May-August 2015

ISMP AmbulatoryCare ActionAgenda

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 May 2015 and August 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
Open the bag to catch errors at the point-of-sale					
07/15	The most common complaint ISMP receives from consumers is that a community pharmacy has dispensed a correctly filled prescription to the wrong patient. Mistakes can happen when placing the prescription in the wrong bag for pick-up or when retrieving the wrong bag from the will-call area. The errors may not be caught at the point-of-sale because the process of patient identification may be flawed and most patients pick up their medication and leave the pharmacy without ever opening the bag. These errors may lead to a patient taking a contraindicated medication, the omission of the correct medication, or the accidental disclosure of confidential information.	At the point-of-sale, ask the patient to provide two patient identifiers (full name and date of birth) when picking up prescriptions. Never ask a "yes" or "no" question by reading aloud the patient's date of birth. Open the prescription bag and have the patient review the pharmacy labels and contents of each prescription container. Talk to the patient about their medication, including its purpose to ensure the correct medication is dispensed. Other recommendations include flagging patients with similar names in the system, separate areas designated for pick-up and drop-off, and periodically perform quality checks.			
Dosing and measuring Vitamin D products in drops should be avoided					
05/15	An infant with dystonia and cachexia was hospitalized with very high calcium blood levels. The mother had been administering a dropperful per day of **Vitamin D3 Drops for Kids** (Natural Factors, Canada) rather than a drop containing 400 units. Confusion between drops and dropperful has led to previous overdoses.	Practitioners caring for babies should never assume that parents know which vitamin D product to purchase, how many units to give, or how it should be administered. For infants, errors are less likely with a vitamin D product that contains 400 units per mL, not 400 units per drop.			
Continued BRINTELLIX (vortioxetine) and BRILINTA (ticagrelor) mix-ups					
08/15 ⚠	A patient was harmed when Brintellix 10 mg was dispensed instead of the prescribed Brilinta 90 mg. The patient fell, resulting in a periorbital hematoma, and was admitted to a hospital after taking Brintellix for 9 days. The dispensing error happened in a pharmacy where the two drugs were stored side-by-side and the wrong container was selected.	Build computer alerts to warn about possible confusion. Prescribers should include both brand and generic names, along with the purpose, on the prescription. Store these medications in separate locations and perform patient education about the medications. Given the number of ongoing reports, it may be time for a name change for one of these products.			

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Name and dosing confusion between mefloquine and MALARONE (atovaquone/proguanil)					
07/15	Errors have been reported to the US Food and Drug Administration (FDA) and ISMP involving mix-ups between mefloquine (formerly marketed as **LARIAM**) and Malarone. Both have similar indications (both are used for the treatment and prophylaxis of malaria) and tablet strengths (both 250 mg). In one case, mefloquine was prescribed as daily instead of weekly. Other errors resulted when mefloquine was mistakenly dispensed instead of Malarone. Healthcare practitioners may incorrectly believe that mefloquine is the generic of Malarone or may not be familiar with the antimalarial products or their dosing due to infrequent use.	Prescribers should include the brand and generic name when prescribing Malarone. They should also include the purpose (e.g., prophylaxis or treatment of malaria) of the medication on the prescription. Confirm the drug, frequency of administration, and dose regimen with each prescription. In order entry systems, establish an alert that will appear if mefloquine is prescribed daily and if Malarone is prescribed weekly. Provide counseling to patients on purpose and directions for use. Advise patients to read the medication guide when dispensing mefloquine and to call their healthcare provider if they have any questions.			
Methotrexate overdose					
05/15 ⚠	A patient was ordered methotrexate 2.5 mg with instructions to take 4 tablets (10 mg) weekly. However, the pharmacy label was typed incorrectly with directions to "Take four tablets once daily for 7 days." Although she was advised about the correct regimen to take by the physician, the patient followed the dosing instructions on the pharmacy label thinking she must have misunderstood the physician. She took 4 tablets (10 mg) daily for 4 days. She experienced shortness of breath, swelling in her legs, and thrombocytopenia.	Computer order entry systems should use a *weekly* dosage regimen default for oral methotrexate. Prescribers should include the purpose (e.g., rheumatoid arthritis) within the prescription. Limit the quantity of medication prescribed to a one-month supply. Consider dispensing methotrexate as a dose pack (e.g., **RHEUMATREX**) whenever possible, to help reinforce the weekly dosing schedule. Establish a system to ensure that patients receive counseling from a pharmacist for new and refilled prescriptions for methotrexate.			
Risk when copying old prescriptions					
06/15 ⚠	To expedite the dispensing process for a patient's new prescription of oxy**CODONE** 5 mg, a pharmacist copied the patient's previous oxy**CODONE** 30 mg prescription. However, he failed to edit the dosage strength, leading to the patient receiving the wrong dose. The same pharmacist conducted the final verification immediately after completing order entry and filling the prescription, limiting the effectiveness of a check.	If possible, have a pharmacist not involved in order entry or production conduct the final verification. Work with your pharmacy computer system vendor to prevent the user from proceeding when copying an old prescription unless critical elements of the prescription (e.g., drug name, strength, quantity, directions) have been confirmed. Otherwise, ensure that your manual process for verifying prescriptions include these steps. Provide patient counseling and open the bag at the point-of-sale.			

