



# Nurse Advise-ERR™

Educating the healthcare community about safe medication practices

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## A medication error trifecta!

Pharmaceutical companies sometimes select different brand names to market the same generic drug if it's used to treat different conditions. For example, finasteride is named **PROPECIA** when it's used to treat alopecia, and **PROSCAR** when it's used to treat benign prostatic hyperplasia. Fluoxetine is marketed as **PROZAC** when it's used to treat depression, obsessive-compulsive disorder and bulimia, and as **SARAFEM** when it's used to treat premenstrual dysphoric disorder.

This is confusing enough for clinicians; imagine how confused a patient might be. One middle-aged man accidentally took too much bupropion, which sent him to the ED with severe nausea, vomiting, and a reported seizure. The patient had a long-standing history of depression treated with **WELLBUTRIN** (bupropion). Six weeks prior to admission, his physician had given him new prescriptions for all his medications. But this time, he prescribed them using generic names. Unfortunately, the patient continued taking his original prescription for Wellbutrin, along with his new prescription for generic bupropion. Around the same time, he attended a smoking

cessation program where another physician gave him a prescription for **ZYBAN** (bupropion). Thus, he was taking Zyban, bupropion, and Wellbutrin — all at the same time. Sadly, even though the patient had given the ED staff a list of his current medications, which included Zyban, bupropion, and Wellbutrin, the nurses and physicians did not recognize the problem. A third-year medical student finally noticed the error after looking up the generic names of all the patient's medications. The patient was discharged from the hospital after 24 hours of intravenous hydration.

**The patient was taking Zyban, bupropion, and Wellbutrin — all at the same time.**

One more thought: A pharmaceutical company, Teva USA, just began marketing a generic version of bupropion under two *different* brand names: **BUDEPRION SR** when indicated for depression, and **BUPROBAN** when indicated for smoking cessation. Add in the different extended-release formulations of bupropion that are available (XL, SR) and it's no wonder that patients are confused!

See *pearls for patients* (right-hand column) for teaching tips to help patients avoid duplicate (or triplicate) drug therapy.

## pearls for patients



Follow these teaching tips to help patients avoid unintended duplicate drug therapy:

- **Generic and brand names.** Teach patients that all medications have one generic name, and possibly one or more brand names. Ensure that they know both the generic and brand name (if applicable) of the medications they are taking, and warn them about the risk of duplicate therapy if the medication prescribed is also marketed under other brand names.
- **Healthcare provider review.** Encourage patients to bring all medications, vitamins, over-the-counter (OTC) products and herbal products when presenting to the hospital or visiting a physician's office (at each annual visit or after new medications have been added).
- **Ongoing list.** Help patients maintain a list of all OTC, herbal, and prescription medications (with brand and generic names, and indications) to keep in their wallet for quick reference.
- **One pharmacy.** Tell patients to obtain all medications from the same pharmacy when possible, and to tell their pharmacist about any prescriptions dispensed elsewhere so duplicate therapy and drug-drug interactions can be avoided.
- **Discontinued medications.** Provide patients with written instructions about which drug previously taken at home is being replaced by a newly prescribed drug. Encourage patients to properly dispose of the discontinued medications.

- **Keep in touch.** Establish a callback system to patients at risk for non-adherence or unsafe self-administration of medications to promote understanding. Keep copies of discharge instructions on the unit to refer to when calling these patients during the first week after discharge.

### safetywire

**Psychiatry lexicon.** A pharmacist received a poorly handwritten prescription from a psychiatrist. After conferring with five pharmacy staff members, he believed the prescription was for **LOXITANE** (loxapine) 10 mg, an antipsychotic and antidepressant (see photo). On day 6 of therapy, the psychiatrist questioned why his patient was not receiving **LEXAPRO** (escitalopram), which he had ordered several days earlier for his patient's newly diagnosed depression. Similar indications, names, and dosage strengths (10 mg) of the two medications contributed to the confusion. If legibility is an issue, the physician



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## did you know...Your patient's inhaler may be running on empty?

**?** Many asthma patients unknowingly continue to use their metered-dose inhalers (MDIs) long after their medication is gone. The newer dry powder drug delivery systems (e.g., salmeterol xinafoate inhalation powder [SEREVENT DISKUS]) are equipped with built-in dose counters or a color gauge that indicates when the canister is nearing empty (now recommended by FDA). However, older conventional inhalers (e.g., albuterol [VENTOLIN, PROVENTIL]) typically do not offer a mechanism to help patients keep track of the number of doses used. Patients may guess the number of doses left, use the MDI until it “feels” empty, or think that the canister contains medication if they hear liquid when shaking it, or can see or taste a “test” spray. But this might only be lubricants or propellants, which could cause bronchospasm if inhaled without the medication. Some patients also believe that an empty inhaler will float, but this “test” is unreliable. You can get different results if the valve stem is up or down, and some MDIs float when full.

Consider the following guidelines to help your patients reliably track the number of doses they use so they do not find themselves with an empty inhaler, or worse, one that's releasing just lubricants or propellants.

