September-December 2015

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 September 2015 and December 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
Severe harm and death associated with medication errors and drug-drug interactions with low-dose oral methotrexate					
10/15 ⚠	One harmful and two fatal errors with low-dose oral methotrexate have been reported. Two of the patients who suffered severe toxic events were taking no more than 20 mg of methotrexate per week. Incidents occurred due to a combination of baseline patient risk factors (renal dysfunction, hypoalbuminemia), drug-drug interactions (amoxicillin, leflunomide), and medication errors (pharmacy labeling error led to daily use).	Use a weekly dosage regimen default when oral methotrexate orders are entered; require a hard stop verification of an appropriate oncologic reason for daily orders; and educate patients, including reminding patients that taking extra doses is dangerous, and providing them with a free ISMP handout (www.ismp.org/sc?id=316). Employ drug-drug and drug-disease interaction screening and resolve alerts with prescribers. Screen patients for risk factors and obtain baseline and periodic lab studies.			
Ribavirin and riboflavin mix-ups					
10/15	A pharmacist intercepted prescribing mix-ups with riboflavin (vitamin B2) and ribavirin. The prescribers intended to order riboflavin 200 mg but incorrectly prescribed ribavirin. Both products have names that sound and look similar and start with "rib." There is also an overlap between the 200 mg dosage strength of ribavirin and the 200 mg dose of riboflavin. Some information systems may only list riboflavin by its alternative name, vitamin B2. If a prescriber attempts to find riboflavin by typing the first three letters, only ribavirin might appear.	Prescribers should include the purpose of the medication with the prescription as most look- and sound-alike name pairs have different indications. Also, including "vitamin B2" in the prescription can help pharmacists and other practitioners correctly identify the intended medication. Pharmacists should confirm a diagnosis of hepatitis C for any patient taking ribavirin and educate patients on new prescriptions. Consider adding this name pair to your internal list of look- and sound-alike drug names.			
Don't cover manufacturer's barcode					
11/15 ⚠	**XARELTO** (rivaroxaban) 10 mg was dispensed instead of **VESICARE** (solifenacin succinate) 10 mg. The barcode on the manufacturer's label was covered by a pharmacy-applied label and was not available to be scanned during the checking procedure.	Ensure stickers, labels, or markings do not obscure the manufacturer's barcode. Review inventories periodically to check that manufacturer's barcodes are not covered. Review compliance with barcode scanning to ensure staff complies with this safety step.			

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Keep children safe from accidental medication poisonings					
11/15	In the US, approximately 60,000 young children are brought to the emergency department each year for accidental medication poisonings. Most medication poisonings happen in the home. Leaving prescription and over-the-counter (OTC) medications as well as dietary supplements, including those brought into the home by visiting friends and family, within reach of children is a predominant risk associated with medication poisonings.	Avoid the use of dual-purpose prescription container caps that can serve as a child-resistant cap but can be flipped over for use as a non-child-resistant cap. Remind patients, parents, and caregivers to keep all medications and vitamins up and away and out of a child's reach and sight. Encourage patients to follow the recommendations at www.upandaway.org and to program the phone number to the Poison Help Line (1-800-222-1222) into their cell phones so they have ready access in the event of an emergency.			
Human and animal medications may lead to drug name mix-ups					
09/15	There is a potential for injury to animals due to confusion between human and animal drugs that have look- or sound-alike names. Recently, a dog mistakenly received the human antidepressant **SINEQUAN** (doxepin) instead of the prescribed animal antibiotic **ZENIQUIN** (marbofloxacin). The dog became ill 24 hours after being administered doxepin.	Alert colleagues to the possibility of look- and sound-alike names for human and animal products. Consider configuring product selection screens so look-alike drug names are not listed consecutively. When possible add a screen or a notes field to provide an alert on possible look-alike or sound-alike drug names. Pharmacies should ask for the spelling of the drug name, if receiving the prescription orally, and then read back the order to the prescriber. At the time of dispensing, advise the owner to call the veterinarian with any questions. Call the veterinarian for clarification of the order if needed.			
HealthAlert! TraMADol in children					
09/15 ⚠	In children 17 years or younger there is a rare but serious risk of slowed or difficulty breathing when taking tra**MAD**ol. The risk may be increased in children using tra**MAD**ol after surgery to remove their tonsils and/or adenoids. After a single dose of tra**MAD**ol a 5-year-old child in France experienced difficulty breathing and required hospitalization. While tra**MAD**ol is not US Food and Drug Administration (FDA)-approved for use in children, data show it is being used "off-label" in the pediatric population.	Healthcare professionals should be aware of this risk and consider prescribing alternative FDA-approved pain medicines for children. Educate parents and caregivers of children taking tra**MAD**ol on the signs of an adverse event including, slow or shallow breathing, difficult or noisy breathing, confusion, or unusual sleepiness; instruct them to seek immediate medical attention if the child experiences any of these symptoms.			

