The Connecticut Alliance for Safe Prescription Practices

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C.A.S.P.P. NEWSLETTER

Timely Information for Pharmacists and Pharmacy Technicians

DID YOU KNOW?

Substitute Senate Bill No. 504 - Public Act No. 02-48 - An Act Concerning the Reporting of Prescription Errors and Requiring Certain Continuing Education for Pharmacists requires pharmacists to have a formal policy on Quality Assurance.

♦ **Quality Assurance** includes, but is not limited to:

- The dispensing process, some examples are:
  - Verifying patient's name, address and date of birth when a Rx is dropped off and picked up
  - A review of computer warnings for drug interactions, contraindications, and duplication of therapies when Rx information is entered by a pharmacist or a technician.
  - Counseling the patient on new prescriptions
  - Telephone or voicemail Rx's are reduced to writing on a prescription pad by a pharmacist (not on a scrap piece of paper) and name of person communicating the order noted.
  - Confirming the original prescription order on the first refill
  - The vial and receipt are verified to the patient before bagging the Rx
- The computer, some examples are:
  - Sig codes are standardized for all locations
  - Drug records are updated regularly
  - Patient's with similar names are "flagged" in the computer
  - The computer detects interactions, contraindications, duplication of therapies, and over and under usage
  - Allergies and disease states are entered for all patients
- The inventory, some examples are:
  - Staff is familiar with sound alike / look alike drugs
  - Similar looking / sounding drugs are separated from each other
  - Stock bottles are placed on shelves facing forward
  - Different generic manufacturers are kept to a minimum
  - When a new product comes on the market, everyone familiarizes themselves with that product and any potential for confusion
- The environment, some examples are:
  - Interruptions and distractions are kept to a minimum
  - Noise is kept to a minimum
  - Lighting and temperature are adequate
  - The workspace is clear of clutter
  - A system is in place when filling more than one Rx for a patient to prevent mislabeling and other mistakes

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CASE REVIEW: YOU DECIDE THE OUTCOME

AN ACTUAL CASE FROM THE FILES OF THE DEPARTMENT OF CONSUMER PROTECTION

Our office received a call from a consumer reporting that he received a misfilled prescription from his pharmacy. These phone calls at our office have become a frequent occurrence. However, upon investigation, this error could have been avoided. The error resulted from numerous assumptions, and a lack of communication with the patient and other professionals. If the pharmacy had a basic quality assurance policy in place then the consumer may never had made the call to our office. Our investigation showed that the patient called in a refill for a routine medication noting at the time of the request that the directions were modified by the prescribing practitioner. The patient reported that when he went to the pharmacy to pick up the prescription, the medication appeared different. The pharmacist on duty insisted that the medication was correct and told the patient to call the doctor if he had further questions. When interviewed, the pharmacist on duty stated that he was not the filling pharmacist and never spoke with the practitioner's office concerning this prescription. He did recall that this practitioner often uses the two medications involved in this case interchangeably as they are used for the same condition. He further stated that he checked the prescription on file and felt comfortable that the Rx was filled properly, therefore he did not call the practitioner. The pharmacist who actually filled the prescription was later interviewed. This pharmacist said the Rx was called in from the practitioner's office for the drug that was dispensed. Although it was normal practice to note prescriptions ordered on the patient's record at the physician's office, a check of the record showed no entry indicating that this prescription had been called into the pharmacy. In addition, there was no record of a medication change for this patient. The doctor did state that the directions were modified.

Based on the above information, it appears there was an error in the verification, transmission or reception of this prescription order. If the pharmacist on duty when the patient picked up the prescription had acknowledged the concerns of the patient initially, then this error could have been avoided

***Your Responses from Previous Feedback Sections (on technician ratios) may be found at* www.ctpharmacist.org**

The Feedback Section
We would like to hear from YOU !

Quality Assurance

Quality Assurance can be defined as a system of standards and procedures to identify and evaluate quality-related events and to improve patient care. Connecticut has recently joined the States of California and Florida to enact legislation that requires all pharmacies to implement Quality Assurance programs. The goal of Quality Assurance is to substantially reduce prescription errors.

The Department of Consumer Protection, along with the Commission of Pharmacy, are currently developing Quality Assurance regulations for Connecticut. These regulations will require every pharmacy to develop and maintain policies and procedures addressing the prevention, detection, reporting, and response to prescription errors. Professionally it is just as important to document interventions as it is to document errors. This is an ideal opportunity for pharmacists to quantify our value as professionals. Will these regulations help to significantly reduce prescription errors ? **Let us know what you think……**

RESOURCES ON THE WEB

www.ctpharmacists.org	*Connecticut Pharmacist Association*
www.ascp.com	*The American Society of Consultant Pharmacists*
www.ctdrugcontrol.com	*The Department of Consumer Protection, Drug Control Division*

REGULATORY REPORT

PRESCRIPTION ERRORS PRESENTED TO THE PHARMACY COMMISSION

September 4, 2001 to August 6, 2002

The Drug Control Division referred 58 prescription error investigations to the Commission of Pharmacy as follows:

