Transcript Details
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Top 10 Med Errors & Hazards, Part 1

Announcer:
You're listening to *The Drug Report* on ReachMD, hosted by Linda Bernstein, Pharm.D., Clinical Professor on the Volunteer Faculty of the School of Pharmacy, University of California, San Francisco.

Dr. Bernstein:
Welcome to *The Drug Report.* I'm Dr. Linda Bernstein.

Medication errors and drug safety have long been the focus of the Institute for Safe Medication Practices (ISMP), the only 501c (3) nonprofit organization devoted entirely to preventing medication errors. During its more than 25-year tenure, ISMP has been an advocate and provider of medication safety information resulting in numerous necessary changes in clinical practice, public policy, and drug labeling and packaging.

For example, ISMP runs the only national voluntary practitioner medication error reporting program, publishes newsletters with real-time error information read and trusted throughout the global healthcare community, and offers a wide range of unique educational programs, tools, and guidelines. ISMP, formally affiliated with ECRI Institute in 2020, to create one of the largest healthcare quality and safety entities in the world. Both organizations will work more closely together for the benefit of providers, patient advocates, governments, and most importantly, patients. As an independent watchdog organization ISMP is unbiased and receives no advertising revenue and depends entirely on charitable donations, educational grants, newsletter subscriptions, and volunteer efforts to pursue its life-saving work.

The Pharmacy Practice News, in their January 17, 2020 issue, has published the "Top 10 List of Med Errors and Hazards" as identified by ISMP. These errors have been persistent and are considered avoidable or can be minimized with system and practice changes. ISMP believes these issues "warrant attention and priority in the coming year if you have not already taken action to mitigate the risk."

Here is the latest list of ISMP Top 10 Medication Errors:

Medication Error 1. Choosing the incorrect medication after typing in the first few letters of the drug name. The wrong drug may be selected from the ensuing list of look-alike names on the computer screen, especially if only 3 letters are entered. This error has become more frequent in light of the upsurge in technology and compares to or even exceeds errors of this nature resulting from handwritten drug orders. The ISMP is urging practitioners to change personal practice habits and promote the use of at least 5 letter characters when searching for a drug name. Indication-based prescribing will also help avoid confusion. ISMP also wants technology vendors, including electronic health record vendors, to consider similar 5-letter search enhancements in product search functionality to reduce the frequency of menu screen selection errors.

Medication Error 2. Incorrect frequency of oral methotrexate: Reports of prescribing, dispensing, and/or administering/taking oral methotrexate daily, instead of weekly, for non-oncologic conditions continued in 2019. An analysis of these errors over 18 months between 2018 and 2019 showed that half of the reported errors were made by older patients who were confused about the frequency of administration, and the other half were made by healthcare providers who inadvertently prescribed, labeled, and/or dispensed methotrexate daily when weekly was intended. An FDA analysis suggests that up to 4 per 1,000 patients may mistakenly take the drug daily instead of weekly.

ISMP encourages every healthcare provider to: 1) default to a weekly dosage regimen when entering electronic orders or prescriptions for oral methotrexate, 2) require an appropriate oncologic indication for all daily methotrexate orders, and 3) provide patient and family education about the importance of weekly administration.

Medication Error 3. Pitfalls of look-alike labeling of manufacturers' products. Stylized company logos and names may distract from critical drug label information. Similar looking labels and cap colors may cause different products to look the same and result in confusion. ISMP recommends setting up a process to ensure that all new products are reviewed by practitioners who may use them, looking at the actual packages in their work environment, before drugs are added to inventory. If look-alike problems are deemed likely, the product should be bought from a different manufacturer if possible, or steps should be taken to avoid a mix-up (e.g., separate storage and warning labels), before the drug is dispensed.

Medication Error 4. Poorly heard verbal orders and communications that occur while speaking or in telephone calls, particularly in a hectic emergency situation, during a sterile procedure or in the course of a telephone drug therapy consultation, may result in errors and misunderstandings. It is desirable for this reason to transmit drug orders electronically whenever possible.

For the ISMP medication errors 5 through 10 check out part two of this program

For *The Drug Report*, I'm Pharmacist, Dr. Linda Bernstein.

Announcer:
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