

# 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 May 2009 and August 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. 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).



Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
<b>A teaspoonful of medicine?</b>					
5/09	<p>Mix-ups involving volume expressions, specifically teaspoon and milliliter, continue to happen. A 10-month-old child was given the antibiotic solution cephalexin. The pharmacy-generated label, along with verbal instructions provided at the point-of-sale, incorrectly instructed the parent to administer three teaspoonfuls 3 times a day (equivalent to 15 mL) instead of 3 mL three times a day. Fortunately, the mother caught the error prior to giving any drug to the child.</p>	<p>Standardize expression of volume on prescriptions and pharmacy labels to the metric system. Remove and prevent use of "teaspoonful" and other non-metric measures in pharmacy computer and e-prescribing systems. Prescribers should express doses for oral liquids only in metric weights or volumes—never by teaspoon or tablespoon. Ensure an appropriate measuring device and patient education is provided to the patient or caregiver. Have the patient or caregiver demonstrate how the dose will be measured.</p>			
<b>True allergy or other symptoms?</b>					
6/09	<p>An elderly patient for whom codeine was listed as an "allergy"—when it only made him tired—received <b>DARVOCET-N</b> (propoxyphene, acetaminophen) postoperatively while also taking carbamazepine. The patient died 2 days later from carbamazepine poisoning. Propoxyphene may decrease the metabolism of carbamazepine, thereby increasing the serum concentration of the drug.</p>	<p>When a patient claims an "allergy" to a medication, the actual reaction should be detailed in order to avoid replacement of needed medications with a less effective alternative. Pharmacists should clarify allergy information with the patient when they set up or update the patient's drug profile. Some computer systems prompt for allergy symptoms.</p>			
<b>Coupons for prescription transfers</b>					
7/09	<p>ISMP has received a number of complaints about the use of coupons or cash incentives for new or transferring existing prescriptions from one pharmacy to another. Public health may be jeopardized because the process fragments care and disrupts store level drug monitoring. There is also a risk of misreading and/or mishearing prescription information when transferring prescriptions between pharmacies.</p>	<p>For patient safety reasons, pharmacies engaged in such incentives should re-evaluate the practice. At the very least, develop standardized protocols to allow transmission of either an electronic or hard copy of the patient's profile when transferring a prescription.</p>			

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
<b>Vesicare – Vesanioid mix-ups</b>					
6/09	<p>A physician intended to prescribe <b>VESICARE</b> (sulfifenacin succinate) for overactive bladder but inadvertently selected <b>VESANOID</b> (tretinoin), an anti-leukemia drug, using an electronic prescribing system. Both products are available in 10 mg solid oral dosage forms. At the pharmacy, the patient's pharmacy benefit manager required a prior authorization. The error was identified when the prescriber indicated that Vesicare was intended.</p>	<p>Investigate strategies (e.g., Tall man letters) to differentiate these products on computer screens. Prescribers should include the indication for the drug with the prescription. Provide patient education, especially for new prescriptions. This can help intercept errors before they impact the patient.</p>			
<b>Kapidex – Casodex confusion</b>					
7/09	<p>There have been reported incidents of medication errors, with both written and verbal prescriptions, due to name confusion between <b>KAPIDEX</b> (dexansoprazole) and <b>CASODEX</b> (bicalutamide).</p>	<p>Take time to verify written or verbal orders and build an alert in your computer system. Consider adding this pair to your confused drug name list. Prescribers should include the drug's purpose on prescriptions.</p>			
<b>TAZ or TAC? A case for avoiding drug name abbreviations</b>					
6/09	<p>A physician prescribed "TAC 0.1% cream" intending the patient to receive triamcinolone; when he crossed the "A" and wrote the "C" it looked like "TAZ." The pharmacy technician entered the prescription using the short code "TAZ1" for the topical acne vulgaris and psoriasis drug <b>TAZORAC</b> (tazarotene) 0.1% cream. The patient noticed the different product after getting home but thought it was likely the same cream he had used before. He applied the Tazorac cream to his rash and suffered chemical burns all over his feet.</p>	<p>Avoid abbreviation of drug names when communicating prescriptions and drug information. Evaluate the short codes used in computer systems and remove ones at risk for error. Review the medication dispensed with the patient, including opening up the bag. Verify the purpose of the medication with the patient when the prescription is dropped off and/or during patient education. Encourage patients to speak up when something does not look right with the prescription.</p>			
<b>For our children's sake, clear up over-the-counter cough and cold product labels</b>					
7/09	<p>Misuse or overdose of over-the-counter (OTC) cough and cold products continues to occur. Many parents still think it is appropriate to give a child less than 24 months old a cold medication. Dosing errors with OTC cough and cold medications can negatively impact patient safety and may result in patient harm or even death.</p>	<p>Store OTC cough and cold products close to or behind the pharmacy counter. Proactively educate customers that the product is not appropriate for children under age 2. Consider restricting the variety of products to reduce confusion. Use signs or stickers to encourage customers to consult a pharmacist for drug and dosing information.</p>			