- ✓ **Know the number of doses.** Teach patients how to read the package insert to find the number of doses available in the inhaler.
- ✓ **Track the puffs.** Show patients who use dry powder MDIs how to read the built-in counter or indicator window to tell when a new canister is needed. Teach patients who use a conventional inhaler to record the number of puffs used in a log. Stickers (e.g., [www.sev.org/members/lmb/about.htm](http://www.sev.org/members/lmb/about.htm)) or a reusable electronic “doser” can be purchased (e.g., [www.doser.com](http://www.doser.com)) to help record each activation of the inhaler. (Electronic “dosers” should not be used with ipratropium, cromolyn, or nedocromil because they may physically interfere with the ability to deliver a spray.)
- ✓ **Schedule refills.** Advise patients to obtain refills 1 week before the MDI is empty (or within a timeframe allowed by insurance). If an MDI is used regularly, teach patients to divide the number of doses listed on the label by the number of puffs they will use daily to determine how many days the inhaler will last. Advise them to mark that date on the MDI, and to mark their calendars 1 week before that date as a reminder to refill their prescription. For rescue inhalers (used to treat symptoms), tell patients to refill their prescription when about 20-30 doses remain.
- ✓ **Discard the medication.** Advise patients to discard the MDI canister when they reach the number of available doses listed on the label.
- ✓ **Keep a log.** Encourage patients to keep diaries of their asthma symptoms and all medications they are using to manage their disease.

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## safetywire continued

should always be contacted directly instead of relying on colleagues to help interpret the order. Also, this hospital now requires nurses to compare any newly prescribed psychotropic medication against the patient's written consent form (on which the drug name is printed).

**⚡ Too many MAR pages?** What's the average number of medication administration record (MAR) pages for each patient at your institution? The answer may be “Too many to be safe.” One reason may be the misuse of preprinted orders. A variety of medications are often included on preprinted orders to cover every possible patient need. (Preprinted orders do not have to cover all possible contingencies; when they do, we refer to them as “Nurse, don't bother me!” orders.) As a result, a typical preprinted order set may include several analgesics, a laxative, antacid, bedtime sedative, antidiarrheal, antiemetic, antipyretic, and so on. Each requires transcription and a separate entry on the MAR, even if electronic prescribing is used. In fact, a single analgesic order may require multiple MAR entries if it's prescribed allowing different doses and routes of administration. If too many MAR pages is a problem at your facility, bring it to the attention of your nursing leaders who serve on the Pharmacy and Therapeutics Committee so they can work with pharmacists and the medical staff to minimize the variety of prescribed medications, routes of administration, and dosages on preprinted orders. Don't forget to consider patients for whom there are multiple preprinted order sets that overlap. These patients might wind up with several different bedtime sedatives, laxatives, antidiarrheals, and so on, unless the typical medications used across different preprinted order forms are standardized. This is no easy task, but well worth the effort.

## Survey on practice site distribution of the ISMP Nurse Advise-ERR

We need the help of individuals who receive the initial copy of this newsletter at each practice site to understand how it's received and redistributed within your organization. The survey will take just a few minutes to complete and will give us the information we need to continually increase distribution of medication safety practice recommendations to even more nurses. **We would greatly appreciate just ONE RESPONSE from each hospital BY THE PERSON WHO RECEIVES THE NEWSLETTER INITIALLY, regardless of whether you redistribute it to others.** Please submit your responses by **September 19, 2004**, via our website at: [www.ismp.org/survey200408nurse.asp](http://www.ismp.org/survey200408nurse.asp) (or by fax to 215-914-1492 only if you do not have Internet access). Thank you!

### 1 As the person who receives the initial copy of the newsletter, what is your professional role? (check one)

- Nurse - **If yes, please note level:**       Staff       Manager       Administrator       Other  
 Pharmacist - **If yes, please note level:**       Staff       Manager       Administrator       Other  
 Physician - **If yes, please note level:**       Staff       Manager       Administrator       Other  
 Educator - **If yes, choose:**       Academic setting       Patient care setting  
 Administrator (other)  
 Risk/Quality manager  
 Patient/Medication safety officer  
 Industry/Regulatory  
 Other (please identify) \_\_\_\_\_  
 Don't know if I receive the initial copy of the newsletter in my facility

### 2 Do you redistribute the newsletter after it is received? Yes \_\_\_ No \_\_\_ If no, skip to question # 7

### 3 Who determines the organization's master distribution list for this newsletter? (check one)

- Nurse       Pharmacist       Physician       Administrator       Risk manager       Quality manager  
 Librarian       Educator       Patient/medication safety officer       Support staff       Don't know  
 Other (please specify) \_\_\_\_\_

### 4 As a general pattern, how do you redistribute the newsletter to others? (check one)

- Send all issues       Send selected issues  
 Send selected items       Rewrite selected items and send  
 Other (please specify) \_\_\_\_\_

### 5 Please tell us how many people in each category actually receive each issue (or selected items) of the newsletter after re-distribution in your facility (please give a number for all categories of staff)

- Staff nurses       Educators  
 Nurse managers or administrators       Students  
 Staff pharmacists       Staff physicians  
 Pharmacy managers or administrators       Physician managers or administrators  
 Risk management staff       Respiratory therapists  
 Quality management staff       Others

### 6 Place a checkmark next to each method used to distribute newsletter information. (check all that apply)

- Fax       E-mail       Internal intranet       Internal website       Bulletin board  
 Sent with meeting minutes       Sent through an internal newsletter  
 Copied and sent to individuals/departments       Other (please specify) \_\_\_\_\_

### 7 Which of the following methods of delivering your newsletter would you prefer?

- PDF version of the newsletter attached to an email message (current method, with attachment)  
 An email message with a link on which to click to view/download a PDF version of the newsletter on your computer (no attachment)

### 8 Please describe your organization. (check all that apply)

- Hospital - **please note bed size:**       Below 100 beds       101-200 beds       201-350 beds       351-500 beds       Over 501 beds  
 Outpatient/community-based provider  
 Academic setting  
 Other (please specify) \_\_\_\_\_

Please submit responses to ISMP at: [www.ismp.org/survey200408nurse.asp](http://www.ismp.org/survey200408nurse.asp), or by fax (215-914-1492) by **September 19, 2004**

*Thank you for participating!*