ISMP Ambulatory Care Action Agenda

ISMP 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 January 2017 and April 2017. 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. The Action Agenda is also available for download in a Word format at: www.ismp.org/Newsletters/ambulatory/actionagenda.asp. To learn how to use the ISMP Ambulatory Care Action Agenda at your practice site, visit www.ismp.org/newsletters/ambulatory/How_To_Use_AA.asp.

Key: ⚠ — ISMP high-alert medication

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
TRESIBA FLEXTOUCH (insulin degludec) U-200 pen won't allow dosing an odd number of insulin units					
01/17 ⚠	A physician prescribed 25 units daily of Tresiba FlexTouch U-200. The pen only has dosing increments in even numbers, starting with 2 units and going up to 160. An elderly patient tried to dial 25 units by estimating the position between 24 units (marked on the pen) and a notch or score that represents 26 units. According to the manufacturer, the design of the pen will not allow insulin to be administered unless the pen is correctly set to a dose—24 or 26 units in this case.	Healthcare professionals prescribing or dispensing pen devices need to be familiar with how they work. Educate healthcare professionals about the difference between U-100 pens and the U-200 Tresiba pen. Use training devices from manufacturers to educate staff and patients. Prescribers should consider providing a U-100 pen when smaller or odd numbered doses must be administered, reserving U-200 pens for patients requiring larger, even numbered doses.			
Concomitant use of ENTRESTO (sacubitril/valsartan) and angiotensin converting enzyme (ACE) inhibitors can lead to harm					
01/17	Entresto should not be administered within 36 hours of switching to or from an ACE inhibitor. More than 50 cases of concomitant use have been reported to the US Food and Drug Administration (FDA), 11 of which required hospitalization due to angioedema, hyperkalemia, acute kidney injury, and hypotension.	Create order entry alerts to warn against the concomitant use of Entresto and ACE inhibitors. Conduct a thorough medication reconciliation to ensure that patients who were taking an ACE inhibitor or angiotensin receptor blocker (ARB) do not restart it when prescribed Entresto. Educate patients about not taking Entresto and ACE inhibitors together.			
FLEET SALINE ENEMA contains phosphate – not just "saline"					
04/17	Fleet Saline Enema contains sodium phosphate monohydrate 19 g and dibasic sodium phosphate 7 g. Because the label states "saline," the phosphate content may be overlooked. Elderly patients with renal insufficiency and those using more than one enema per 24 hours are more at risk for phosphate toxicity.	Consider storing these products behind the pharmacy counter or posting signs near these products directing patients to consult with a pharmacist or doctor before purchasing. Warn patients about the need to carefully follow label directions and to not use more than one enema in 24 hours.			

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Using information from external errors to signal a "clear and present danger"					
03/17	Despite repeated descriptions of harmful and fatal errors in publications, many organizations fail to use this information to decrease the risk of similar errors. Attribution biases that cloud the way we judge the behavior of others when errors happen often thwart our ability to learn from their mistakes. Unfortunately, recommended actions go unheeded by those who feel they don't apply to them.	Establish a systematic way to identify and review information about external errors and assess the organization's vulnerability to similar errors. Identify reliable sources of information about external errors, such as ISMP newsletters, peer-reviewed journals, and alerts from the US Food and Drug Administration (FDA). Establish group (practice site level, district level, corporate level) responsibility for reviewing the external errors or events, with standing items on meeting and committee agendas.			
Vaccine abbreviations and acronyms lead to errors					
02/17	Long nonproprietary vaccine names have spurred the use of abbreviations. The Centers for Disease Control and Prevention (CDC) provides a list of standard abbreviations, but nonstandard abbreviations are used often, and some standard abbreviations are very similar, sharing a main root to identify the target disease. Mix-ups have been reported, the latest involving Hib (*Haemophilus influenzae* type b conjugate vaccine) and HPV (correct abbreviation is 9vHPV for human papillomavirus 9-valent vaccine, recombinant).	If vaccine abbreviations are permitted, allow only current CDC-approved abbreviations to be used. Order sets or protocols should include the vaccine's brand name (if applicable) and full nonproprietary name. Review these order sets at least annually and update them as needed. If CDC-approved vaccine abbreviations are used in electronic formats, configure the display to allow viewing of the full nonproprietary name when hovering over the vaccine abbreviation. List full vaccine names on patient vaccination records and provide patients with a copy.			
Using open-ended questions is critical					
01/17	When a pharmacy clerk called out that a prescription for a child was ready for pick up, an elderly patient approached the counter. The clerk was uncertain if this was intended for her so she asked the patient "Are you here to pick up for [the child's name]?" The woman answered "Yes" and left with the wrong medication. The error was discovered before the woman ingested any tablets.	Avoid using closed-ended questions to verify a patient's identity and assess their understanding of their drug regimen. Ask patients to state their name and date of birth in order to confirm their identity. Open the bag at the point-of-sale and review the medication and prescription label with the patient before they leave.			

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Barcode your return to stock process					
03/17	A pharmacist was verifying a prescription for rif**AMP**in 150 mg capsules. When she opened the prescription vial to visually inspect the capsules, she noticed capsules with very slight differences in appearance. The prescription had been filled with both rif**AMP**in 150 mg and rif**AMP**in 300 mg capsules. It was determined that rif**AMP**in 300 mg capsules from a previous prescription had been returned to stock and added back into a bottle of rif**AMP**in 150 mg.	Do not return drugs into manufacturer stock bottles. Best practice calls for the pharmacy computer system to generate a return-to-stock (RTS) label that includes the drug name and strength as well as a barcode that can be scanned during production and/or verification when used to fill a subsequent prescription. Apply the RTS label to all vials or bottles of products that are returned to stock. Develop a policy for recording the expiration date on the RTS label and periodically review and observe the process to ensure adherence.			
Open the bag!					
04/17	We received a report in which a pharmacist who was assisting the pharmacy technician grabbed the wrong patient's bag and gave it to the technician to provide it to the patient. Neither the pharmacist nor technician verified the patient's identity using two unique identifiers or opened the bag.	Open the bag of filled prescriptions at the point-of-sale to verify that the medications are for the correct patient. Always ask the patient to provide at least two patient identifiers—their full name and date of birth—when picking up prescriptions. Talking with the patient about their medications can further reduce the risk of errors.			
Look-alike bottles from Cipla and Sandoz					
01/17 02/17	Bottles of gemfibrozil 600 mg tablets and gabapentin 600 mg tablets, both made by Cipla, look nearly identical. Both products have similar looking names and overlapping dosage strengths. The containers also use the same colors. Furthermore, bottles of Sandoz's atenolol 25 mg and **ALPRAZ**olam 0.25 mg look very similar. The containers share the same color scheme, layout design, and the numerical combination "25." Also, it is likely that these may be stored near one another, increasing the risk of mix-ups.	Explore ordering one item of each of these pairs from a different manufacturer. If this is not an option, make the bottles look different by marking the drug container or adding auxiliary warnings. Do not store these drugs side-by-side on the pharmacy shelf. Use shelf dividers to keep stock separated and neatly organized. If you separate storage of these products, post signs or shelf stickers to direct pharmacy staff to the location of the product that was moved. Barcode scanning can identify when the wrong product is selected from the shelf.			