The Connecticut Alliance for Safe Prescription Practices

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C.A.S.P.P. NEWSLETTER

Timely Information for Pharmacists and Pharmacy Technicians

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 institutional 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. This publication is for all Connecticut Pharmacists and Registered Technicians and is designed to foster awareness and create a participatory dialogue to address safe medication practices.

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CASE REVIEW: YOU DECIDE THE OUTCOME

ACTUAL CASE FROM THE FILES OF THE DEPARTMENT OF CONSUMER PROTECTION

Our office received a call from a woman who reported that she presented a new Luride prescription to be filled for her daughter. After a significant wait, she got her bagged prescription and left the store. Later she opened the bag and found a Prozac prescription for an unknown person. Based on this information, this seems like a fairly simple case to investigate. The incident was anything but simple or ordinary. The customer was told the prescription would take twenty minutes to fill. After 30 minutes, she approached the counter about her prescription. The person behind the counter (non-pharmacist) asked her questions about insurance that she answered. She was told the plan provided a one-month supply and her co-pay was $15.00. She questioned this because her co-pay had been $5.00. At this point the pharmacist intervened for the first time in the prescription process. She reviewed the insurance information and confirmed the co-pay was $15.00. According to the complainant the pharmacy staff, including the pharmacist, did not look at the prescription label or receipt to confirm the patient name with the customer.

1) Do you believe that insurance demands and getting product out are the only concerns of you and your entire staff?
2) What steps could or do you take to prevent this scenario from occurring and thereby promoting safe prescription practices?

THE FEEDBACK SECTION

WE WOULD LIKE TO HEAR FROM YOU!

One of the most frustrating tasks that a pharmacist or pharmacy technician performs is processing third party prescription claims. Inconsistent and confusing prescription drug cards are responsible for pharmacists utilizing up to 20% of their workday as intermediaries between patients and their insurance company. This will only become worse over the next five years as prescription volume is expected to double by year 2004. *(This figure does not take into account the potential Medicare benefit, which is being discussed at the national level.)* The National Association of Chain Drug Stores, National Community Pharmacist Association, and American Pharmaceutical Association have recently started a national campaign to enact legislation to mandate a standardized prescription medication card for all patients with prescription drug benefits. Their position is that the lack of standardized cards hinders the dispensing process and decreases the time that pharmacists spend with patients.

1) Do you think that the lack of a standardized prescription card creates unnecessary interruptions and distractions for the pharmacist (or staff) which may contribute to prescription errors?

2) Do you think that a standardized prescription card would be burdensome to insurance companies and lead to increased premiums?

Please let us know what you think….

REGULATORY REPORT

PRESCRIPTION ERRORS PRESENTED TO THE PHARMACY COMMISSION

July 12, 2000 to February 06, 2001

The Drug Control Division referred 34 prescription error investigations to the Commission of Pharmacy, as follows:

Wrong Drug:

Ordered:	*Dispensed:*
Hydroxyzine 25mg	Hydralazine 25mg
Hytrin 1mg	Tenormin 25mg
Metoprolol 50mg	Atenolol 50mg
Prilosec 10mg	Prozac 10mg
Prilosec 20mg	Prozac 20mg
Zoloft 100mg	Levoxyl 150mcg

Wrong Strength:

Ordered:	*Dispensed:*
Celebrex 100mg	Celebrex 200mg
Depakote 250mg	Depakote 125mg
Diazepam 10mg	Diazepam 5mg
Inderal LA 60mg	Inderal LA 160mg
Neurontin 300mg	Neurontin 400mg
Xopenox 0.63mg	Xopenox 1.25mg
Zocor 20mg	Zocor 10mg and 20mg in bottle

Incorrect Labeling:

Labeled as:	*Dispensed:*
Ami-Tec	Levaquin 500mg
Inderal LA 160mg	Depakote 125mg
Lactulose 10gm/15ml	Glucophage 500mg
Levaquin 500mg	Ami-Tec

Incorrect Directions:

Medication:	*Ordered:*	*Labeled as:*
Depakene Syrup	2 tsp qid	5 tsp qid
Zantac Syrup	1.2 ml bid	1/2 tsp bid

Miscellaneous Errors:

10 – Filled under the wrong patient's name
1 – Un-reconstituted pediatric antibiotic suspension dispensed
1 – Birth control case dispensed with no medication
1 – Dispensed with the generic medication when the doctor specified "No Substitution"
1 – Fiorinal with Codeine filled for the wrong patient and this patient was allergic to codeine
1 – Patient received Betapace 80mg that was never prescribed for them.

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.identadrug.com
(Drug identity site)
Pharmacist Letter

www.drugfacts.com
Facts and Comparison

www.ismp.org/cgi/config.pl
Institute of Safe Medication Practices listserv**

www.cga.state.ct.us/default.htm
(legislative site)
CT General Assembly
You can find your Representative at
www.cga.state.ct.us/maps/map.htm
OR your Senator at
www.cga.state.ct.us/maps/Senate/county_mapsenate.htm,
by selecting your town. You can also contact any of your professional associations

www.nccmerp.org
The National Coordinating Council for Medication Error Reporting and Prevention

www.usp.org
The U.S. Pharmacopeia

www.ashp.org
The American Society of Health System Pharmacists

www.ctdrugcontrol.com/caspp.htm
The CT Drug Control Division

Please e-mail any suggestions for Resources on the 'Web'

DID YOU KNOW?

- Did you know that AN ACT REQUIRING STANDARDIZED PRESCRIPTION DRUG INFORMATION CARDS has been raised in the Connecticut General Assembly?

⇒ This legislation is intended to facilitate prescription processing by requiring health insurance plans, including state plans and self-insured plans, to provide those insureds with prescription coverage a uniform prescription card containing uniform data, and to prohibit such plans from conducting business in this state if the plan is in violation of this act.

⇒ Did you know that you can have an impact on this legislation? The insurance industry will be fighting this issue, contact your legislator immediately to express your view point.

- Did you know that many times prescriptions are filled with 100% accuracy, but end up being given to the wrong person?

⇒ Who is responsible for assuring that the prescription filled with 100% accuracy (**right** medication) ends up with the **right** person?

⇒ Do you know the 5 R's

⇒ What Safe Prescription Practices do you use? Please let us know……..

- There are five federal bills on errors described in the November 2000 Pharmacy Times (pp. 22-25). They are the Medical Error Reduction Act (MERA) of 2000 (S.2038), the Medication Error Prevention Act (MEPA) of 2000 (H.R.3672), Stop all Frequent Errors (SAFE) in Medicare and Medicaid Act of 2000 (S.2378), Voluntary Error Reduction and Improvement in Patient Safety Act (VERIPSA) (S.2743), and the Patient Safety and Errors Reduction Act (PSERA) (S.2738). These can all be accessed at www.senate.gov by searching the bill number. On this site there are ways to contact our Senators electronically.