September-December 2014

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 2014 and December 2014. 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.

Key: ⚠ – ISMP high-alert medication

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
Injection technique error with LANTUS SOLOSTAR (insulin glargine) insulin pen					
10/14 ⚠	Two patients dialed a Lantus Solostar insulin pen to the prescribed units of insulin. But they failed to administer any insulin because they dialed the pen back down to zero, believing the twisting mechanism released the insulin, instead of pushing the button at the end of the pen. This error could also occur with other insulin pens with a similar design.	Healthcare providers who educate patients about insulin pen use must adequately explain how each dose is prepared and delivered, and have the patient demonstrate how they will use the pen to confirm proper technique. Be alert to potential confusion regarding how to administer a dose.			
Possible dosing dilemma for infants prescribed REVATIO (sildenafil)					
12/14 ⚠	The US Food and Drug Administration (FDA) has clarified situations where Revatio may be acceptable for certain children with pulmonary arterial hypertension. Pediatric dosing is based on mg/kg. The 10 mg/mL liquid formulation comes with a 2 mL oral syringe with 0.5 mL (5 mg) and 2 mL (20 mg) dose markings, which may not correspond to the child's dose and make accurate dose measurement difficult.	Dispense Revatio oral suspension with a 1 mL oral syringe to correctly administer doses that don't conform to the scale on the provided oral syringe. Pharmacists should determine a process for when the doses for a child are outside of the 5 mg and 20 mg doses typically prescribed, since it is unlikely that Pfizer will consider changing the dosing device provided.			
Use caution when prescribing and dispensing XARELTO (rivaroxaban) to first-time patients					
11/14 ⚠	When discharged from the hospital, the patient was given two prescriptions for Xarelto to treat deep vein thrombosis (DVT). The pharmacy dispensed both prescriptions since the insurance carrier paid for both on the same day. The patient incorrectly took both the 15 mg and the 20 mg tablets for 10 days because he hadn't received instructions that the 20 mg tablets were not to be started until the 15 mg tablets were finished. Fortunately, the patient did not have any serious bleeding issues.	Prescriptions should include instructions for the 20 mg tablets to begin after the 15 mg tablet prescription supply is completed (after 21 days). Provide education to patients when dispensing prescriptions, especially for high-alert medications like anticoagulants. Include alerts, particularly those for high-alert medications, in computer systems so they are not easily bypassed. The recently released starter pack that guides patients to proper dosing for the first 30 days of treatment should help prevent these dosing errors.			

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Expanded use for methotrexate may lead to dosing errors					
09/14 ⚠	Mix-ups between daily and weekly dosing of methotrexate have occurred leading to accidental overdoses resulting in serious patient harm. And, it appears that the use of methotrexate may be increasing for some conditions (www.ismp.org/sc?id=414). When used to treat rheumatoid arthritis, psoriasis, and other inflammatory diseases (including scleroderma), methotrexate is administered weekly or twice a week instead of daily.	Include the indication for therapy on the prescription. If not included, contact the provider to obtain the indication and verify the dosing regimen. Program computer systems to generate alerts when daily methotrexate is entered, and require the pharmacist to document that the dose and indication was verified before the order is processed. Counsel patients picking up new and refilled methotrexate prescriptions.			
Persistent safety gaffes in the community and ambulatory settings that still need to be resolved					
10/14	Numerous safety concerns remain unresolved over the years, including: minimal patient counseling; vaccine mix-ups, particularly with DTaP and Tdap; wrong patient errors and not opening the bag at the point-of-sale; disrespectful behavior in healthcare; aggressive marketing of compounded pain creams with potential for toxicity, particularly in children; and minimal or callous response from pharmacists after a dispensing error.	Bring attention to these crucial repetitive issues and take action for their resolution. For example, make patient counseling mandatory for new prescriptions and high-alert medications. Open the bag of filled prescriptions at the point-of-sale to verify that the medications are for the correct patient. Promote a safe and just culture to discourage disrespectful behaviors. Engage patients in honest disclosure of errors and risk-reduction action plans.			
Keep patient instructions in mL					
11/14	A pharmacy incorrectly converted prescription directions for guai**FEN**esin with codeine from 10 mL to 2 tablespoonfuls every 4 hours as needed. The error was identified when the patient ran out of medication after only 2 days. Many practitioners continue to convert mL doses to non-metric units (e.g., teaspoonful or tablespoonful).	ISMP and other groups support the use of mL as the standard unit of measure for oral liquid medications. All practitioners should express doses for oral liquids in metric units only, never by teaspoonful or tablespoonful. Appropriate dosing devices with markings in mL should be provided to patients when an oral liquid medication is dispensed.			
COVARYX HS (esterified estrogens and methyltestosterone) and COVERA HS (verapamil extended release)					
10/14	A prescriber intended to prescribe Covaryx HS to help treat a patient's vasomotor symptoms associated with menopause. However, he inadvertently selected the calcium-channel blocker Covera HS from his electronic prescribing application.	Change the appearance of look-alike product names on computer screens and configure computer systems to prevent look-alike drug names pairs from appearing consecutively in lists. Adding an indication to the prescription helps pharmacists in matching medication to indication prior to dispensing.			

