

ISMP Ambulatory Care Action Agenda

July - December 2008



One of the most important ways to prevent medication errors is to learn about problems that have occurred in other organizations and to use that information to prevent similar problems at your practice site. To promote such a process, the following selected agenda items have been prepared for you and your staff to stimulate discussion and collaborative action to reduce the risk of medication errors. These agenda topics appeared in the *ISMP Medication Safety Alert!* Community/Ambulatory Care Edition between July 2008 and December 2008. Each item includes a brief description of the medication safety problem, recommendations to reduce the risk of errors, and the issue to locate additional information as desired.

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
12/08	ConsumerMedSafety.org is the first and only website (www.ConsumerMedSafety.org) exclusively designed to bring the message of adverse drug event prevention directly to consumers. It was created to empower patients and improve health outcomes related to medication use, medication adherence, health literacy, and patient/provider collaboration and communication.	We hope that you will consider linking your practice site or organization's website to www.ConsumerMedSafety.org , and that you and your family will take advantage of our unique medication alert system. Please also keep us in mind for any safety issues you would like communicated to a wide audience of consumers, including patients, family members, and caregivers.	ConsumerMedSafety.org		
Tragic events with concentrated opiate oral solutions					
7/08	An 18-year-old teenager was prescribed oxy CODONE oral solution to treat throat pain associated with strep throat. However, he mistakenly received a 100 mg dose of concentrated oxy CODONE solution instead of 5 mg as prescribed. The patient suffered organ failure, entered into a coma, and required mechanical ventilation.	When appropriate, consider non-opiate therapies for pain relief. Reserve concentrated solutions for patients who require higher than usual doses due to severe chronic pain or are unable to swallow larger volumes of liquid. Prescribe liquid medications with the dose specified in milligrams. When dispensing, include the dose in both milligrams and milliliters on pharmacy label directions, assure an appropriate measuring device is provided, and educate patients regarding the safe use of opiate oral solutions.			
Unsafe morphine dispensing					
11/08	An opiate-naïve patient with a kidney stone received a prescription for morphine 5 mg orally every 4 hours as needed for pain. The patient was given a parenteral syringe full of morphine sulfate 20 mg/mL liquid with a label that instructed him to take 1/4 mL (5 mg) every 4 hours as needed for pain. The patient was not given instructions on how to measure the dose, and the calibration on the syringe did not allow for accurate measurement of 0.25 mL.	In an outpatient setting, morphine should never be dispensed in any container other than the manufacturer's original package. In addition, parenteral syringes should never be used to dispense oral liquids in any setting. (This practice has led to accidental swallowing of the syringe cap as well as inadvertent IV administration of oral liquids in inpatient settings.)			

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Ambulatory e-Rx requires patient's check					
8/08	A doctor prescribed a topical corticosteroid, using a handheld device to place the order electronically. He asked which pharmacy the family used but he never told them what drug he was prescribing. This raises an important question when prescriptions are sent electronically: How will the patient know what they're supposed to receive if they are not told the prescribed medication, strength, and directions for use, and given a written copy of the information to compare with the dispensed medication?	Anytime a medication is ordered, the prescriber and pharmacist should provide education to the patient regarding the name, purpose, use, dose, and administration of the medication. Patients should be given an opportunity to ask questions, and also be provided with a corresponding "voucher" that lists the prescribed medication, dose, and directions for use.			
Jantoven, Januvia, and Janumet					
9/08	An ambulatory surgical center expressed concern regarding the brand name for a warfarin product named JANTOVEN because it has potential for confusion with the anti-diabetics JANUVIA (sitagliptin) and JANUMET (sitagliptin and metFORMIN).	Confirming the diagnosis of diabetes for any patient taking a diabetic agent can help to reduce errors if a prescription is mistakenly misread.			
Carac-Kuric mix-ups					
10/08	Sanofi-aventis distributed a letter that provides details about a dispensing error caused by an improperly transcribed verbal order for Altana's KURIC (ketoconazole) cream (2%), used for the topical treatment of fungal infections and seborrheic dermatitis, which was misheard as CARAC (fluorouracil) cream (0.5%), used for the topical treatment of multiple actinic or solar keratoses of the face and anterior scalp, and dispensed to a patient.	Sanofi-aventis has suggested precautions to prevent this mix-up, including clarification of oral and written orders, verification of the brand and generic names, spelling the product name when reading back oral orders, matching the product's indication to the patient's condition, and drawing attention to the differences in the names of these products. Please visit www.ismp.org/docs/CaracLetter20080110.pdf to view the letter.			
Warfarin by generic name					
12/08	Some health professionals and patients may not recognize that JANTOVEN is a brand of warfarin, and patients could easily end up taking two warfarin products together. A case was reported to us in which the patient took warfarin prescribed and dispensed under both generic and brand names, which resulted in an INR of 9.7!	When branded generics are dispensed to patients, it is important that the generic name be listed on the prescription container label, along with the brand name, as necessary, whether Jantoven or COUMADIN . Patient education should be an integral component of both discharge reconciliation and outpatient pharmacy dispensing.			

