The Connecticut Alliance for Safe Prescription Practices

Volume 1, Issue 1

Fall 2000

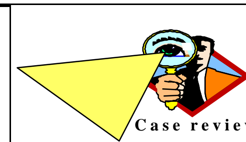
C.A.S.P.P. Newsletter

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 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.

Case Review: You Decide the Outcome

Actual case from The Files of The Department of Consumer Protection



A person complained that their physician telephoned the pharmacy to order Synthroid 25mcg to be taken with a prescription for Synthroid 200mcg previously filled at this pharmacy. The complainant stated that the pharmacist never explained that the medications were to be taken together, but instead the pharmacist told her that the Synthroid 25mcg was a replacement for the Synthroid 200mcg. The pharmacist who filled the Synthroid 25mcg acknowledged dispensing the prescription, but could not recall telling the patient that it was a replacement for the Synthroid 200mcg strength. A review of the pharmacy's phone log showed that another pharmacist received the prescription for Synthroid 25mcg. It was also determined that the practitioner rarely calls in his own prescription orders, as office employees perform this function. The practitioner felt that the pharmacist was advised to inform the patient to take both strengths of Synthroid. Our investigation determined that while no dispensing errors were found, there was an obvious breakdown in communication. It could not be determined if the breakdown occurred, in the practitioner's office, between the office and the pharmacy, or within the pharmacy. Based on the investigation, this case was not referred to the Commission of Pharmacy. However, this does not change the fact that the patient took the wrong strength of Synthroid for a period of time. What could or should a pharmacist have done, even without any explicit directions from the practitioner's office, when presented with the request to fill the prescription for Synthroid 25mcg?

Welcome and Introduction

Welcome to the Connecticut Alliance for Safe Prescription Practices (C.A.S.P.P.) Newsletter! A publication for all Connecticut Pharmacists and Registered Technicians designed to foster awareness and create a participatory dialogue to address safe medication practices.

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The Feedback Section

We would like to hear from YOU!

Please use this forum to comment on any topic in this newsletter or issues facing the pharmacy community concerning safe prescription practices. We encourage pharmacists to be part of the solution to the challenges in our profession. Here are several challenges that will affect us all in the near future:

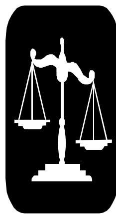
In the next four years the prescription volume is expected to double. This will occur more quickly if a Medicare Prescription Drug Benefit is passed. The supply of pharmacists will only increase 6% in the same time frame. How will we keep up with the demand without compromising the quality of care or the safety of our patients?

Over the past several months there has been discussion about scheduled lunch/work breaks as a way to minimize fatigue and stress. Two possible strategies have emerged from this: *1.) Requests for legislative or regulatory changes 2.) Benefits offered by employers.*

1. Do you think scheduled work breaks would be beneficial in promoting safe prescription practices?
2. To what extent should our professional practice standards be determined by regulators, pharmacists, employers, or patients?

Regulatory Report

Prescription Errors presented to the Pharmacy Commission



January 01, 2000 to July 11, 2000

The Drug Control Division referred 40 prescription error investigations to the Commission of Pharmacy, as follows:

Improper Substitution/Drug Allergy:

Patient allergic to SULFA

Ordered:	*Dispensed:*
Eryped	Erythromycin/Sulfasoxizole

Wrong Drug:

Ordered:	*Dispensed:*
Accolate	Accupril
Amitriptyline	Allopurinol
Humulin N	Humulin U
Natafort	*Unknown **
Noroxin	Neurontin
Norpramin	Nortriptyline
Ortho-Tricyclen	Ortho-Cyclen
Pepcid	Prinivil
Phenergan	Cafergot
Tylox	Tapazole
Zoloft	Levoxyl

Wrong Strength:

Ordered:	*Dispensed:*
Cogentin 1mg	Cogentin 0.5mg
Neurontin 300mg	Neurontin 400mg
Oxycontin 10mg	Oxycontin 20mg
Paxil 10mg	Paxil 20mg
Prednisone 10mg	Prednisone 20mg
Prempro 0.625/5mg	Prempro 0.625/2.5mg
Sumycin 250mg	Sumycin 500mg
Verapamil SA 180mg	Verapamil SA 120mg
Wellbutrin SR 100mg	Wellbutrin 100mg

Correct Prescription Label/Wrong Medication in Vial:

Ordered:	*Dispensed:*
Keflex	Prednisone

Miscellaneous Errors:

2 with wrong patient name
3 Outdated prescription medications dispensed
1 Un-reconstituted pediatric antibiotic suspension dispensed
1 with wrong directions

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.fda.gov
Food and Drug Administration
www.ctdrugcontrol.com/caspp.htm
The CT Drug Control Division
www.ismp.org
Institute of Safe Medication Practices
www.nccmerp.org
The National Coordinating Council for Medication Error Reporting and Prevention
www.riskmanco.com
The most frequently litigated medication errors
www.usp.org
The U.S. Pharmacopeia
www.ashp.org
The American Society of Health System Pharmacists
www.npsf.org
The National Patient Safety Foundation

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Did You Know?

- Did you know that some pharmacies may stock a limited variety of dosage strengths available for drugs such as SYNTHROID (levothyroxine). Combinations of partial or multiple tablets may need to be dispensed for a single dose, with detailed and sometime confusing directions for administration. In response to this potential problem, the Institute of Safe Medication Practice (ISMP) recommends that pharmacies stock the full variety of strengths of SYNTHROID (levothyroxine) to avoid confusing drug administration directions and minimize the possibility of error. (ISMP Quarterly Action Agenda-fourth quarter 1999)
- New Sound-a-like: Sarafem (severe PMS) and Serophene (Fertility).
- Orders for Avandia can look like Coumadin. Avandia was ordered as 4mg once daily and Coumadin was dispensed. Both are available in 4mg strengths. Pharmacists should keep in mind some errors may occur with drugs that don't look or sound alike.
- Coumadin (warfarin) may interact with Mobic (meloxicam). Mobic is a new NSAID that may potentiate warfarin effects; patient monitoring may be required. Issues with International Normalized Ratio (INR) have been reported.
- Coumadin may interact with St. John's Wort. St. John's Wort may induce the cytochrome P450 2C9 enzymes with a result of reduced anticoagulation.*Yue QY, Bergquist C, Gerden B. Safety of St John's Wort (Letter to the Editor). 2000. The Lancet. 355(9203):575.

The 9 most common reported prescription errors

1. Interchanged drugs with similar names
2. Adjacently stored drugs interchanged
3. Incorrect directions for use
4. Switched prescription labels
5. Prescription given to wrong patient
6. Outdated drugs dispensed
7. Confusion of routes of administration
8. Incorrect strength is dispensed
9. Mistakes in dosage calculations involving compounded prescriptions

(Source: Drug Control Division, errors reported 1985-1997)