

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 2009 and April 2009. 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 as desired.



Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
“Bagging” errors reach patients					
2/09	A patient was given another patient’s antibiotic at an ambulatory pharmacy. The prescription appears to have been filled accurately but was inadvertently placed into another patient’s bag. Once in the will-call area, the chance that the bagging error will reach the patient is almost guaranteed unless the bag is opened and checked with the patient.	Consistently use a second identifier at the point-of-sale. Ask the person picking up the prescription to provide the patient’s name and address or, in the case of similar names, date of birth. Compare the answers to the information on the prescription receipt and container. Present each prescription container to the patient at the point-of-sale and have the patient verify that each medication is correct. This step is critical to make sure the right patient receives the right drug.			
Don’t “hold” the verification					
4/09	A patient received the incorrect dose of digoxin (125 mcg daily instead of 250 mcg daily) for six months from an ambulatory care pharmacy in a community health clinic. The error was discovered when the prescriber sent a new prescription to the pharmacy. The pharmacy’s investigation of the event revealed that one cause may have been the lack of verification when the first prescription was placed “on hold” in the pharmacy computer system.	As order entry is occurring when the prescription is placed on hold, it is critical that the prescription undergoes the same verification process used when a prescription is actually dispensed. This includes conducting a double check of the order entry by comparing the information in the computer system to that contained on the original prescription. When the prescription is eventually dispensed, verification against the original prescription or its scanned image should be done again.			
Important Fer-In-Sol concentration change not well known					
1/09	FER-IN-SOL (ferrous sulfate drops), has recently undergone a change in concentration, from 15 mg of iron per 0.6 mL (25 mg/mL) to 15 mg of iron per mL. Iron drops from other manufacturers continue to use the 15 mg of iron per 0.6 mL concentration leading to potential confusion or even under dosing.	Write prescriptions for elemental iron in mg, never by volume. Verify the concentration of iron in the product being dispensed and administered. Verify the volume needed to provide the intended dose. Parents should be educated if they will be purchasing the over-the-counter product, and advised to read the concentration on the bottle to assure they are purchasing the correct strength.			

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Unusual explanation for hyperglycemia in patients on insulin					
3/09	<p>Some patients who became familiar with the NovoFine Autocover while in the hospital were later confused as they began to use a standard BD pen needle (BD Ultra-Fine III) after discharge. This is due to the differences between the passive safety needle system used in the hospital (with a sheath) and the two caps on the needles used at home. If the second cover is not removed, the needle is not exposed and the insulin will not be injected.</p>	<p>Educate patients about the need to remove both caps from standard pen needles. If blood glucose levels are elevated after injection, the patient should be reminded to consult with their diabetes educator or physician, who should review injection techniques with the patient. Community pharmacists dispensing pen device supplies should also educate patients regarding their proper use.</p>			
Methotrexate overdose					
4/09	<p>A patient taking methotrexate for rheumatoid arthritis was admitted to the hospital for an unrelated reason. On admission, her medication reconciliation form correctly listed oral methotrexate 10 mg BID on Mondays. At discharge, it was transcribed as "methotrexate 10 mg po BID." The patient began to take the methotrexate BID, leading to symptoms thought to be methotrexate toxicity.</p>	<p>Ensure patients receive counseling when picking up methotrexate prescriptions. Provide clear verbal and written instructions about the weekly dosage schedule when used as an immunomodulator and explain why that is important for this medication. Dispense methotrexate in dose packs, when possible, to help reinforce the weekly dosing schedule. Investigate and follow up if a patient is attempting to refill a prescription too early.</p>			
Acetaminophen: Staying Below the Limit					
2/09	<p>Acetaminophen is a widely used analgesic and often considered the safest analgesic available. However, serious harm (e.g., acetaminophen-induced liver failure [ALF]) can occur if too much acetaminophen is intentionally or unintentionally ingested.</p>	<p>Practitioners should query patients about prescription and OTC medications. Alert patients to the amount of acetaminophen in each dose, the maximum number of doses per day, and whether other acetaminophen products can be used simultaneously. If the total dose could exceed 4 grams a day, consider a change to a product containing less or no acetaminophen.</p>			
Safety Cap that Won't Protect Kids					
3/09	<p>Dual purpose caps can be used either as a child resistant cap or "flipped over" to be used as a non child-resistant cap. Their use may increase the risk of poisoning, as adults who previously never had problems open a child-resistant cap may now be using these caps.</p>	<p>Avoid dispensing medications with these caps unless the consumer specifically requests them. While these caps meet the requirements set in the Poison Prevention Packaging Act (PPPA), the Consumer Product Safety Commission discourages their use.</p>			

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Topical anesthetics					
2/09	Shortly after the release of findings from a study that used topical lidocaine to reduce discomfort during breast mammography, FDA issued an advisory to remind patients, health-care professionals, and caregivers about potentially serious hazards—including death—associated with overuse of topical anesthetics.	Warn staff and consumers to use topical anesthetics that contain the lowest possible amount of local anesthetic to relieve pain, apply it sparingly on unbroken, non-irritated skin, and avoid wrapping or covering the skin with any occlusive dressing or other material.			
Confusing nomenclature with valproic acid					
4/09	Valproic acid is available in various dosage forms and salts, so products can be confused. For example, a patient was supposed to receive DEPAKOTE ER (ordered as “divalproex ER”) but received divalproex “EC” (the enteric-coated form of divalproex). Another product, DEPAKENE , contains valproic acid when it is in capsule form and valproate sodium in liquid form. Valproate sodium is known as DEPACON in parenteral form.	Educate staff about the different dosing schedules, indications, and formulations of divalproex sodium. If possible, initiate a computerized alert to remind staff about the potential for mix-ups and design computer mnemonics to decrease the likelihood that the drugs will appear on the computer screen simultaneously. When repeating back oral orders, use full words (e.g., extended release), not abbreviations.			
Patch advisory					
3/09	FDA issued a public health advisory in March regarding transdermal patches worn during an MRI. Some patches are formulated with an aluminumized backing or invisible metal layer that could cause excessive heating and tissue damage to the patient if worn during an MRI.	Educate patients using a transdermal drug to notify radiology staff if they undergo an MRI and to remove the patch temporarily. Clinics and physician practices that schedule MRI's should have procedures to alert patients with patches at the time of scheduling. Facilities which perform MRI's should follow published recommendations (www.jimrser.org).			
Benadryl topical product poses danger if swallowed					
2/09	The FDA adverse event reporting system has collected at least seven reports of people who have swallowed BENADRYL ITCH STOPPING GEL (diphenhydramine), an over-the-counter (OTC) topical product used to relieve itching, which has led to serious adverse reactions requiring hospitalization or emergency treatment. In our opinion, the labeling of the product does not sufficiently warn consumers not to ingest the product.	Prescribers should specify either a topical or oral formulation when recommending an OTC Benadryl product. Pharmacies should separate oral and topical products on over-the-counter shelves and notify staff to alert patients obtaining the Gel that it is for topical use only.			