

National Alert Network Issued: EPINEPHrine Shortage May Cause Dangerous Medication Errors

6/18/2010

A National Alert for Serious Medication Errors (NAN) was issued yesterday by the American Society of Health-System Pharmacists (ASHP) and the Institute for Safe Medication Practices (ISMP), warning health care practitioners about dangerous medication errors that could be caused by a shortage of EPINEPHrine* pre-filled syringes.

The alert was prepared as a caution to health care organizations and practitioners even though there had been no reports of deaths or serious errors at that time. However, days before the alert was finalized, news media in Bangor, Maine, reported the death of a hospital patient from an overdose of EPINEPHrine. It is unknown at this time whether the EPINEPHrine shortage was a factor in the deadly error.

The NAN warns health care practitioners about dangers posed by this drug shortage and includes recommendations to prevent medication errors that could result from the shortage.

The NAN was developed by the American Society of Health-System Pharmacists and the Institute for Safe Medication Practices to help bring an end to deadly medication errors. Physicians, pharmacists, and nurses are expected to use the recommendations to take immediate action to prevent serious medication errors at their facility.

Alerts are issued by ASHP and ISMP only when a significant risk for serious or fatal errors is detected through ISMP's Medication Error Reporting Program (MERP) and the alert is distributed by the National Council on Medication Error Reporting and Prevention.

*EPINEPHrine is spelled here with some Tall Man Letters, which ISMP and the FDA recommend to help prevent medication errors caused by look-alike drug names.

About ASHP

For more than 60 years, ASHP has helped pharmacists who practice in hospitals and health systems improve medication use and enhance patient safety. The Society's 35,000 members include pharmacists and pharmacy technicians who practice in inpatient, outpatient, home-care, and long-term-care settings, as well as pharmacy students. For more information about the wide array of ASHP activities and the many ways in which pharmacists help people make the best use of medicines, visit ASHP's Web site, www.ashp.org, or its consumer Web site, www.SafeMedication.com.

About ISMP

The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 35 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. ISMP is a federally certified patient safety organization (PSO), providing healthcare practitioners and organizations with the highest level of legal protection and confidentiality for patient safety data and error reports they submit to the Institute. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org.