Type of Error	Medication Ordered	Medication Dispensed
Allergic Reaction	Silvadene Cream – Sulfur allergy noted on Rx	SSD AF Cream 1%
Expired Medication	Cephalexin 125mg/5ml – Dispensed 05-12-2001	Cephalexin 125mg/5ml – Expired 05-01-2001
Failure to Inform Patient Of Generic Substitution	Humibid DM Tablets Keflex 250mg Capsules	Guaifenex DM Tablets Cephalexin 250mg Capsules
Improper Reconstitution	Amoxicillin 400mg/5ml Augmentin 200mg/5ml	Amoxil 400mg/5ml – Not reconstituted Augmentin 200mg/5ml – Wrong quantity of water
Medication Not Labeled	Captopril 50mg Tablet – #1	Captopril 50mg Tablet – Vial not labeled
Medication Mislabeled	Amaryl 4mg for Patient 'A' Humulin N 100u/ml Cartridges Humalog 100u/ml Cartridges Cephalexin 500mg Capsules Oxycodone/APAP 5/325 Tablets Propranolol 10mg for Patient 'C'	Labeled Coumadin 5mg for Patient 'B' Labeled Humalog 100u/ml Cartridges Labeled Humulin N 100u/ml Cartridges Labeled Oxycodone/APAP 5/325 Tablets Labeled Cephalexin 500mg Capsules Propranolol 10mg for Patient 'D'
Unauthorized Prescription	No medication ordered	Methylprednisolone 4mg – 21 pack
Wrong Directions	Cardizem CD 180mg – 1 capsule every day Augmentin 400mg/5ml – 3cc twice daily Chloral Hydrate - 5cc 1/2 hour before …	Cartia XT 180mg – 3 capsules every day Augmentin 400mg/5ml – 3cc three times daily Chloral Hydrate - 30cc 1/2 hour before …
Wrong Doctor	Celebrex 200mg from Doctor 'A'	Celebrex 200mg from Doctor 'B'
Wrong Medication	Biaxin 250mg Tablets Cefzil 250mg Tablets Coumadin 2mg for Patient 'E' Doxazosin 2mg Tablets Gantrisin Suspension Hydrochlorothiazide 50mg for Patient 'F' Hydroxychloroquine 200mg Tablets Lanoxin 0.125mcg Tablets Lotensin 10mg Tablets Lotensin 10mg Tablets Lotensin HCT 20/12.5 Tablets Metoclopramide 5mg Tablets Metoprolol 50mg Tablets Ortho-Tricyclen Tablets Oxycodone 5mg Tablets Penicillin VK 500mg Tablets Prilosec 20mg Capsules Prilosec 20mg Capsules Prozac 20mg Capsules Relafen 500mg Tablets Ritonavir 100mg Capsules (Norvir) Serzone 100mg Tablets Tincture of Opium Camphorated Zantac Syrup 15mg/ml Zestril 2.5mg Tablets Zyrtec 10mg Tablets	Lanoxin 250mcg Tablets Ceftin 250mg Tablets Hydrochlorothiazide 50mg Tablets Clonazepam 2mg Tablets Unable to be determined [2 RPh involved] Coumadin 2mg Tablets Amitriptyline 10mg Tablets Lorazepam 1mg Tablets Metoprolol 100mg Tablets Prinivil 10mg Tablets Zestoretic HCT 20/12.5 Tablets Metoprolol 50mg Tablets Neurontin 100mg Capsules Ortho-Novum 7/7/7 Tablets Oxycodone/APAP 5/325 Tablets Prednisone 5mg Tablets Pravachol 20mg Tablets Prozac 20mg Capsules Prilosec 20mg Capsules Methocarbamol 750mg Tablets [2 RPh involved] Retrovir 100mg Capsules Seroquel 100mg Tablets Tincture of Opium Zyrtec Syrup 1mg/ml [Error occurred 3 times] Warfarin 2.5mg Tablets Zyprexa 10mg Tablets
Wrong Patient	Cephalexin 500mg for Patient 'G'	Cephalexin 500mg for Patient 'H'
Wrong Quantity	Hycodan Syrup – 150cc	Hydromet Syrup – 115cc
Wrong Rx in Bag	Concerta for Patient 'I'	Lorazepam for Patient 'J'
Wrong Strength	Actonel 5mg Tablets Cephalexin 250mg Capsules Cytomel 5mcg Tablets Lorazepam 0.25mg Tablets Pamelor 25mg Capsules Paxil 20mg Tablets Paxil 30mg Tablets Synthroid 0.025mg Tablets Tegretol 100mg Chewable Tablets	Actonel 30mg Tablets Cephalexin 500mg Capsules Cytomel 50mcg Tablets Lorazepam 0.5mg Tablets Pamelor 10mg Capsules Paxil 30mg Tablets Paxil 20mg Tablets Synthroid 0.125mg Tablets Tegretol 200mg Tablets