SAVING AN EXTRA DOSE
Not worth the risk

A prescriber ordered metoclopramide liquid (Reglan), 5 mg/5 mL, for a child with nausea. The pharmacy sent a unit-dose cup containing 10 mg/10 mL of the medication. After administering the correct oral dose, the nurse saved the extra 5 mL in a parenteral syringe in case another dose was ordered. She applied the original pharmacy label, which listed the dose as 5 mg/5 mL.

A pharmacy technician on rounds discovered the syringe and returned it to the pharmacy for disposal. Had the oral drug in the parenteral syringe not been discarded and another dose prescribed, a different nurse might have mistakenly administered the medication parenterally.

The pharmacy should dispense exact doses of oral liquids and provide them only in labeled oral syringes. If you have leftover medication, return it to pharmacy or discard it according to facility policy.

EARDROP MEDICATIONS
The eyes have it

Eardrops (most commonly, cerumenolytics used to remove earwax) are sometimes mistakenly administered into the eyes. According to the Veterans Affairs (VA) patient-information-system database, one-third of VA facilities have documented cases of eardrops being placed in patients’ eyes:

- 68%, staff administered ear medications into patients’ eyes.
- 11%, patients administered ear medications into their own eyes.
- 19%, erroneous instructions from pharmacy.
- 2%, prescribers ordered eardrops for instillation into the eyes.

Factors contributing to these events included storing eardrops and eyedrops side by side in the pharmacy, leading to the wrong vial being dispensed; instructions for use reading as “optic” rather than “otic”, and instructions indicating drops to treat the affected eye rather than the ear.

Ironically, in a VA unit for blind patients, the incidence of placing eardrops in the eyes was rare. The staff agreed that this may be because the patients receive multiple eye medications and attentive review of labels on these medications is routine.

These safeguards help reduce the risk of placing eardrops in eyes:

- pharmacy placing auxiliary labels on dropper bottles to specify “eardrops” or “eyedrops”
- scanning bar codes on the vials if this technology is available
- keeping medications in their original cartons, which commonly show an eye or ear icon
- providing eardrops in snap-top pharmaceutical boxes or distinctive vials with ear symbols
- confirming the medication with the patient before administration of eardrops or eyedrops
- administering once-daily eye-drops and eardrops on different schedules, if possible
- using less caustic substances such as water and saline to remove earwax.

NAME CONFUSION
Soundalike neuro drugs

Azilect is a trade name for rasagiline, a monoamine oxidase inhibitor used to treat Parkinson’s disease. Available in 0.5 mg and 1 mg tablets, it’s commonly prescribed in daily doses of 0.5 mg or 1 mg. Another drug, Aricept (donepezil), is available in 5 mg and 10 mg tablets and prescribed as 5 mg or 10 mg daily doses to treat Alzheimer’s dementia. Both drugs are commonly prescribed by neurologists.

The fact that handwritten orders for Azilect and Aricept can look alike, the drug names can sound alike, and both medications can be given once daily, raises the risk of confusion. Make sure you understand your patient’s medical history and the reason any drug has been prescribed.

The reports described in Medication Errors were received through the USP-ISMP Medication Errors Reporting Program. Report errors, close calls, or hazardous conditions to the Institute for Safe Medication Practices (ISMP) at http://www.ismp.org or the United States Pharmacopeia (USP) at http://www.usp.org. You can also call ISMP at 1-800-FAIL SAFE or send an e-mail message to ismpinfo@ismp.org.