






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 2015 and April 2015. 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
Life-threatening errors with flecainide suspension in children					
04/15 	Flecainide is only available commercially as 50 mg, 100 mg, and 150 mg tablets. It must be compounded into an oral suspension when needed for infants and small children. ISMP is aware of multiple cases of life-threatening flecainide overdoses that happened with compounded oral suspensions in the recent past. Unrecognized changes in drug concentration, math errors, labeling errors, and inaccurate dosing instructions led to the confusion in these cases.	Prescribers should always order flecainide in terms of the mg dose. This allows pharmacists to address the suspension concentration (mg/mL) and volume per dose, which should be expressed in metric units (mL). If the drug is prescribed by volume, the concentration MUST be specified, or the prescriber must be contacted for clarification. The pharmacy should insert a flow restrictor into the neck of the bottle before dispensing. An oral syringe to measure and administer doses should be provided. Label directions should express the dose in terms of mL. Have parents perform a “teach back” to demonstrate how to measure and administer proper amounts.			
Recommendations to address system-based causes of vaccine errors					
12/14 03/15	Analysis of data submitted to the ISMP National Vaccine Errors Reporting Program (VERP) in 2013-2014 identified the vaccines most often associated with errors—influenza, DTaP-IPV, HepA, Tdap, HPV, DTaP, MMRV, and HepB. Analysis also identified the most common contributing factors—choosing among age-dependent formulations to prevent the same disease; unfamiliarity with vaccine doses, schedule, ages, and components of combination vaccines; similar vaccine names/abbreviations and labeling/packaging; using the wrong diluent; and unsafe storage conditions.	Compare the patient's age with information in the immunization schedule and Vaccine Information Statements (VIS). Structure appointments to vaccinate one patient at a time. Check immunization records before vaccination to avoid omissions and duplicate doses. Make easy-to-read immunization schedules available in clinical areas. Provide patients/caregivers with VIS to read before vaccination. Highlight the route of administration on medication administration records and labels. Keep vials of 2-component vaccines together. Label all prepared syringes. Use full vaccine names or CDC standard abbreviations. Separate pediatric and adult formulations in storage areas. Ask the patient/parent to verify information on the immunization record.			

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Severe bleeding associated with opening PRADAXA (dabigatran) capsules					
02/15 	A patient in an assisted living facility was admitted to the hospital with hematemesis while taking Pradaxa. It is believed that nurses at the facility may have been opening the Pradaxa capsules and sprinkling the contents on the patient's food. The oral bioavailability of Pradaxa increases by 75% when the pellets are taken without the capsule shell, thus increasing the risk of bleeding.	Alert staff to the risk of bleeding if capsules are not administered intact. Also add a statement to the medication administration record listing for dabigatran—"Do NOT break, chew, or open capsules." Before opening any capsules or crushing any tablets, encourage staff to reference the Do Not Crush list: www.ismp.org/Tools/DoNotCrush.pdf .			
FARXIGA (dapagliflozin) and FETZIMA (levomilnacipran) mix-ups					
01/15 	Several medication errors due to name confusion between Farxiga and Fetzima have been reported. The errors can be largely attributed to the drugs being approved and marketed within 6 months of each other; Fetzima in July 2013 and Farxiga in January 2014. The container labels may look similar since both display the brand name of the product in red font.	Add computer alerts to verify the indications for these drugs—to lower blood glucose levels in adults with type 2 diabetes with Farxiga, and to treat depression with Fetzima. Encourage prescribers to include the indication with prescriptions. Community pharmacists should counsel patients receiving these drugs and confirm the indication.			
Vaccine administration practices need review					
01/15	A patient received an influenza vaccine at a community pharmacy. The pharmacist administered the vaccine high on the patient's arm near the shoulder and the patient experienced severe pain leading to a visit to her physician. The physician noted that the vaccine was administered into the patient's bursa and not the deltoid muscle as intended.	Pharmacy management should verify that pharmacy staff have the required skills to administer vaccinations through direct observation of administration technique and proper infection control practices on an ongoing basis. Management must also ensure that pharmacists have the necessary time and resources to provide pharmaceutical services, administer vaccines, and conduct medication therapy management.			
Misidentification of alphanumeric symbols					
02/15	Problems may arise during written or electronic communication because of similarities in appearance of alphanumeric symbols. For example, the letter "l" can look like the numeral "1," especially when the drug name and dose are close together like "Levoxyl25 mg." Other letters and numerals that share similar characteristics can also cause confusion and result in an error.	Use mixed-case letters. Encourage prescribers to clearly print handwritten orders. Provide lightly lined order forms to prevent interference with symbols. Use symbolic differentiation carefully. Be selective about font and typeface. Avoid italics and underlining. Ensure proper spacing between drug names and doses, and between numerical doses and the unit of measure.			

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ClomiPHENE and ClomiPRAMINE confused					
04/15	A consumer reported that his wife was given clomi PRAMINE , a tricyclic antidepressant, instead of clomi PHENE , a fertility drug. This error happened after the physician's office called in the clomi PHENE prescription. ISMP is aware of 4 previous reports involving this pair of look- and sound-alike drugs. Both products are available in 50 mg strengths which increases the risk of confusion.	When accepting telephone orders, pharmacists should write the order on a pharmacy prescription blank and read it back to the prescriber, spelling the drug name, sounding out the dosage and frequency, and stating its indication. Prescribers should include both brand and generic names as well as the purpose of the medications when prescribing these drugs. Differentiate names on computer screens and storage shelves. Consider storing products with look-alike names in different locations; use shelf stickers to help locate products that have been moved.			
Transdermal medications and exposure to heat sources					
01/15 	A patient with multiple myeloma was prescribed transdermal fenta NYL (DURAGESIC) for back pain management. She tolerated therapy well for the first 2 weeks but later developed disorientation, nausea, and vomiting. After some investigation, it was discovered that the fenta NYL patch was applied to the patient's back (the area that was hurting) and she routinely sat in a recliner that has a heating component. The heat from the chair likely increased absorption of the drug and lead to the patient's symptoms of fenta NYL toxicity.	Educate patients and caregivers to avoid exposing transdermal medication patches to heat from any source while wearing the patch. Remind patients to avoid tight coverings over the patch and strenuous exercise since this can heat the body and increase absorption. Counsel patients to apply patches to non-irritated skin on the chest, back, flank, or upper arm and to avoid areas that will be in contact with heat sources. Remind patients that transdermal fenta NYL works systemically so it is not necessary to place the patch directly over the area of pain.			
Communicating cancelled e-prescriptions					
04/15 	A prescriber sent 2 electronic prescriptions (e-Rx) for warfarin for the same patient to a community pharmacy. He electronically discontinued or cancelled the first e-Rx before sending the second e-Rx. The pharmacy never received notification that the first e-Rx was discontinued and dispensed both prescriptions to the patient. The patient took double the dose of warfarin daily for several days before presenting to a clinic with an elevated INR. Most pharmacy systems are not implemented in such a way to receive discontinued e-Rx.	Pharmacies, prescribers, health information network operators, pharmacy computer system vendors, e-prescribing/electronic health record vendors, and regulators should improve the interoperability of these systems. As we move toward that goal, technology vendors and systems that transmit prescriptions must make all prescribers aware of this short fall.			