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Skipped scans					
11/08	<p>A patient received an incorrect strength of the allergic rhinitis medication SINGULAIR (montelukast). The pharmacy technician did not scan the barcode on the manufacturer's bottle to confirm the product's identity and covered the manufacturer's container label and barcode with the pharmacy-generated label preventing the pharmacist from reading or bar-code scanning the label. While investigating this event, it was uncovered that the pharmacy technicians were presenting a large number of prescriptions to the pharmacist without the product having been confirmed by barcode verification. These deviations from the intended workflow process represent drifts into at-risk or unsafe behaviors.</p>	<p>Investigate errors to uncover the system-based reasons for at-risk behavior and decrease staff tolerance for risk taking. For example, there may be issues with the technology or workflow that need to be addressed in order for the bar-code technology to be accepted and fully utilized. Or, there may be unrealistic quotas placed on personnel or corporate promotion of 'turn-around' times for dispensing prescriptions made to the public. Once the incentives for at-risk behaviors have been addressed, workers should be coached on making better behavioral choices.</p>			
Schools need to teach the 5 R's: Reading, Writing, Arithmetic, AND the Right medication at the Right time					
8/08	<p>A kindergarten student wearing a DAYTRANA (methylphenidate transdermal system) patch shared it with a peer who wore it for several hours. Luckily neither child was harmed. This event signals the need to evaluate how medications are used and/or administered in schools.</p>	<p>Each school should have a local pharmacy that they can call with questions about medications. Pharmacists can provide in-service education to staff, demonstrate the proper use of devices, and teach parents to share initial and updated information about their child's medications with the child and school. See the newsletter for more risk reduction strategies.</p>			
Get parents involved to prevent vaccine errors					
8/08	<p>ISMP has received many reports that described vaccine errors in which children received incorrect vaccine products. In one case, an adult booster form of diphtheria, tetanus, and pertussis toxoids was given to a child less than 7, while in another case, a 13-year-old girl received a similar product meant for children less than 7 years old. Similarities between the nonproprietary names and vaccine abbreviations (DtaP and Tdap) are believed to have contributed to the confusion.</p>	<p>Separate stock of the pediatric and adult formulations, use shelf-talkers to direct staff to the location of each formulation, and place alerts on the products (e.g., "Adult" or "Pediatric") and on automated dispensing cabinet screens. Consider including parents or caregivers in safety processes. Make them aware, in writing, of the names and purposes of vaccines that are needed. Use the vaccine log on the patient's chart so that confirming the lot number and expiration date is included in the verification process. Have the nurse and the parent sign and date the log.</p>			

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Auto-Injectors - A Shot in the Dark for Untrained Consumers					
9/08	Confusion and medication errors have occurred due to the design of epinephrine auto-injector devices like EPIPEN or TWINJECT . The design of the device may be confusing to consumers and practitioners. One consumer, even after becoming familiar with how the device was meant to be operated, was afraid she would not be able to use the device properly in an emergency.	Pharmacists and prescribers should provide hands-on training at the time of prescribing or dispensing. Materials on how to use the devices should be given to the parent or patient to take home. The manufacturers' websites (i.e., www.twinject.com and www.epipen.com) should be used as a learning vehicle. Practitioners should consider providing training and materials that parents and patients can share with other caregivers.			
Voice mail: What's that you said?					
12/08	An event occurred when a nurse called and left a voice mail prescription for "Six mercaptopurine 50 mg daily for 30 days, a one month supply" for ulcerative colitis. The pharmacy technician who retrieved the prescription from the voice mail system transcribed it as "mercaptopurine 50 mg, 6 QD, # 150." As a result, the instructions on the dispensed prescription directed the patient to take 6 tablets per day instead of 1 a day as the prescriber intended.	Prescribers and their staff must speak clearly when communicating orders. Clear and specific instructions should be provided on each prescription. Avoid "use as directed." Include the medication's indication and route of administration with the order. Spell out drug names that have been confused and sound out digits for dosages (e.g., one - five instead of fifteen). Have a second person listen to the order. See the newsletter for other strategies and voice mail prompts.			
The danger with cutting medication patches					
9/08	A physician instructed staff from a hospice healthcare agency to cut a 50 mcg/hour fentanyl transdermal system patch and apply it to a patient to deliver a 25 mcg/hour dose. Fortunately, the patient suffered no adverse effects; however, serious harm, including fatalities, has been reported under similar circumstances in which patients cut and applied a reservoir membrane fentanyl patch to their skin, intending to reduce the dose but instead delivering an overdose.	Fentanyl transdermal patches should never be cut to titrate doses. Instead, prescribers should provide patients with a new prescription for a reduced strength of the patch. Patients should be warned about the risks associated with cutting patches. For other products offered via a transdermal system, always refer to the package insert and follow the manufacturer's recommendations regarding the safety and efficacy of cutting patches.			
Why doctors need to include the purpose on prescriptions					
10/08	An obvious mental slip occurred when a physician prescribed hydroxyzine 25 mg prn itch instead of hydroxyzine for a patient who was experiencing an allergic reaction.	Encourage prescribers to include the indication for the medication as part of the prescription.			