Medication Safety Alerts

David U

This column draws on US and Canadian experience and includes, with permission, material from the *ISMP Medication Safety Alert!*, a biweekly bulletin published by the Institute for Safe Medication Practices (ISMP), Huntingdon Valley, Pennsylvania.

SAFETY NEWS

Abboject syringe products from Abbott Laboratory have been reintroduced into the Canadian market, effective mid-December 2000. Now, Canadian health-care professionals have the choice of purchasing either the Abboject product line or the new Lifeshield product line from Abbott Laboratory. ISMP Canada circulated a "Safety Alert" advisory to Canadian hospitals advising them of the reported incompatibility between the Lifeshield syringes and the Baxter Continu-Flo IV solution sets.[1]

ISMP Canada has received a number of reports expressing concerns about the labelling of **Cipro** (ciprofloxacin) **oral liquid**, both on the small bottle containing the active ingredient and on the large bottle containing the diluent. In response to these concerns, ISMP Canada has worked with Bayer Canada to implement changes to improve patient safety. Bayer Canada has recently informed ISMP Canada that work is in progress at the company's international source plant in Italy to improve label specifications.

ISMP Canada is also examining other reported **labelling concerns**. The problems identified involve primarily injectable products. ISMP Canada is organizing a meeting for pharmacists, physicians, manufacturers, CSA International (formerly the Canadian Standards Association), and Health Canada to revisit pharmaceutical label requirements. Some guidelines for improving patient safety have already been developed. Practitioners and hospitals are encouraged to forward label and packaging concerns to ISMP Canada so that information can be shared. ISMP Canada will continue to work toward corrective actions that will prevent errors.

In partnership with The CQI Network, ISMP Canada will be sponsoring a 2-day conference entitled "Breaking the Silence: Error in Health Care". The conference is scheduled for April 20 and 21, 2001, in Toronto, Ontario. Well-known speakers will include Michael Cohen, David Bates, David Cousins, and Joanne Turnbull. The Conference Planning Committee is cochaired by Cynthia Majewski, executive director of The CQI Network, and Tom Paton, a member of the ISMP Canada Board. The conference is aimed at physicians, pharmacists, nurses, and quality improvement staff, as well as administrative and risk management staff.

[Note: Reference appears on p. 44.]

SAFETY BRIEFS

Reported Errors because of Drug Name Confusion: M-Eslon/Mestinon and Indocid/Endocet

A recent reported error involved a written order for "Meselon" 30 mg bid. The pharmacist interpreted the order as Mestinon (pyridostigmine bromide) 30 mg bid. The order was intended to be for M-Eslon, a brand name for morphine, whereas Mestinon is a cholinergic antimyasthenic agent. The order was also interpreted incorrectly during the double-check process by another pharmacist. Fortunately, the pharmacy did not stock Mestinon, nor did other local pharmacies. A close look at the documentation that came with the patient on transfer from another hospital revealed that the patient had been receiving morphine, and the Mestinon was not procured or administered. Fortunately, this was only a near-miss incident for the hospital. A root-cause analysis by the hospital uncovered a range of system-wide problems. The on-call physician writing the order was pressed for time and was not familiar with the process of reviewing all patient transfer documents. The pharmacy department was short-staffed at the time, and the dispensing pharmacist was a newly trained hospital pharmacist.

A second reported case of confusion between drug names involved a 76-year-old woman admitted to hospital with as-yet-undiagnosed flank pain. A prescription of Indocid (indomethacin) 25 mg PO qid was ordered while she awaited further tests. A pharmacist was consulted to optimize pain control. Discussion with

the patient and a review of her personal medications revealed that she was in fact taking Endocet (oxycodone–acetaminophen) 1 tablet PO qid. Apparently her physician, in asking the patient about her home medications, had misheard the drug name Endocet as Indocid. The prominent root cause here was the similarity in the sound of these product names. Furthermore, Endocet is not as familiar to practitioners as Percocet, another brand of the same drug.

Although it might be difficult to have confusing drug names changed, these examples prove again that careful consideration is required when manufacturers are deciding on a drug name. Preventive measures include having the pharmacist participate in medication history-taking, teaching patients to keep a written list or chart of their medications, and teaching patients to know the indications for their medications and the generic and trade names of the medications.

SPECIAL FEATURE

The special feature presented here is taken directly from *ISMP Medication Safety Alert!*, volume 5, issue 22, November 1, 2000.

Orders to "Continue Previous Meds" Continue a Longstanding Problem

Problem: How do you interpret those dreaded orders to "resume all pre-op medications" or "continue home medications?" While complete drug orders are basic to medication safety, prescribers may transfer this responsibility to patients, nurses, and pharmacists at the most vulnerable periods in the healthcare continuum: admission, post procedure, transfer to a different level of care, and discharge. Too often, orders to simply resume or continue medications have led to errors. We've previously reported that an order to "continue same meds" upon transfer from a critical care unit has led to continued use (sometimes fatal) of neuromuscular blocking agents for restless, but extubated, patients. In the following case, an order to "resume all meds" led to a serious drug omission. A woman with a history of atrial fibrillation and stroke was admitted to the hospital with nausea, vomiting, anemia, and rapid atrial fibrillation. She had been taking Coumadin (warfarin) 2.5 mg daily before admission and the same dose was prescribed in the hospital. A few days later, an order was written to "hold Coumadin" in preparation for a colonoscopy scheduled the following day. In response, the pharmacist discontinued Coumadin so it would not appear on the computer-generated MAR [medication administration record], risking accidental-administration. The next day after the colonoscopy, the physician wrote an order to "resume all meds." Since Coumadin had been discontinued, the pharmacist did not resume it along with the patient's other ongoing medications. After six days without Coumadin, the patient suffered an embolic stroke. In another case, orders to "resume home medications" were written for a lung transplant patient who had just undergone minor surgery. When the patient was first admitted, the physician had ordered only two of the "home medications" listed on the admission assessment. A pharmacist had to call the physician to determine if the same two drugs were to be resumed, or if all drugs on the unverified "home medication" list were to be ordered.

Safe Practice Recommendation: Prescribers should always write complete medication orders. Yet, policies that prohibit orders to "resume" or "continue" therapy may not be successful and may simply transfer responsibility to nurses and pharmacists to clarify incomplete orders. Indeed, one pharmacist told us that clarifying orders for "take home medications" constituted the largest portion of all pharmacy interventions! Therefore, it's important to convene a small group of prescribers to identify the underlying reasons that it may be difficult to write complete admission, transfer, and discharge orders. For example, prescribers may not know all the drugs patients are taking at home, especially if prescribed by several physicians. Likewise, they may not have easy reference to all prescribed therapy in the hospital, or may lack comprehensive knowledge about certain classes of drugs. Ask prescribers for feedback on how the organization can help. For example, we know of hospitals that have established a process where nurses, pharmacists, and physicians work together as a team within the first few hours of inpatient admission to verify all medications taken at home and reconcile their use during hospitalization. An initial list of "home medications" should not be used to guide the prescribing process until it has been verified (one hospital's verification form is located on [the ISMP] web site with this article). Educate patients to bring a current list of medications (or actual drug containers) to the hospital when admitted to help with the verification process. Have pharmacy print a daily summary of each patient's medications, which lists both active and discontinued drugs for prescriber reference (perhaps this would have alerted staff to the inadvertent discontinuation of Coumadin in the above cited error and minimized patient harm). We'd like to hear from you if you have additional suggestions. Write to ismpinfo@ismp.org.

Reference

1. U D. Medication safety alerts. *Can J Hosp Pharm* 2000;53:355-7.

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