alixaRx™

March 2015 Issue

From the Front Lines

AlixaRx Clinical Pharmacists Address Everyday Challenges in Long-Term Care

Medication Names Can Be Confusing, Lead to Medication Errors

What's in a name? Plenty if we are talking about medication names. Brand name medications are usually ones that we know and trust. Generic name medications have had a harder time establishing trust among the public, but have been shown to be just as safe and effective – and more cost effective – than the already trusted brand name. However, some medication names can be confusing, misleading and increase the potential for medication errors.

One area where medication names can be confusing is for over-the-counter (OTC) products. Many times, an already established brand name company will try to capitalize on the brand familiarity and name many of their products in a similar way. An "umbrella name" or "trade extension name" is a way of naming a product that uses a well-known established brand name to name a new product. This new product may contain an active ingredient that could be completely different from the active ingredient in the original product.

In this issue:

For example, Claritin Eye drops do not contain loratadine. Zyrtec eye drops do not contain cetirizine. Both of these products contain Ketotifen, another antihistiamine. Mucinex Allergy does not contain Guaifenesin like original Mucinex, but rather contains fexofenadine 180mg, similar to Allegra. Arm & Hammer's "Simply Saline" lines of products do not contain saline at all. There are many other examples of how "umbrella names" or "trade extension names" can be misleading and can even be harmful in many cases.

Several medication errors have been reported through the Institute of Safe Medication Practices (ISMP) National Medication Errors Reporting Program where the wrong product or medication dose was administered or a medication was used when the product was actually contraindicated. Confusion regarding a product's actual ingredients, strength and concentration has been observed among both patients and health care practitioners alike. Product names that are confusing or misleading can also cause problems when attempting to treat side effects or accidental ingestion of these medications.

Most OTC products have a drug facts panel that lists the active and inactive ingredients. However, many do not take the time to read this information, assuming that they have the correct product. Before administering OTC products, check the drug facts panel to ensure you are administering the product intended.

Use caution when entering new orders into the E-MAR. Since many of these umbrella name products have similar sounding names, it is very easy to select an incorrect product. Make sure the dose being administered matches the dose of the product selected. When administering OTC products, double check the name of the product being administered against the E-MAR.

Clarify all confusing orders with the prescriber. If you need further information about any medication product, call the pharmacy or refer to your AlixaRx Clinical Pharmacist (ACP).

Reference: "FDA Proprietary Drug Name Draft Guidance;" Long-Term Care Advise-ERR, Volume 3, Issue 1; January 2015

Vial2Bag® | A Safer, Convenient IV Drug Delivery System

In October 2014, West Pharmaceutical Services received FDA 501(k) clearance to market the Vial2Bag® DC device. This device allows point of care reconstitution and IV admixture preparation with many advantages to long term care. Vial2bag DC allows needle free transfer of a medication vial to a standard IV fluid eliminating the risk for needle sticks. This device is connected to the set port of the IV fluid bag along with the medication vial using a standard IV spike. Once connected , the medication vial is reconstituted with fluid from the IV bag. Once reconstituted the contents of the medication vial can be easily transferred to the IV solution making it ready for patient administration.

