

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 2011 and December 2011. 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. 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.

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
How safe are the liquid dispensing devices you provide patients?					
12/11	In the home, adapters that fit on bottles of oral liquid medications make it easier for parents to withdraw the medication into an oral syringe. After use, some parents have left the adapter in the bottle rather than replacing it with the child-resistant safety cap. Children can access the liquid medication by easily removing the adapter, which has led to accidental poisonings that require hospitalization. Some adapters can even be choking hazards.	Dispense oral liquid medications only with an oral syringe adapter that allows the child-resistant bottle cap to be replaced without removing the adapter. Even when liquid medications are intended for adults, this precaution is critical to prevent a young child from accessing adult medications. Patients and caregivers must be educated on the safe use of these devices and to always re-secure the child-resistant cap after each use.			
Up and Away and Out of Sight Campaign					
12/11	More than 60,000 young children end up in the emergency department every year because they consumed medications while parents or caregivers were not looking. The Centers for Disease Control and Prevention and the Consumer Healthcare Products Association Educational Foundation launched Up and Away and Out of Sight (www.upandaway.org) that provides tools to remind everyone of the importance of keeping drugs and vitamins "Up and Away" out of every child's reach and sight.	ISMP has joined the Up and Away and Out of Sight campaign. We sincerely hope that your pharmacy or healthcare facility will also support and participate in this important initiative. Patients and caregivers must be educated on the importance of safe medication storage and keeping medicines and vitamins up and away and out of sight.			
Prescribing by volume presents a hazard					
12/11	While SUDAFED (available as Children's Sudafed Nasal Decongestant) liquid comes only in a 15 mg/5 mL concentration, many generic liquid pseudoephedrine products come in a 30 mg/5 mL concentration. If physicians prescribe or instruct parents to administer this product by volume (e.g., mL) rather than in mg, errors are possible. If one of the more concentrated generic products is used, but not recognized, patients, including children, could receive twice as much drug as intended.	Healthcare providers should specify the dose in mg, as with all liquid medications, and alert parents that multiple concentrations are available. If possible, stock just one concentration (preferably the lower concentration) in the pharmacy. If both concentrations are available for over-the-counter (OTC) purchase, consider placing a sign on the shelf to alert parents: "Confirm with the pharmacist that the dose prescribed by your physician is appropriate for your child's age and weight."			

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Infant acetaminophen shipped in new concentration					
11/11	The new 160 mg/5 mL infant acetaminophen concentration has been arriving in pharmacies, although manufacturers may not be providing notification about the change. Supplies of the former 80 mg/0.8 mL product have been available up until now, and pharmacies may still have the older concentration in stock. Some pharmacies that have the new concentration may inadvertently intermingle it with the old concentration as the products can look quite similar.	Pharmacies should either exhaust all supplies of the older product (80 mg/0.8 mL) before circulating the new one, or be sure that all remaining older product is removed from shelves before distribution of the newer product begins. Work with all staff, and pediatricians and pediatric nurses, to create awareness of the change. Educate parents about the proper dosing of acetaminophen.			
ActHIB component of two-vial Pentacel is repeatedly missed					
09/11	PENTACEL is a two vial vaccine product for active immunization against diphtheria, tetanus, pertussis, poliomyelitis, and invasive disease due to <i>Haemophilus influenzae</i> type b. A vial of DTaP-IPV liquid component (blue-capped vial) is used to reconstitute each single-dose vial of lyophilized <i>Haemophilus influenzae</i> type b vaccine (ActHIB) component (green-capped vial). In the most recent case, a nurse failed to use the DTaP-IPV component to dilute the ActHIB in the other vial before administration.	Consider keeping green-top and blue-top vials together using a rubber band or another process to keep the vials together (e.g., placing the two vials in a zip-lock bag) and the use of an auxiliary label for the carton to remind staff to use both vials. To confirm administration of both components, staff should make sure the NDC number for each vial has been documented in the vaccine log before administration. Documenting the actual administration of the vaccine should always occur <i>after</i> it is given.			
ADEs in elderly on long-term nitrofurantoin					
10/11	Nitrofurantoin is often prescribed for suppressive therapy in patients who suffer recurrent urinary tract infections. Although it is usually thought of as a relatively benign medication, be aware that the drug has been associated with potentially serious adverse drug events (ADEs) (e.g., chronic active hepatitis, chronic lung reactions, peripheral neuropathies). Nitrofurantoin is contraindicated for patients with a creatinine clearance of less than 60 mL per minute. Older adults with decreased renal function should NOT receive nitrofurantoin given the availability of safer therapeutic alternatives.	Pharmacists may want to build an alert in the computer system to remind them to check the patient's creatinine clearance whenever this medication is prescribed to avoid drug toxicity. Prescribers should consider the drug-induced adverse effects of this medication (and others, as appropriate) as a potential cause of illness or declining health in a patient and discontinue the medication if there is any question about its contribution to illness.			

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PCN-200, not penicillin					
10/11	A discontinued nutritional supplement called "PCN-200" may still be an option if "PCN" is typed when entering penicillin allergies into your computer system. If "PCN-200" is selected in error, no warning would appear if a penicillin prescription was entered for a penicillin-allergic patient. Discontinued drugs originally included by your computer system may not have been eliminated from the allergen pick list.	Check your computer system's allergen pick list (type "PCN" in your allergen pick list) to determine if PCN-200 is still listed as an option. If it is, either remove it manually or work with your computer system vendor to remove it.			
Metolazone – methimazole mix-up					
11/11	The prescriber ordered the antithyroid agent methimazole (TAPAZOLE) 10 mg every eight hours but the patient mistakenly received the diuretic metolazone (ZAROXOLYN) from his community pharmacy. While both medications are available in overlapping dosage strengths (i.e., 5 and 10 mg tablets), they are not administered on the same schedule. Methimazole is administered every eight hours while metolazone is typically dosed on a daily basis.	Include brand and generic names as well as the indication when prescribing these drugs. Consider storing one of these products in a different area so that they are not located near one another; use shelf-talkers to direct staff to the location of each product. Pharmacists should talk with patients to confirm why they are taking the medication. Consider adding this pair to your look-alike/sound-alike drug name list.			
Prescription medications are widely abused by US teens: Working toward a solution?					
11/11	Prescription drug diversion is a major issue. In the 2010 Partnership Attitude Tracking Study (PATS) report (www.ismp.org/sc?id=56), 51% of teens indicated they have obtained prescription drugs for self use from their own family's medicine cabinets. Also, teens continue to report that their parents do not talk to them about the risks of taking prescription drugs as they may about the risks of other substances of abuse. Almost all oral solid drugs are dispensed as loose tablets or capsules in a plastic vial which is labeled for the patient. This manner of dispensing makes diversion of a few tablets or capsules relatively easy.	Pharmacies should examine and strengthen their procedures for dispensing and maintaining stock of controlled substances. It is critical that education be provided to patients, caregivers, and healthcare providers to increase awareness about the dangers of prescription drug abuse and about ways to appropriately prescribe, dispense, store, and dispose of prescription medications. Deployment of consumer-friendly and environmentally-responsible prescription drug disposal programs may also help to limit diversion (as well as reduce the risk of accidental ingestion) of drugs by family members and friends. For more information, go to: www.SafeguardMyMeds.com .			