don't hesitate to question the cost of your prescription!** It could even prevent an error. After a man complained to his doctor about allergies, a prescription for Allegra (fexofenadine) was called into the pharmacy. After picking up the prescription, the man called his doctor to find out why he'd prescribed something that was so expensive - $450! The doctor called the pharmacy to find out why the medicine cost that much. On further check, the pharmacist realized that he'd misheard the prescription as "60 Viagra" (sildenafil), which is medicine men take for impotence.

Brand name medications appear in green; generic medications appear in red.

Learning from mistakes

Take time to read medication leaflets

The story: If the medication you receive doesn't look right, chances are an error was made. Yet, sometimes people ignore this clue.

A 56-year-old man with diabetes went to the pharmacy to refill his prescription for Glucophage (metformin). This medication helps people with diabetes maintain a healthy blood sugar level. Mistakenly, the man was given 850 milligram tablets instead of 500 milligram tablets. Right away, he recognized that the tablets looked different, but he didn't say anything.

> ...one out of every 20 prescriptions filled in a pharmacy has an error.

The error was discovered two months later when he refilled his prescription. Luckily, he suffered no permanent harm; however, he lacked energy and felt weak because he took too much medicine.

The rest of the story: Why didn't he speak up? Some consumers may worry that questioning a health professional could be insulting. Others may think that the medicine looks different because it's a generic drug. Too many people may dismiss their concerns because they feel they don't know as much about medications as health professionals. Even the slightest hint of anxiety can stop many from speaking up.

Healthcare workers face the same dilemma. A nurse may hesitate to point out a possible medication error to a well-respected physician.

Even when people speak up, they may accept an unsatisfactory explanation or easily be convinced that no mistake has been made. This sad truth is clearly seen when we investigate deadly medication errors. In most cases, someone had a feeling that something was not right, but failed to speak up or was convinced by others that there was no problem.

Lessons learned: Be confident and ask questions, especially when there are clues that a mistake has been made. Don't be satisfied with an answer that doesn't make sense. Ask for more information and insist that your doctor, pharmacist or nurse investigate the issue. If necessary, ask for a second opinion.

If you have a gut feeling that something is wrong, you're often right! Just remember that one out of every 20 prescriptions filled in a pharmacy has an error. See **Check it out!** for a list of *Clues to mistakes with medicines*.

Ask the pharmacist

Q Why do medications have more than one name?

A All medications have a generic name. These generic names often contain word stems that help tell what type of medication it is. For example, the generic names for all the different cholesterol-lowering medications end with "vastatin."

Medications also may have one or more brand names. The drug company that makes a medication chooses a brand name that is usually easier to pronounce and more memorable than the generic name. For example, Motrin is a brand name for a medication used to treat pain. Its generic name is ibuprofen.

Motrin was chosen as a brand name by the company that first made ibuprofen. However, after the patent on Motrin expired, other manufacturers were permitted to make a generic version, provided it met standards set by the U.S. Food and Drug Administration. While the generic name of the medication will always be ibuprofen, all the companies that now make ibuprofen can choose a different brand name for their products. So today, Motrin, Advil, Nuprin and Profen are just a few of the many brand names for ibuprofen.

Occasionally, a company may decide that a specific brand name is not necessary. In that case, the medication has only one name, the generic name.

In *Safe Medicine*, we'll use color to help you tell generic names apart from brand names. We'll always list the generic name of medications in red. If we're referring to a specific brand name medication, we'll capitalize it and list it in green, and put its generic name in parentheses.

Check it out!

Clues to mistakes with medicines

Sometimes you need to look for clues that could alert you to a mistake with your medication. Check it out with your doctor, nurse, or pharmacist before taking your medicine if:

- The appearance (color, shape, markings on tablet) is different than expected.
- The smell is different than expected or extremely unpleasant.
- The amount of liquid in a syringe or bottle is more or less than expected.
- The number of pills in a prescription bottle is more or less than expected.
- The directions on a prescription bottle differ from what your doctor told you.
- The name of the medication on the prescription bottle is not as expected.
- The reason for taking the medication (on the prescription bottle, in a leaflet, or mentioned by the pharmacist) is different than the condition you are treating.

for more go to: **www.ismp.org**

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