

ISMP AmbulatoryCare ActionAgenda



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 July 2006 and December 2006. Each item includes a brief description of the medication safety problem, recommendations to reduce the risk of errors, and the issue number to locate additional information as desired.

Issue No.	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
7	<p>Exubera is a new inhaled form of insulin dosed in mg. Confusion between doses ordered in mg and units seems inevitable. The equivalency of mg to units is not evenly incremental (1 mg is equal to 3 units of insulin, but 3 mg is equal to 8 units, not 9 units). Also, consecutive inhalation of three 1 mg blisters results in greater insulin exposure than inhalation of one 3 mg blister.</p>	<p>To ensure proper use, warn practitioners about the potential for errors when dosing Exubera. Also educate patients about potential dose confusion before prescribing, dispensing, and/or administering the product.</p>	<p>EXUBERA (insulin human [rDNA origin]): risk of dosing errors</p>		
<p align="center">DIASTAT ACUDIAL (diazepam rectal gel) dosing errors</p>					
8	<p>Errors have occurred when Diastat Acudial, a prefilled diazepam rectal syringe, was not dialed, set, and locked to the prescribed dose by the dispensing pharmacist. This has happened even if the maximum dose available in the syringe (10 mg or 20 mg) was prescribed. Some of the dosing errors have led to respiratory depression requiring emergent interventions.</p>	<p>Pharmacists should check that the dose has been dialed and locked for both syringes in each package. Practitioners should educate patients and caregivers about proper use of the device, including confirming that the prescribed dose is visible in the display window, the green "ready" band is visible, and the appropriate rectal tip size is used for the age and size of the patient.</p>			
<p align="center">OptiClick pen: problematic design</p>					
11	<p>LANTUS (insulin glargine [rDNA origin] injection) and APIDRA (insulin glulisine [rDNA origin] injection) are available in 3 mL cartridges to be used with the OptiClick pen device. The pen could be dialed to the wrong dose if it is oriented in the wrong direction; it could be held "backwards" with the needle to the right, causing the numbers to be upside down.</p>	<p>Demonstrate to the patient how to insert a new cartridge, attach a needle, and measure and administer a dose. Illustrate to patients the proper way to hold the device to ensure the number in the dose display window is viewed correctly. Have the patient demonstrate proper use of the device before leaving your practice site.</p>			

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ASMANEX TWISTHALER (mometasone furoate) dose counter					
11	When the dosage counter of the Asmanex Twisthaler reaches "00" and enough force is applied while twisting the inhaler cap, the dosage counter can fall and reset to "199."	Educate patients about the location of the dosage counter and proper use of the device. Remind patients to discard the Twisthaler 45 days after the pouch has been opened or if the counter reaches "00" before then.			
YAZ and YASMIN mix-ups					
9	Yaz (drospirenone 3 mg and ethinyl estradiol 0.02 mg) and Yasmin (drospirenone 3 mg and ethinyl estradiol 0.03 mg) have names that may look and sound alike. They also could be located within close proximity in drug databases, on computer order entry screens, and on pharmacy shelves.	Educate staff about the availability of Yaz. Do not abbreviate Yasmin as "Yas" when prescribing. Add an alert to the computer system. Caution patients that these two products may be confused and include the patient as a "final check" when picking up prescriptions.			
CLINDETS (clindamycin pledgets) and CLINDESSE (clindamycin vaginal gel) mix-ups					
10	A prescription left on a pharmacy voice mail system for Clindesse with the instructions, "use as directed" was accidentally interpreted on playback as Clindets and dispensed as such.	Since these two names sound alike, clear and specific instructions should be provided on each prescription. Avoid "use as directed." Include the medication's indication and route of administration.			
ADACEL (Tdap) and DAPTACEL (DTap) mix-ups					
8, 12	The similarities of brand names, generic designations, vaccine abbreviations, and packaging have led to several mix-ups between these two products. Most often, adults have received the pediatric vaccine, which contains greater amounts of the detoxified pertussis toxin and diphtheria toxoid. Many drug information systems and wholesalers list the component antigens of Adacel as diphtheria, tetanus, and acellular pertussis, rather than the way they are listed on the package label, with tetanus first, making it easier to confuse these products.	Separate the stock of the pediatric and adult formulations, and place alerts on the products and in computer software to remind practitioners about the differences between these two products. Verify the patient's age before dispensing or administering any vaccine. Check how these products are listed in your computer system and make alterations as needed to avoid confusion.			

