



Medication Safety Alerts

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

News

Abboject products from Abbott Laboratory have been available to Canadian hospitals since the middle of December 2000. Now Canadian healthcare professionals have a choice to purchase the Abboject product line or the Lifeshield product line.

ISMP Canada received a number of reports expressing concerns on the labeling on the **Cipro oral liquid**, both on the small bottle containing the active ingredient and the large bottle containing the diluent. ISMP Canada contacted Bayer Canada and suggested a change of the label to improve patient safety. Bayer Canada recently informed ISMP Canada that the work had been initiated with their international source plant in Italy to work on the label specification.

ISMP Canada is also examining other **concerns on labels** that have been reported. The concerns involve primarily on injectable products. ISMP Canada would be organizing a meeting inviting pharmacists, physicians, manufacturers, CSA International and Health Canada to re-visit the pharmaceutical label requirement and suggested guidelines for the purpose of improving patient safety. Practitioners and hospitals are encouraged to forward label and package concerns to ISMP Canada for corrective actions.

In partnership with The CQI Network, ISMP Canada will be sponsoring a two day conference titled: "Breaking the Silence: Error in Health Care" on April 20 and 21, 2001 in Toronto. International well known speakers will include Michael Cohen, David Bates, David Cousin (UK) and others. The Conference Planning Committee is co-chaired by Cynthia Majewski and Tom Paton. The conference audience is aimed at physicians, pharmacists, nurses, quality improvement staff as well as administration.

Safety Briefs

Drug Names Mix-up: M-Eslon/Mestinon and Indocid/Endocet

Pharmacists are asked to more vigilant about look-alike and sound-alike drugs. Recently in a long term care facility, a physician wrote an order for Meselon 30 mg bid, and the pharmacist interpreted the order as Mestinon 30 mg bid. The original order was supposed to be M-Eslon which is a brand name for morphine while Mestinon is a cholinergic agent used as an antimuscarinic. The order was again interpreted incorrectly when double-

checked by another pharmacist. Fortunately, the pharmacy did not stock Mestinon and local pharmacies did not carry it either. A closer look at the transfer documentation that came with the patient who was transferred from an acute care hospital revealed that patient was supposed to be on morphine.

A root cause analysis by the hospital on this error had uncovered a range of system wide problems ranging from the on-call physician who was writing the order in a hurry and who was not familiar with the process of reviewing the patient transfer documents properly. The pharmacy department was short-staffed, and the first pharmacist who interpreted the order incorrectly was a newly trained hospital pharmacist and was not fully backed up by other more experienced pharmacists.

In another case, a 76 old female was admitted to a hospital with not yet diagnosed flank pain. She was prescribed Indocid 25 mg PO qid while awaiting further tests. A pharmacist was consulted to optimize pain control. Upon discussion with the patient and review of her personal medications, it was discovered that the patient was in fact taking Endocet 1 tablet PO qid. Apparently, her physician in asking the patient about her home medication misheard the drug Endocet as Indocid. Fortunately the patient did not receive any Indocid. Other than the two names sound dangerously alike, Endocet, to many hospital practitioners, is not a usual name for Percocet and therefore upon hearing Endocet, practitioners will most likely relate it to Indocid.

While it might be difficult to have one of these drug names changed, it again proves that having pharmacist directly involved in patient care pays off. In this particular case, having pharmacist performing a pre-admit medication history by closely examining the medications brought over by the patient would likely avoid this near-miss.

(The special feature described below 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, 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 our 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.