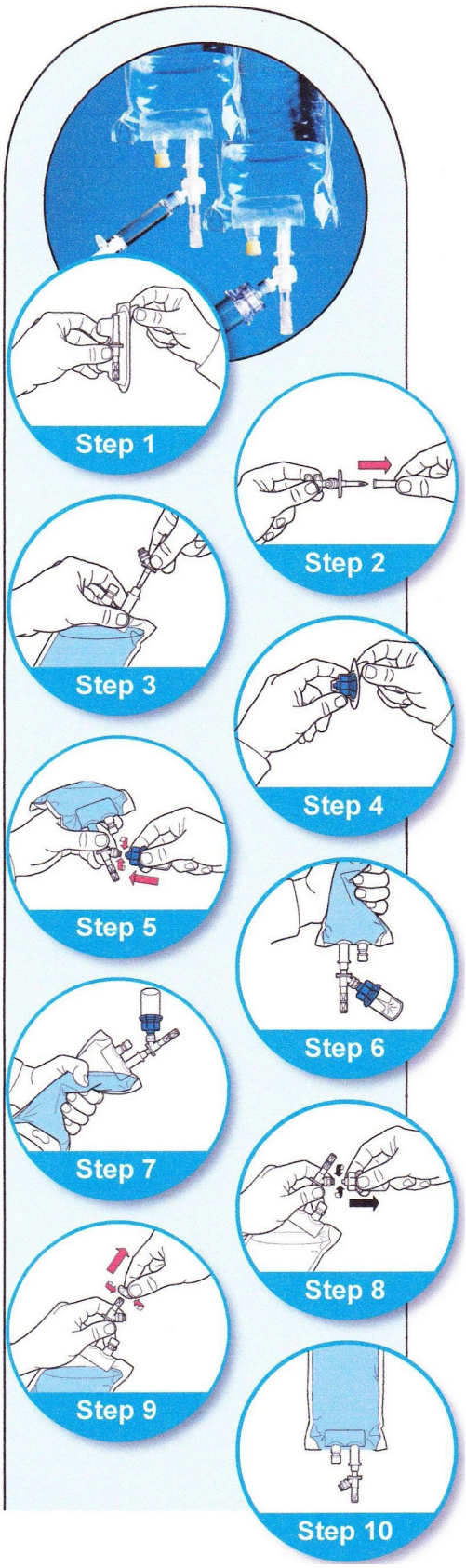
This easy to use system will help promote safety and it can used with any 13mm to 20mm diameter medication vials. In addition the Vial2Bag® device:

- fits standard IV systems
- needle free
- helps standardize admixture systems in the facility
- reduces IV waste
- helps to deliver medication faster to nursing personnel

For in-services and future reference, videos for the use of Vial2Bag® DC device can be found on the following sites:

- http://www.westpharma.com /en/videos/Pages/Vial2Bag.aspx.
- https://www.youtube.com /watch?v=FEOkglxNBrs.

See the next page for instructions on the Vial2Bag® reconstitution system.



Before handling the components, wash your hands with soap and hot water.

Place the package on a clean, flat surface.

Step 1: Remove the cover from the Vial2Bag package.
- Remove the Vial2Bag from the blister pack.

Step 2: Remove the spike cover from the Vial2Bag and discard the cover.

Step 3: Insert the Vial2Bag spike into the IV port of the bag.

Step 4: Remove the Flip-Off button from the lyophilized drug product vial.
- Disinfect the vial injection site with an alcohol pad.
- Peel the cover off the vial adapter pack. Do not remove the adapter from the pack. Using the pack as a holder, seat the adapter on the vial, pushing down until the spike penetrates the elastomeric stopper and the adapter snaps in place.

Step 5: Connect the vial to the Luer port of the IV bag.

Step 6: With the vial lower than the bag, squeeze the bag to transfer the liquid from the bag into the vial to reconstitute the drug.

Step 7: Invert the vial and squeeze air from the bag into the vial; the re constituted drug will flow into the bag.

Step 8: Remove the empty vial, or the vial can remain in place as a reminder that medication has been administered.

Step 9: Open the IV port on the Vial2Bag system.

Step 10: Remove the protector from the IV set spike and insert the spike into the IV port of the Vial2Bag system as you normally would.

The drug is now ready for administration.

