



Drug Safety Review

Similarities in products can lead to errors

Cases submitted through the U.S. Pharmacopeia's Medication Errors Reporting (MER) Program underscore how similarity in product labeling and packaging between drug products can lead to errors or have a potential to cause errors. The following error descriptions/recommendations are summarized from reports received through the USP Medication Errors Reporting (MER) Program during the time period July-September 2003.

Similar labeling/packaging

Potential error. The facility ran out of labetalol, which required a purchase from a nearby hospital. The hospital carried a different brand of labetalol (Abbott) than the one normally stocked. The facility realized that the labeling of the Abbott brand of labetalol looked similar to A.H. Robins' Dopram when the vials were placed side by side on an anesthesia cart. Dopram is indicated for respiratory depression; labetalol is for hypertension.

Reporting pharmacist's action/recommendation. To prevent this potential error, the facility removed the look-alike labetalol and replaced it with the brand it usually purchased.

Error description. A technician noticed that a lorazepam Carpuject (for anxiety disorders) was returned to the pharmacy and placed in the bin for diphenhydramine (for allergic symptoms). Abbott manufactures both products. Upon further investigation, it was noticed that both Carpujects have green caps and look very similar to each other.

Reporting pharmacist's action/recommendation. The manufacturer should consider changing the cap color on the Carpujects and changing to a different color for the drug name.

Similar tablets

Error description. A patient noticed two different medications in the prescription vial. The medications were Lipitor 10 mg (for hypercholesterolemia) and Zyrtec 10 mg (for allergic symptoms), both manufactured by Pfizer. The patient's prescription was for Zyrtec. A prescription for Lipitor was filled in the automatic counter first. The counter may not have been fully emptied prior to filling the Zyrtec prescription. The pharmacist attributed the mix-up to the two products' similar tablet color and size. Short staffing was also suggested as a contributing factor to this error.

Reporting pharmacist's action/recommendation. Check the automatic counter for remaining tablets after each fill and provide adequate staffing to enable double-checks to be performed routinely.

Error description. A patient was prescribed diazepam 2 mg, but received alprazolam 2 mg (both are used to

treat anxiety disorders). The bottle the patient received was labeled as diazepam 2 mg. The patient felt tired and dizzy and contacted the physician. Staffing at the pharmacy was adequate. The possible cause of this error was the similarity in the tablets' shape, color, and markings (both are manufactured by Mylan Pharmaceuticals).

Reporting pharmacist's action/recommendation. Technicians must check the NDC before counting tablets; red dividers distinguish drugs with potential for error; drugs with no image in the computer are placed with the original prescription.

Error description. The wrong strength, 0.112 mg vs. 0.2 mg, of Levoxyl (Jones Pharma) was dispensed to the patient. The tablets are the same color, size, and shape, and the bottles are identical except for the strength.

Reporting pharmacist's action/recommendation. The two strengths are now placed in different areas of the pharmacy. The color of the bottle and tablets should be changed.

Error description. Atenolol 25 mg (for hypertension), by Geneva Pharmaceuticals, and prednisone 5 mg (a corticosteroid), by West-Ward Pharmaceuticals, were packaged by a technician. The wrong labels were placed on the blister cards by the technician and the stock bottles were left with the cards to be checked by the pharmacist. The pharmacist did not catch the error, as the tablets are very similar in size, shape, and color. The nurse administering the medications caught the error.

Reporting pharmacist's action/recommendation. All drugs should be double-checked against the original stock bottles by the pharmacist. The original containers should be opened and the tablets should be examined closely (i.e., with a magnifying glass, if necessary) to ensure that the appropriate product is being dispensed.

Conclusion/recommendations

Sometimes staffers are not aware that a potential problem exists or that an error has occurred. It's a good idea to ensure that all staffers are notified of potential problems by posting fliers and circulating newsletters such as the USP Quality Review that identify which products may cause confusion. Sending e-mails, posting the information on your Intranet, or conducting an in-service education program is also recommended. It is very important to find ways to reach every person in your institution. Remember to include floating and temporary staff, the night shift, and part-time employees.

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USP operates two complementary reporting programs: the Medication Error Reporting Program, presented in cooperation with the Institute for Safe Medication Practices, and MEDMARX. For more information on how to report errors, visit: www.usp.org/patientsafety.

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