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Double check changed NDCs					
05/15	ISMP has received a number of reports which describe events in which the wrong medication was dispensed when a technician or pharmacist changed an NDC number after the original order entry and corresponding verification had been completed. The NDC number was changed to match a product selected from stock which, in each case, was the wrong product or dosage strength. In each case, an independent check of the change in NDC was not conducted prior to the production phase.	Examine your processes for reviewing changes made after entering a prescription. Build in an independent double check using the original prescription anytime a change is made to a prescription that has already undergone some sort of verification. This verification step should occur before the prescription can proceed to the next step in your pharmacy workflow.			
Don't miss important computer alerts seen by technicians and office staff					
08/15	In many community pharmacies, technicians or interns enter prescriptions into the pharmacy computer system. Later, a pharmacist performs a final verification of the prescription and medication. However, the checking pharmacist may not be aware of alerts that displayed during the order-entry process unless the technician or intern notifies them. As a result, important drug interactions, allergies, or other identified contraindications may be missed. The same scenario occurs when physician office staff enters e-prescriptions that are then sent to the pharmacy.	Require prescribers and pharmacists review clinically significant alerts; it should be impossible for technicians or office staff to bypass a clinically significant alert. Some IT systems have the ability to print out significant alerts along with the other product labels to allow the pharmacist or prescriber to view the bypassed alerts when checking the final product. Print a daily report of bypassed alerts for a pharmacist or prescriber to review. Review can take place when workload or staff is better, or a pharmacist or prescriber is scheduled for this task.			
Eliminate non-metric measurements					
06/15 ⚠	While checking a refill for cetirizine 1 mg/mL, a pharmacist noticed that the directions incorrectly read, "Take 2.5 mL (1.2 teaspoonsful)" instead of "Take 2.5 mL (1/2 teaspoonful)." Typing a decimal point instead of a slash mark (1.2 instead of 1/2) can easily happen when the wrong key on the keyboard is tapped as the keys are side-by-side. ISMP and other organizations, including the Centers for Disease Control and Prevention, the National Council for Prescription Drug Programs, the US Food and Drug Administration, and the American Academy of Pediatrics support the elimination of non-metric measurements.	Designate oral liquid doses by only using metric (mL) measurement in electronic health records and patient directions printed on pharmacy labels. The Office of the National Coordinator for Health Information Technology is calling for information technology systems to limit prescribers to use the metric system, which would enable prescription directions to also be in mL only. Provide patients with an appropriate oral dosing device, such as an oral syringe or dosing cup that measures in mL only.			