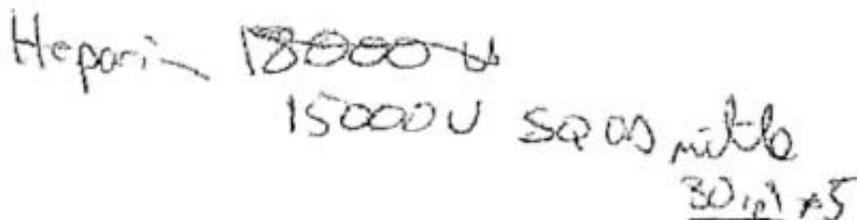


## ALERT: Medication Mix-up with a Faxed Prescription

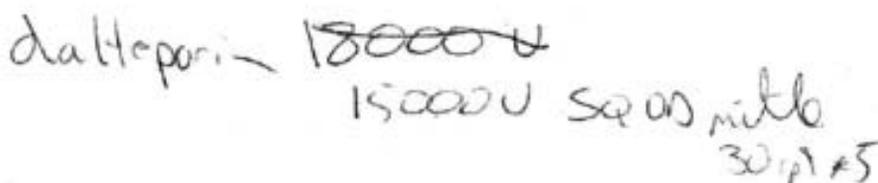
A prescription for a patient who had been discharged from hospital was received by fax at a community pharmacy (Figure 1).



A handwritten prescription on a white background. The word 'Heparin' is written in cursive. To its right, '18000U' is written and crossed out with a horizontal line. Below this, '15000U SQ OS' is written in cursive. To the right of 'SQ OS' is 'mitb' and below that is '30ip1 x5'.

**Figure 1:** Prescription for anticoagulant as *received* by fax at a community pharmacy.

Heparin was dispensed, and the patient received 2 doses. When the hospital sent a request to the pharmacy to provide syringes and alcohol swabs for the duration of the “dalteparin” therapy, the community pharmacy recognized that an error had occurred. Further investigation revealed that the hospital had in fact sent a prescription for “dalteparin 15 000 U” (see Figure 2), but during fax transmission, the first 2 letters of the drug name, “da”, were cut off, which resulted in the appearance shown in Figure 1. The hospital’s fax transmission log indicated that the fax had been sent correctly, giving no indication of any problem.



A handwritten prescription on a white background. The word 'dalteparin' is written in cursive. To its right, '18000U' is written and crossed out with a horizontal line. Below this, '15000U SQ OS' is written in cursive. To the right of 'SQ OS' is 'mitb' and below that is '30ip1 x5'.

**Figure 2:** Prescription for anticoagulant as *sent* by the hospital.

The following are some recommendations to help minimize transmission errors when prescriptions are sent electronically (e.g., by fax):

- Educate all users about potential errors that can occur with faxes, scanners, and other technology and how to identify such errors.<sup>1</sup>
- Review all transmitted prescriptions for quality issues (e.g., truncation of a prescription header, extraneous marks in the prescription area), in addition to legibility of the prescription itself.<sup>2</sup> In this case, the names of the prescriber and of the hospital, which appeared in the upper left-hand corner of the original prescription, were cut off during receipt of the faxed prescription.
- When sending a prescription by electronic means, ensure the presence of suitable margins, and avoid writing in the margin or borders of prescriptions.<sup>3</sup>
- Whenever possible, include both the generic and brand names of the intended medication, to provide an additional opportunity for verification. For example, integrate this information into computerized prescribing systems.

- Avoid using dangerous abbreviations (e.g., U for units).<sup>1,4</sup>
- If using a fax machine or scanner, ensure that only original prescriptions are transmitted or scanned; do not transmit NCR (i.e., no-carbon-required) copies of prescriptions.<sup>5</sup>
- Implement a process to establish when a prescription has been scanned (e.g., use a “Faxed” stamp, with time and date of transmission).<sup>5</sup>
- Schedule regular maintenance and cleaning of fax machines and other equipment to ensure optimal transmission of medication-related information.<sup>1,3,5</sup>
- Engage and educate patients throughout the medication-use process, especially at transition points (e.g., discharge). Provide patients with a list of their medications, including dose, frequency, and other information. Patients can and do identify discrepancies and errors and are in an ideal position to improve the safe use of their medications.<sup>6</sup>
- Whenever possible, provide patients with a copy of any electronically transmitted prescriptions (clearly distinguished from the original) to give to the community pharmacist, as an additional opportunity for verification during dispensing.
- As another way of identifying potential errors, always consider the appropriateness of various aspects of the prescription in relation to the specified drug dosing (e.g., dose, frequency, route, indication). In the case described above, for example, unfractionated heparin for subcutaneous administration is to be given every 8 or 12 hours.<sup>7</sup>

Refer to references on page 3.

### Beware of Mix-ups Between CycloSPORINE and Cyclophosphamide

SafeMedicationUse.ca has received a report from a consumer who identified a potentially harmful mix-up between cycloSPORINE and cyclophosphamide. The consumer was discharged from hospital with a prescription for cyclophosphamide for the treatment of an autoimmune disease, but cycloSPORINE was dispensed in error by a community pharmacy. Fortunately, the consumer recognized the mistake and did not take the cycloSPORINE. It appears that thorough education about new medications before discharge from hospital was a factor in allowing the consumer to identify this incident.<sup>1</sup> The full SafeMedicationUse.ca newsletter is available from [http://www.safemedicationuse.ca/newsletter/downloads/ISMPC\\_2012\\_05\\_similarNames.pdf](http://www.safemedicationuse.ca/newsletter/downloads/ISMPC_2012_05_similarNames.pdf)

A previous mix-up between cycloSPORINE and cyclophosphamide was described by the Institute for Safe Medication Practices in the United States.<sup>2</sup>

In 2010, a Canada-wide survey of oncology practitioners was conducted as part of a joint initiative on TALLman lettering of drugs used in oncology. As a result of the survey, cycloSPORINE and cyclophosphamide were recognized as a drug name pair with the potential to cause harm.<sup>3</sup> CycloSPORINE is now included on the list of TALLman lettering for look-alike/sound-alike drug names in oncology developed and recommended by ISMP Canada and the Canadian Association of Provincial Cancer Agencies. Use of TALLman lettering (for example, within pharmacy information systems and on storage bins within pharmacies, including community pharmacies) could help to prevent incidents due to drug name mix-ups.

This near-miss report also highlights the role that consumers can play in preventing harmful medication incidents. Healthcare practitioners are reminded of the importance of providing patients with the necessary information and education to support this role.

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ISMP Canada is a national voluntary medication incident and ‘near miss’ reporting program founded for the purpose of sharing the learning experiences from medication errors. Implementation of preventative strategies and system safeguards to decrease the risk for error-induced injury and thereby promote medication safety in healthcare is our collaborative goal.

**Medication Incidents (including near misses) can be reported to ISMP Canada:**

**(i) through the website: [http://www.ismp-canada.org/err\\_report.htm](http://www.ismp-canada.org/err_report.htm) or (ii) by phone: 416-733-3131 or toll free: 1-866-544-7672.**

ISMP Canada can also be contacted by e-mail: [cmirps@ismp-canada.org](mailto:cmirps@ismp-canada.org). ISMP Canada guarantees confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications.

***A Key Partner in the Canadian Medication Incident Reporting and Prevention System***