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Vancomycin injection for oral use given intramuscularly					
10/14	Due to the high cost of **VANCOCIN** (vancomycin) capsules, the injectable form of vancomycin powder is often used to prepare an oral solution for the treatment of *Clostridium difficile*. In two long-term care (LTC) facilities, the pharmacy provided vials of vancomycin injection and diluent with directions for mixing and administering each dose. Nurses were unfamiliar with this practice and administered each dose intramuscularly, rendering it ineffective to treat *C. difficile*.	Pharmacies should prepare the injectable solution for oral use and provide each individual dose in an oral syringe marked "FOR ORAL USE ONLY." Dispensing medications in the most ready-to-administer form should be the prevailing practice for all pharmacies that provide medications to LTC and other facilities.			
Patient dissatisfaction with pharmacy's response to a dispensing error					
11/14	When patients report medication errors to ISMP involving pharmacy dispensing errors, they are usually more upset with the response, or lack of response, from pharmacy personnel versus the actual error. All too often pharmacy staff and managers (including corporate leaders) are leaving patients dissatisfied.	Develop and regularly update procedures for handling medication errors. Be specific regarding what to do and say, what not to do or say, and who should be contacted when an error occurs. Practice and role-play possible scenarios using established procedures and guidelines. Train everyone to respond to patient concerns with compassion and empathy. Assure the patient reporting a potential or actual error that it is important and a priority. All alleged incidents should be handled by a pharmacist and approached with professionalism, courtesy, and sincerity.			
Securing cap on QUILLIVANT XR (methylphenidate) oral suspension					
10/14 ⚠	A toddler was able to remove the cap from the bottle of Quillivant XR and access the medication. Quillivant XR is used to treat attention deficit hyperactivity disorder (ADHD) and is available as a powder for reconstitution. A manufacturer-supplied bottle adapter is to be inserted into the neck of the Quillivant XR bottle after reconstitution by the pharmacist. In this case, the pharmacist neglected to insert the adapter, so the parent inserted it. Unfortunately, the adapter was not seated correctly preventing the child-resistant cap from fully engaging. The child required hospitalization to treat the unsupervised ingestion.	Pharmacists should insert the bottle adapter and confirm that the child-resistant cap properly engages the bottle prior to dispensing. Consider adding a note to the pharmacy receipt to remind the pharmacist to insert the adapter after reconstitution. Pharmacists should use a teach-back method to verify that parents or caregivers can accurately prepare a dose of the medication using the oral syringe and adapter and securely close the bottle. Educate parents and caregivers to store this product, and other medications, up and away and out of the sight and reach of children at all times.			

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