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
<b>Kids and color mix-ups</b>					
7/09	<p>A child began to experience respiratory difficulty due to his asthma and went to retrieve his rescue inhaler <b>ProAir</b> (albuterol). However, he used his maintenance inhaler <b>SYMBICORT</b> (budesonide and formoterol). The child had been educated to use the “red inhaler” for rescue, but mouthpieces for both products are red and similar in size.</p>	<p>Color should never be used as the primary means of identifying items. Provide thorough instructions. Always check for the patient’s understanding; have patients demonstrate how the medication is to be used. Consider adding easy to understand, age-appropriate auxiliary labels to the products to make it easier for children to differentiate.</p>			
<b>A cautionary note for ambulatory e-Rx users!</b>					
8/09	<p>A doctor sent electronic prescriptions for moxifloxacin and sotolol to a pharmacy. The pharmacy computer system flagged a drug interaction between sotolol and moxifloxacin during pharmacist verification. The prescriber was contacted and stated he realized the drug interaction after he sent the prescription and discontinued moxifloxacin in his computer system assuming that would send a message to the pharmacy. That did not happen.</p>	<p>Educate prescribers using electronic prescribing software that a discontinuation in their computer system may or may not reach the pharmacy. Prescribers need to contact the pharmacy and the patient to ensure the cancelled medications are not dispensed or taken. NCPDP should adjust its standards to require support for cancelled prescriptions in both the pharmacy and prescriber systems.</p>			
<b>Inattentional blindness: what captures your attention?</b>					
6/09	<p>When someone fails to see what should have been plainly visible—a warning sticker on a medication label, for example—the cause is usually rooted in inattentional blindness, a condition all people exhibit periodically. To combat information overload, the brain scans until something sticks out to capture its attention. Unfortunately, the brain is a master at filling in gaps, compiling a cohesive portrait of reality based on just a flickering view.</p>	<p>To combat inattentional blindness: 1) increase the conspicuity of critical information on product labels, computer screens, and other sources of information, by using a high degree of contrast with the background; 2) ensure that the critical information provided is perceived as relevant by those who need it; 3) decrease multi-tasking and diversion of attention when carrying out complex tasks; and 4) reduce over-reliance on technology.</p>			
<b>Smoking cessation drug update – CHANTIX (varenicline) and ZYBAN (buPROPION)</b>					
7/09	<p>FDA is requiring new boxed warnings and medication guides for the risk of serious neuropsychiatric symptoms (e.g., hostility, suicidal ideation) in patients using varenicline and <b>buPROPION</b>. There also have been reports of traffic and other accidental injuries in patients taking varenicline.</p>	<p>Educate patients about the drugs’ risk profiles and when to call the prescriber if they begin to experience neuropsychiatric adverse effects. To review the public health advisory, visit <a href="http://www.fda.gov/Drugs/DrugSafety/PublicHealthAdvisories/ucm169988.htm">www.fda.gov/Drugs/DrugSafety/PublicHealthAdvisories/ucm169988.htm</a>.</p>			