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Decades-long errors still occurring: hydrALAZINE and hydrOXYzine					
11/15	ISMP continues to receive reports of mix-ups between the blood pressure medication hydr**ALAZINE** and the antihistamine hydr**OXY**zine. Recently, a community pharmacy received a printed prescription for hydr**OXY**zine but mistakenly entered and dispensed hydr**ALAZINE**. The patient presented to the emergency department with a blood pressure of 105/57 mmHg, shortness of breath, and numbness in his extremities just 3 hours after taking the incorrect medication.	Pharmacies should encourage prescribers to include the purpose of the medication on the prescription. Differentiate names (e.g., tall man letters, bolding, highlighting) 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. Pharmacists should discuss new therapies with patients to verify that the medication is appropriate to treat the patient's condition.			
ACTIVELLA (estradiol and norethindrone) strength confusion					
09/15 ⚠	Confusion may arise between the two dosage strengths of Activella due to similar and overlapping dosage strength numbers. It is available in 1 mg/0.5 mg and 0.5 mg/0.1 mg of estradiol and norethindrone respectively. Patients have received the lower strength by mistake.	Alert healthcare practitioners of the mix-ups. Reminders or alerts about the potential for error should be included in prescriber and pharmacy computer systems. Highlighting the strengths on the product may help to differentiate them. Patients should receive education about all of their medications.			
Serious liver injury with Viekira Pak and Technivie					
10/15	The US Food and Drug Administration (FDA) issued a warning that the hepatitis C treatments **VIEKIRA PAK** (dasabuvir, ombitasvir, paritaprevir, and ritonavir) and **TECHNIVIE** (ombitasvir, paritaprevir, and ritonavir) can cause serious liver injury, mostly in patients with underlying advanced liver disease. FDA identified cases of hepatic decompensation and liver failure in patients with liver cirrhosis taking these medications.	Closely monitor patients for signs and symptoms of worsening liver disease. Educate patients to contact their physician or pharmacist immediately if they develop signs of liver injury (e.g., fatigue, weakness, loss of appetite, nausea and vomiting, yellow discoloration of the eyes or skin, or light-colored stools). Visit www.fda.gov/Drugs/DrugSafety/ucm468634.htm for the complete FDA drug safety communication.			
Opioid mix-ups: HYDROcodone-acetaminophen and oxyCODONE-acetaminophen					
11/15 ⚠	A number of regulatory and product changes that occurred years ago may still be contributing to mix-ups between **HYDRO**codone-acetaminophen and oxy**CODONE**-acetaminophen combination products. For example, all approved opioid-acetaminophen combination products are now limited to 325 mg of acetaminophen or less.	Avoid storing these next to each other. Consider tall man letters, bolding, or highlighting to differentiate the drug names. If the prescribed combination product is not available, the pharmacist should contact the prescriber. Review the prescription with the patient at the point-of-sale to help prevent mix-ups.			