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11	Two infants were mistakenly administered an incorrect dose of Synagis after a nurse mistakenly selected the volume to be injected based on kilograms instead of pounds.	Provide specific drug information and education to all staff administering Synagis. Develop a dose and administration check list for any medication administered at your practice site. Standardize all documented weights for your patients to kilograms, as this is how weight-based medications are dosed.	SYNAGIS (palivizumab) weight based dosing		
7	Mercaptopurine is a metabolite of azathioprine. If mercaptopurine is given to a patient who is also taking azathioprine, profound adverse effects can be expected. Many drug information and computer order entry programs lack warnings of duplicate therapy with concomitant administration.	Test your computer system for an interaction or duplicate entry warning. If not alert occurs, modify your system as necessary. Reference material lacking a duplication warning should be modified. Prescribers should reconcile patient medications before new medications are ordered.	IMURAN (azathioprine) and mercaptopurine duplication		
8	FDA notified healthcare professionals of the risk of serotonin syndrome associated with the concomitant use of 5-hydroxytryptamine receptor agonists (triptans) with selective serotonin receptor inhibitors (SSRIs) and selective serotonin/norepinephrine reuptake inhibitors (SNRIs).	Remember these products may be prescribed intermittently, and by different physicians; weigh the risk of serotonin syndrome with expected benefit of using these products in combination; discuss possibility of serotonin syndrome with patients; and follow patients closely during treatment.	Risk of serotonin syndrome with use of "Triptans" and SSRIs/SNRIs		
9	Warnings offer a valuable strategy for providing important safety information. However, the design of the warnings often fail to influence staff behavior in ways intended to improve safety.	To be effective, warnings must reach their target audience, capture their attention, and cause the recipient to understand, agree with the warning, and respond accordingly. Warnings should be designed in a way that: takes into account the lowest literacy level among the target audience; uses larger fonts with adequate white spacing between words; are presented in mixed-letter case (not all capital letters); and uses signal words like danger and corresponding color backgrounds (e.g., red background, white lettering for danger). Additional recommendations appear in the newsletter article.	Designing effective warning labels		

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Increasing error reporting					
10	Error reporting is a fundamental component of learning, but it may be challenging to persuade healthcare workers to submit reports unless a culture of safety exists.	To improve reporting, the following characteristics are crucial: (1) the process must be clear, easy, and detailed enough to get causative information; (2) those who receive reports must be trustworthy and just, keep the identities of reporters and involved workers confidential, and provide feedback about how the information will be used; and (3) expectations for reporting should be included in job descriptions and performance evaluations.			
e-Educated consumers are your best patients					
12	It is estimated that 113 million adults have searched the Internet for information on health topics. Many online resources may not be credible and may be sponsored by companies with a vested interest in patients using their products.	Patients need assistance in finding credible information on health topics from the Internet. Visit websites that your patients are using and confirm that the information is reliable, timely, and accurate. Refer to the complete article for more recommendations.			
Medication reconciliation and community pharmacy					
11	Pharmacists who work in the community setting may be unaware of the medication reconciliation process used in hospitals and may be uneasy or resistant to sharing information about a patient's current medications.	Under HIPPA, providers may disclose protected health information to other practitioners for the treatment of a patient. Build relationships with area hospitals to streamline the process of sharing information. Provide each patient with a printout of her active drug therapy profile when she receives a new prescription. Educate your colleagues about medication reconciliation. Refer to the complete article for more recommendations.			
Preventing compounding errors					
12	A pharmacist discovered that his partner had been improperly compounding a medication over a four-year period. The error was attributed to ambiguous instructions written by the original pharmacist who filled the prescription. The instructions gave no milligram strength for the preparation, just the resulting end volume.	Institute a process to ensure all compounding recipes undergo a documented approval process before use. Establish an independent double check process for all calculations completed each time a compound is made. A log book should be maintained and reviewed weekly and with each refill as a quality control check.			