The Connecticut Alliance for Safe Prescription Practices

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C.A.S.P.P. NEWSLETTER

Timely Information for Pharmacists and Pharmacy Technicians

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 woman who reported that she had left three new prescriptions for filling at her regular pharmacy to be picked up at a later time. After the prescriptions were picked up she checked the bag and found it contained only one prescription. She then telephoned the pharmacy and spoke with a pharmacist who stated that all three prescriptions had been picked up. At this point she made her complaint. This information and our subsequent investigation revealed that the woman left three new prescriptions for filling. They were processed by pharmacist A who noted that they were written by different practitioners and further that two of the products ordered were incompatible and possibly could cause a serious interaction. These two prescriptions were put aside and both practitioners called to notify them of the problem. Pharmacist A filled and bagged the third prescription. There was no notification included concerning the status of the two remaining prescriptions. Subsequently the prescriptions were picked up and after checking the bag, the woman called the pharmacy and spoke with pharmacist B, who informed her that all prescriptions had been picked up. She felt confused and concerned and contacted our office. Our investigation showed no statutory violations or errors in the handling of the product, therefore after advising the complainant of our findings, no further action was taken. However, had pharmacist A communicated his actions to the patient and co-workers and/or if pharmacist B had been sensitive to the woman's complaint and more diligent in checking the pharmacy department, there would have been no distrust in the quality of service.

Your Responses from Previous Feedback Sections

Do you believe insurance demands and getting product out are the only concerns of you and your staff? What steps could or do you take to promote safe prescription practices? Your responses follow:

- "I left the profession when it was clear that the insurance companies made it impossible to meet the level of professionalism that we were taught in pharmacy school. It did not help that the low fees forced employers to cut staff even in the face of rising volume."
- "Insurance demands and getting product out are the only concerns of upper management and patients….We are expected to do the jobs of the insurance benefits office on top of our own jobs….We have been so consumed by insurance issues that true pharmacy has been almost lost. By true pharmacy, I mean patient counseling and individual attention…"
- "I do not, and should not, be expected to monitor people's insurance plans. My focus is to getting the proper drug in the proper bottle for the proper person…It is the fault of our employers, but also the fault of this state government that incidents like this happen ALL THE TIME!…Public safety is my #1 concern…"
- "Many prescription errors, in my opinion, can be directly related to the number of interruptions a pharmacist receives while he or she is trying to fill a prescription."
- "Perhaps a more prudent use of WELL TRAINED technical staff would alleviate some of the "insurance company intermediary" responsibility of the pharmacist…. Why should customers look at us other than as another "fast food" outlet complete with drive through window service!…There needs to be a radical philosophical/ culture change within the retail section of our profession as has occurred (for the most part) in institutional practice. Meaningful QI/QA/PI programs with the goal of objective measurements, problem identification, actions targeting system issues and follow-up are needed….I'll know we're moving in the right directions when I hear….I was really busy today…identified 4 adverse drug reactions, 6 drug-drug interactions and 4 potential overdoses and counseled 3 patients on diabetes management !!!"

In response to the lack of standardized prescription card creating unnecessary interruptions and distractions for the pharmacist (or staff) which may contribute to prescription errors…The overwhelming answer was YES! "…everything needs to be done for the benefit of the patient."

The 5 R's? **R**ight drug, **R**ight dose, **R**ight person, **R**ight directions, **R**ight route.

The Feedback Section
We would like to hear from YOU !

Pharmacist/Technician Ratios

The appropriateness of pharmacist/technician ratios is beginning to be questioned by pharmacists who are facing an unprecedented increase in demand for their services. The Commission of Pharmacy has enacted a task force to study current technician ratios and make recommendations for possible change.

The role of a pharmacy technician is to provide support for a pharmacist and the drug distribution process. Delegating tasks to technicians, which do not involve professional judgement, frees up the pharmacist to spend more time counseling patients. Thirty-five states currently specify the maximum number of technicians a pharmacist may supervise. In an ever-changing work environment should this be determined by regulation or should pharmacists determine for themselves how much support they need?

Some feel that pharmacist/technician ratios protect the public by providing pharmacy technicians with adequate supervision and by ensuring that tasks, which require professional judgment, will only be performed by a pharmacist. Others feel that these restrictions are arbitrary and represent a one-size fit all approach to the practice of pharmacy. Would increasing or eliminating technician ratios decrease prescription errors and enhance patient care?

Let us know what you think…….

