

Statin And Aspirin: A Package Deal

Pravigard PAC is pravastatin sodium (Pravachol) and buffered aspirin tablets packaged together, for patient and prescriber convenience. Pravastatin and buffered aspirin are both indicated to reduce the occurrence of cardiovascular events, including heart attack and stroke, in patients who have heart disease.

The usual dose of Pravigard

PAC is one aspirin tablet with one Pravachol tablet once a day. Pravigard PAC contains 30 tablets of each of the two drugs. The buffered aspirin comes in 81 mg or 325 mg tablets, and the pravastatin comes in 20 mg, 40 mg, or 80 mg tablets.

This drug combination should not be taken by patients with certain liver or kidney problems. Also,

it shouldn't be taken by pregnant patients, those who are planning to become pregnant, or those under age 18.

Food and Drug Administration. "FDA approves first co-packaged treatments to reduce occurrence of serious cardiovascular and cerebrovascular events." 2003. www.fda.gov/bbs/topics/NEWS/2003/NEW00917.html (1 July 2003).

Bristol-Myers Squibb Company. "Bristol-Myers Squibb receives FDA approval of Pravigard PAC (Buffered aspirin and Pravastatin sodium) tablets." 2003. www.bms.com/news/press/data/fg_press_release_3819.html (30 July 2003).

Error Watch

Is Your Patient A Diabetic? Watch That Insulin Dose!

In 2000 and 2001, there were a total of 4,764 insulin errors reported to the USP's Medmarx database. Just over 6.5% of these errors caused harm to the patient. That's more than double the historical average of *all* drug errors reported to Medmarx that caused patient harm (2.8%).

Insulin errors can result from any number of factors. Certainly, mixups can—and do—occur because of products with similar names. But other factors can also lead to errors, including:

- ▶ the "sliding-scale" approach used by many hospitals, in which short-acting insulin is administered, at scheduled times, with the dose dependent upon the patient's blood glucose level at the time;
- ▶ clinicians using "u" as an abbreviation for "units;" and
- ▶ the accessibility of insulin as floor stock.

Consider these two cases:

In the first case, a sliding scale order was written for regular insulin "4U" when the patient's blood sugar was 240 – 300 mg/dL. The order was misinterpreted and the patient was given 44 units of NPH (intermediate-acting) insulin instead of regular (short-acting) insulin. When the error was discovered, the patient was given three cups of juice and transferred to the ICU for close monitoring.

In the second case, a dialysis technician inadvertently administered insulin instead of heparin to a patient in the dialysis unit of a hospital. Insulin was kept as floor stock in this unit. The patient suffered fatal neurological damage due to decreased glucose levels.

To prevent a similar tragedy in the future, the facility removed insulin from floor stock and instituted a policy requiring that all insulin doses carry patient-specific labeling and be kept in patient-specific bins.

To avoid an error like the one in our first case, clinicians should spell out "units" instead of abbreviating the word with a "u." Also, be sure to use *only* regular insulin in sliding-scale protocols and to use pre-printed ordering sheets for insulin use, where possible. Don't hesitate to call the doctor and clarify an order, and, no matter what the situation, remember to always double-check the insulin dosage before administering it to the patient.

THE AUTHORS

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