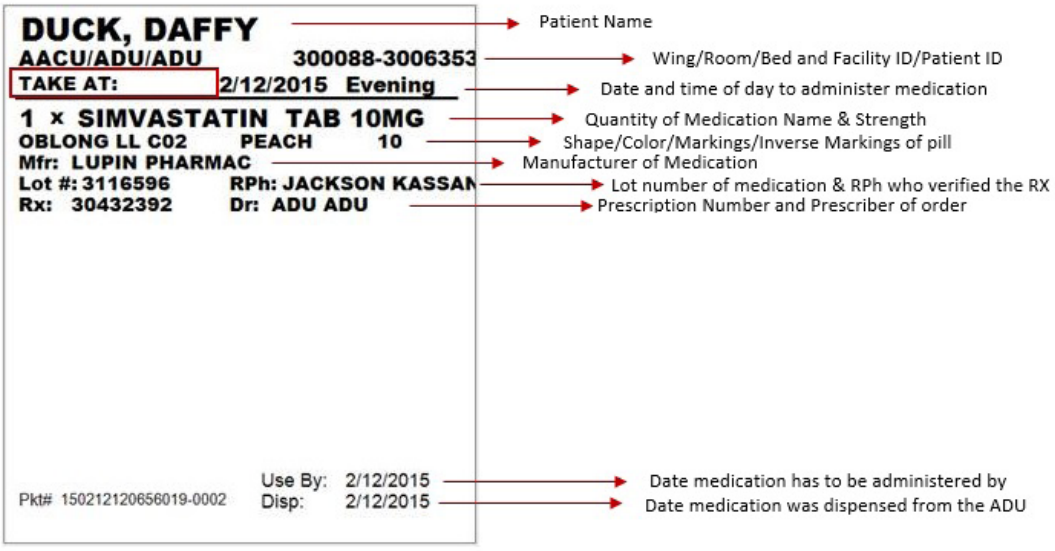
Follow normal safety practices to administer the drug.

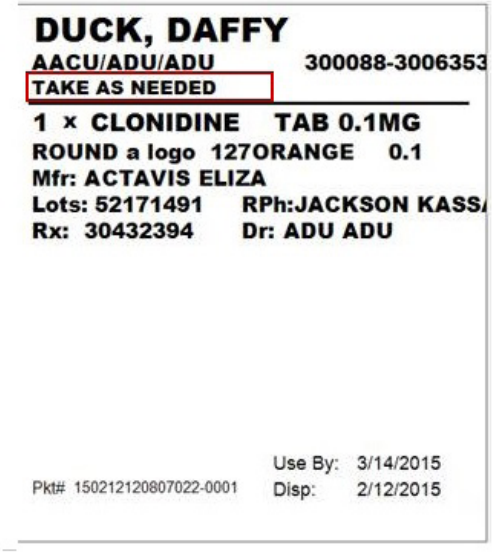
For detailed directions on reconstituting drugs with the Vial2Bag® system, please refer to the system's Instructions For Use.

Label Changes and Medication Error Prevention

AlixaRx has updated its ADU Packet Labeling. Due to State Regulations, the ADU packet format no longer includes the route of administration listed in the directions. The new packets will now only specify the date and time of which to take the medication. These new packet changes are already in place at your facility as of Thursday, February 19th. The dispensing and administration of ADU packets has not changed, and should continue to occur according to your MAR system.

Screenshots of the new packet formats are provided below for your convenience. The area of the packet boxed in red is the area where the new label change has occurred. All areas of the packet have been outlined below for your convenience. These ADU packet changes will affect all ADU packets dispensed from the new, routine, and PRN functions.





This is a good time to review the five rights of medication administration and remember to double check all orders for:

- Right patient
- Right drug
- Right dose
- Right route
- Right time

One of the recommendations to reduce medication errors and harm is to use the “five rights”: the right patient, the right drug, the right dose, the right route and the right time. When a medication error does occur during the administration of a medication, we are quick to blame the nurse and accuse her/him of not completing the five rights. The five rights should be accepted as a goal of the medication process not the “be all and end all” of medication safety.[1]

The five rights focus on individual performance and not on human factors and system defects that may make completing the tasks difficult or impossible.

There are a number of factors that may interfere with a nurse’s ability to complete these functions. It is imperative that both nursing and pharmacy work together not only to achieve the five rights, but ensure that procedures are followed correctly to achieve the appropriate outcomes. If there are any procedural rules that can’t be followed due to system issues, then the interdisciplinary team (IDT) has a duty to review and report the problem so it can be remedied.

1. ISMP Medication Safety Alert. January 25, 2007;12(2)

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