CASPP
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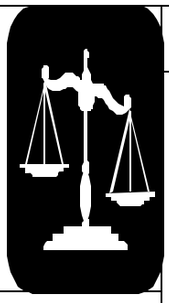
REGULATORY REPORT

PRESCRIPTION ERRORS PRESENTED TO THE PHARMACY COMMISSION



February 07, 2001 to August 07, 2001

The Drug Control Division referred 24 prescription error investigations to the Commission of Pharmacy, as follows:

Wrong Drug:

Ordered:	*Dispensed:*
Methotrexate 2.5mg	Bromocriptine 2.5mg
Sertraline 25mg	Serentil 25mg

Wrong Strength:

Ordered:	*Dispensed:*
Synthroid 0.137mg	Synthroid 0.1375mg

Wrong Dosage Form:

Ordered:	*Dispensed:*
DDAVP 0.2mg tablets	DDAVP Nasal Spray

Prescription Correctly Labeled and the Wrong Medication was Dispensed:

Ordered:	*Dispensed:*
Amoxil 200mg/5ml	Amoxil 400mg/5ml
Amoxil 400mg/5ml	Augmentin 400mg/5ml
Clonazepam 0.5mg	Lorazepam 0.5mg
Dexedrine 15mg	Dexedrine 5mg
Isosorbide 60mg	Lipitor 10mg
Lamisil 250mg	Lanoxin 0.25mg
Lipitor 10mg	Isosorbide 60mg
Neurontin 100mg	Neurontin 300mg
Nifedipine ER 90mg	Xalatan Eye Drops
Paxil 10mg	Zestril 10mg
Paxil 30mg	Paxil 20mg
Prilosec 20mg	Pravachol 20mg
Serzone 100mg	Seroquel 100mg
Synthroid 50mcg	Remeron 30mg
Terazosin 5mg	Terazosin 2mg
Warfarin 4mg	Warfarin 10mg
Xalatan Eye Drops	Nifedipine ER 90mg
Zantac 15mg/ml	Zyrtec 1mg/ml

Miscellaneous Errors:

1 – Thyrolar was not stored in accordance with manufacturer's directions

1 – A new prescription label was applied over a previous prescription label exposing confidential information

DID YOU KNOW?

- A medication error may be broken down into two types: mechanical and intellectual errors. (Drug Topics, April, 2000) One study concluded approximately 82% of the reported errors were mechanical and the other 18% were intellectual. A mechanical error includes wrong drug , wrong strength and wrong directions. Intellectual errors include mistakes in the drug review, counseling process, and other errors. Other studies show 83% of errors are *discovered* during the patient counseling process. Michael R. Cohen, founder of the Institute for Safe Medication Practices (ISMP) has been quoted to say: " The single most important step pharmacists can take to avoid errors is to spend time talking with the patient about their medications. We should take advantage of the fact that patients know their medications, and they know how errors can happen." (April 1998)

- **Sound alike/ look alike** account for approximately 15% of all reports to the USP Medication Errors Reporting (MER) Program. Here are a few from the USP list

  Oxybutynin.....Oxycontin
  Hyzaar.....Cozaar
  Epivir.....Combivir
  Human Insulin Lente.....Human Insulin Lantus

Safety Tips:

- Step into the RED ZONE: Some practice sites place red tape on the counter and a red taped box on the floor to indicate a specific area where all prescription checking occurs. When the pharmacist steps into the RED ZONE the pharmacist is NOT TO BE INTERRUPTED until the pharmacist steps out of the zone. Technicians and clerks are trained that the pharmacist takes no phone calls or questions until they are out of the red zone. Also, the process you use in checking the prescription matters. In the case of a new prescription, the pharmacist should look at the script first and verify everything to that script. Many times pharmacists start with the prescription bottle and verify to that. If an error has already occurred, the pharmacist may not catch it.

- LOOK in the bottle: Taking that extra step to open the prescription bottle and verify what is inside can prevent an error. Take the time!

Let us know your suggestions for safe pharmacy practice!

RESOURCES ON THE WEB

An extensive variety of Internet sites that provide additional information on the subject of safe prescription practices are available. Here are several examples for the next time you are surfing the 'Web'.

www.medscape.com/home/network/pharmacists/pharmacists.html : *Medscape Pharmacists*

www.nlm.nih.gov/medlineplus: *Medline Plus*
www.drugfacts.com: *Facts and comparison*
www.state.ct.us/dph/ :*The Connecticut Department of Public Health*
www.cdc.gov/ :*The Centers for Disease Control and Prevention*
www.ashp.org/shortage: *The American Society of Health System Pharmacists: Drug Shortages*

Contact us:

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The Connecticut Alliance for Safe Prescription Practices (C.A.S.P.P.) , formed in 1997, is a coalition of Connecticut pharmacy educators, practitioners, regulators and professional associations. The group came together to study the problem of pharmacy related medication errors, with emphasis on the prescription dispensing process in community and ambulatory care pharmacies. The primary objective of C.A.S.P.P. is to develop and promote the implementation of safe prescription practices as a means of reducing prescription errors. Representation in the group is voluntary and we are not affiliated with, nor do we speak for any government, private organization, or entity.