Epinephrine IV vs. IM – A Costly Error
Recently within the Methodist system, a patient with angioedema presented to the ED and was ordered epinephrine 0.5mg IM once. A nurse retrieved the medication and prepared the medication for administration. However, instead of administering the medication, it was handed off to another health care professional to administer. The medication was not labeled and was given IV push instead of IM. After administration, the patient developed chest pain, hypotension, and diaphoresis. The patient eventually was taken for a cath procedure. The patient was found to have suffered a heart attack and ended up staying an extra night in the hospital. It is imperative that we as healthcare professionals take notice of all aspects of a medication order, including checking to ensure it is administered via the correct route. Providing good communication and proper hand-off between co-workers will help ensure patients receive the safest care possible.

An Update on Oral Fluconazole in Pregnant Patients
Oral fluconazole is commonly used in the treatment of vaginal, oral, and esophageal yeast infections. Currently, the product labeling states that there is no data to suggest an increased risk of pregnancy complications or fetal abnormalities with the single 150mg dose of fluconazole. However, higher doses (400-800mg/day) in pregnant women taken for longer periods of time have shown an increased risk of birth defects. However, a recent Danish study suggests a possible increased risk of miscarriage with oral fluconazole. In this study, fluconazole was dosed 150mg for one or two doses. The FDA currently states that, until the complete FDA review is finished, to use caution when prescribing oral fluconazole in pregnant patients or patients planning to become pregnant. Health care professionals should also abide by the CDC’s guidelines which recommend the use of topical antifungal agents to treat pregnant women with vaginal yeast infections. Lastly, female patients of childbearing age should be educated of the potential risks of oral fluconazole therapy.

Look Alike Sound Alike (LASA) Medications:
The Medication Safety Committee has received reports of the following LASA errors:

Pneumovax 23/Prevnar 13
Metoprolol Succinate/Metoprolol Tartrate
Trazodone/Topiramate
Novolog/Novolin
Drug Diversion – BE AWARE!

Drug diversion in health care leads to harm in addicts, employees/employers, and patients, and it is becoming problematic amongst healthcare professionals. Usually, theft of controlled substance arises for personal use or financial gain mainly due to stress of the profession, fatigue, pain, and having easy access to these drugs. Drug diversion can occur from taking medication directly out of the dispensary, cabinet, or pharmacy. It can also occur by removing patches from the patient’s body or waste containers or syringes/needles from biohazard boxes.

With drug diversion, there is a possibility of serious adverse events such as infections and death. Also, it can lead to poor judgment, and higher rates of making a serious error. Recently, ISMP highlighted a documented case of a nursing assistant diverting discarded drugs and self-injecting the diverted drugs, leading to her death.

In order to prevent drug diversion from occurring, ISMP recommends that many programs be put into place. At Methodist, we have several programs in place to help monitor for and prevent drug diversion. The “Security and Handling of Controlled Substances” policy, located on the clinical standardization website, outlines several steps that are in place at Methodist to help prevent drug diversion. Quick actions to identify and stop the diversion, abuse, and addiction can provide a safer healthcare environment for all patients and providers.

February 2016: Good Catch System Winner
North: Trina Crigler, PharmD
Patient had ibuprofen ordered 10mg/kg for a 6 year old. Patient weight was entered incorrectly at 64.5kg when the weight was actually 64.5lb (30.5kg). The pharmacist noticed the dose was very large for a 6 year old. The pharmacist called the ED to re-weigh the patient, and the correct weight was entered. A new dose was calculated and given.

GREAT CATCH!

Awesome Reporting! Good Catch System Winners receive a gift certificate to BoneFish Grill.
Remember to report any “Good Catch,” and you could catch dinner too!!!

February 2016

Adverse Drug Event Report
Total Medication Errors: 149
Medication Errors with Harm: 3
Adverse Drug Events Reported: 62

References:

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