



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 2016 and April 2016. 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](http://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
U-500 regular insulin pen (HUMULIN R U-500 KWIKPEN)					
01/16 	No dedicated syringe is available to measure doses of U-500 insulin from a vial. Patients and clinicians administering U-500 insulin must use a U-100 syringe or a tuberculin (TB) syringe, both of which risk confusion and serious errors when measuring doses. If using a U-100 syringe, the dose must be converted to the markings of a U-100 syringe, or if using a TB syringe, to the volume markings. Miscommunication of the actual insulin dose based on U-100 syringe markings or volume has also led to serious errors.	The US Food and Drug Administration (FDA) has approved HumuLIN R U-500 KwikPen, a prefilled pen device. The pen holds 1,500 units, and the dose can be set in 5 unit increments. Consider using the U-500 pen, which is now available, to eliminate dose conversion problems. However, patients using U-500 insulin from a vial may still communicate their dose in U-100 syringe markings or volume, so always verify the dose and syringe/device used at home.			
Paregoric, not “opium tincture”					
02/16 	Paregoric was recently reintroduced into the market after being unavailable for several years. However, the nomenclature “opium tincture, 2%” was mistakenly added by the manufacturer to the label along with “paregoric.” Paregoric is NOT “opium tincture.” A dose of 5 mL of paregoric delivers 2 mg of morphine; a dose of 5 mL of opium tincture (10 mg/mL) delivers 50 mg of morphine.	The manufacturer is in the process of relabeling this product as paregoric 2 mg/5 mL (0.4 mg/mL). For now, add labels to the bottles so they are not confused with opium tincture.			
Ask about safety caps					
04/16	Medication bottles with safety caps are designed to protect children from accidental ingestion, but, on occasion, can contribute to patient harm. An elderly patient with multiple myeloma suffered a spiral fracture of the humerus while trying to remove the child-resistant cap on her medication bottle. The act of pushing down and twisting broke the weakened bone and caused the fracture.	Pharmacists should talk to patients to discuss problems they may have accessing their medications. If patients express difficulty, offer them the choice of having their prescriptions(s) dispensed in a bottle without a safety cap. Make sure to periodically update this type of information. Educate patients about the risk of accidental poisoning of children and safe medication storage (www.upandaway.org).			

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Errors with two-component vaccine MENVEO (meningococcal groups A/C/Y, W-135 diphtheria conjugate vaccine)					
02/16	Menveo is supplied in two vials, one containing lyophilized powder and the other a liquid component, which must be mixed together prior to injection. A government analysis identified 390 reports involving more than 400 patients during the past 5 years where only one component of the vaccine was administered, usually the MenCYW-135 liquid component. Several patients received only the MenA lyophilized component, reconstituted with a “generic” diluent. Errors are serious because they leave people exposed to a potentially deadly disease.	To prevent these errors, more is needed than just staff education and carefully following instructions—the only strategies suggested in the government analysis. Manufacturers must improve the labeling and packaging of 2-component vaccines to distinguish each container and connect the two so their contents are administered together. Until then, keep two-component vaccines together if storage requirements do not differ. Clearly distinguish each component if the manufacturer’s label could mislead staff into believing either is the vaccine itself. Require barcode scanning of both components prior to mixing and administration.			
Confusion among “Depo-” medications leads to wrong drug, route, or strength/volume errors					
03/16	Several drugs are available with names that begin with the prefix “Depo-.” Misadministration of these drugs by the IV route and confusing one Depo- medication with another has been reported frequently. Recently, DEPO-PROVERA (medroxyprogesterone acetate) and DEPO-MEDROL (methyl-PREDNISolone acetate) were mixed up; Depo-Medrol was administered IV instead of IM; and the volume/strength of DEPO-TESTOSTERONE (testosterone cypionate) vials was confused.	Recommendations to prevent potentially harmful mix-ups include: utilizing barcode scanning prior to stocking and administering these medications; limiting inventory to a single strength and vial size of Depo-Testosterone; utilizing auxiliary labels to indicate the route of administration; purchasing products in prefilled syringes to differentiate look-alike products; and utilizing tall man letters when expressing drug names. See the FDA and ISMP List of Recommended Tall Man Letters at: www.ismp.org/Tools/tallmanletters.pdf .			
Label characteristics of stock bottles contribute to errors					
01/16	Various strengths of Apotex’s ARIP iprazole are packaged in bottles of similar size, shape, color, and labeling. Of most concern is that the tablet strengths are displayed at the far right of the label and can be missed if the container is turned slightly. In addition, the strength font size is much smaller than the drug name font size. As a result, a pharmacist picked up the wrong bottle and nearly dispensed the wrong strength of ARIP iprazole tablets.	When there’s a choice of brands for specific products, avoid labels that separate the dose/strength from the product name. Use DailyMed (https://dailymed.nlm.nih.gov/dailymed/) to check container label appearance. Use barcode scanning when selecting products. Call attention to the strength by drawing an arrow from the drug name pointing to the strength. Face labels forward when bottles are stored on a shelf.			

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Ambiguous abbreviation					
03/16	A nurse transcribed an order for insulin aspart with the frequency as “c B-L-D.” The pharmacist initially misread this as “BID” but upon further review noticed the hyphens between the letters and requested clarification. The abbreviation was intended to mean with breakfast, lunch, and dinner.	Do not abbreviate instructions in handwritten or electronic prescriptions. Avoid ambiguous abbreviations when communicating drug and patient information. Clarify any ambiguity with the prescriber or nurse.			
HealthAlert! Revised warnings for metFORMIN					
04/16 	The US Food and Drug Administration (FDA) announced that it is revising warnings for the use of metFORMIN in certain patients with reduced kidney function. FDA will be requiring manufacturers to change the recommended measure of kidney function used to determine if metFORMIN therapy is appropriate for a patient. The measure will change from one based on a single blood creatinine concentration to one that estimates renal function.	Review the full FDA Drug Safety Communication (www.ismp.org/sc?id=1712), including details on how and when kidney function should be measured in patients receiving metFORMIN. Review with patients the Medication Guide or Patient Package Insert they receive with their prescriptions for metFORMIN-containing drugs.			
Confusing warfarin tablet color					
03/16 	The green warfarin 2.5 mg tablet manufactured by Exelan pharmaceuticals looks similar to the blue warfarin 4 mg tablet. This could contribute to dispensing errors as healthcare professionals and patients have become accustomed to standard colors for the strengths of warfarin tablets.	Determine if your pharmacy stocks the Exelan warfarin product. Inform staff of the possible confusion. Ensure you provide patient education, including opening the prescription bag and bottle with the patient, to answer any questions and increase the chances of intercepting an error.			
Rooting out errors in your community pharmacy					
01/16	Every community pharmacy needs to find a way to identify and control risk in order to prevent or mitigate harm from errors. Conducting a thorough root cause analysis (RCA) following an event or close call of what could have been a serious event is one way to assist in this process. Identifying root causes adds value by pointing out underlying and fundamental systemic conditions that increase the risk of adverse events.	The keys to success of RCA are the quality of the information collected, careful analysis of the information, and subsequent actions taken to improve the system and prevent harm. ISMP’s <i>Root Cause Analysis Workbook for Community/ Ambulatory Pharmacy</i> (www.ismp.org/tools/rca/) provides community pharmacies with tools designed to meet regulatory requirements in the full investigation of the causes of a sentinel event, and to help identify and implement effective strategies to prevent similar occurrences.			

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