Covers Still Being Applied Without the cloNIDine Patch

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ISMP and the U.S. Food and Drug Administration continue to receive error reports about patients and caregivers who apply only the adhesive cover to the skin, without the intended clo**NID**ine medication patch. The error has contributed to uncontrolled blood pressure.

The clo**NID**ine transdermal system (**CATAPRES-TTS**) is packaged in a carton containing individually labeled pouches of 4 clo**NID**ine patches and 4 adhesive covers (**Figure 1**).

ISMP published a safety brief about a healthcare provider who applied only the adhesive cover to a patient for several weeks (ISMP, 2011). The adhesive cover is larger than the clo**NID**ine patch, which makes it difficult to confirm that the patch is underneath. Also, though the individual pouches are labeled, the patches themselves are not labeled with the drug name, and the adhesive cover does not state that it does not contain any medication.

Application of the adhesive cover is optional; it does not contain any drug and should be applied directly over the cloNIDine patch only if the patch begins to separate from the skin.

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Please consider the following talking points to help patients and caregivers learn about the appropriate use of the clo**NID**ine transdermal system:

- The clo**NID**ine transdermal system is packaged in a carton that contains both clo**NID**ine patches and adhesive covers.
- The adhesive cover does **<u>not</u>** contain any medication.
- Only apply the adhesive cover if the clo**NID**ine patch begins to loosen from the skin after application during the 7-day period; if used, place the adhesive cover directly over the patch.
- Read the *Patient Instructions*, found in the carton, before using the clo**NID**ine transdermal system.

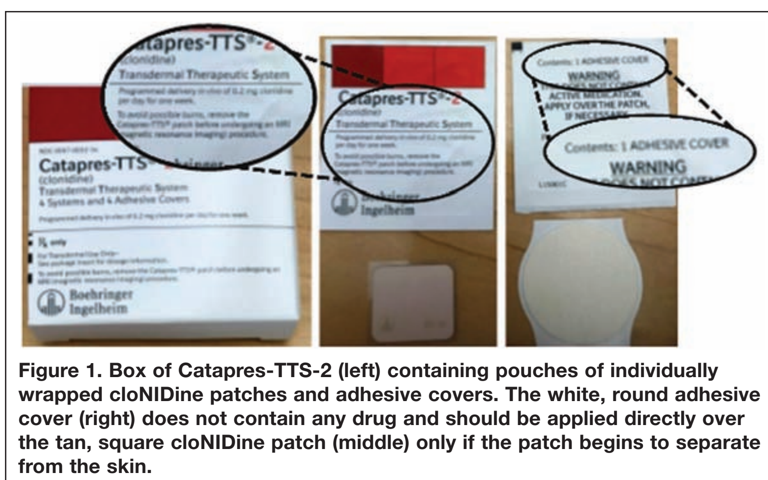

Figure 1. Box of Catapres-TTS-2 (left) containing pouches of individually wrapped cloNIDine patches and adhesive covers. The white, round adhesive cover (right) does not contain any drug and should be applied directly over the tan, square cloNIDine patch (middle) only if the patch begins to separate from the skin.

This Oral Syringe Is Not Like the Others

The oral syringes (or pipettes) packaged with risperi**DONE** oral solutions are uniquely labeled and may cause confusion for patients. Unlike the oral syringes most practitioners are familiar with, the barrels of risperi**DONE** oral syringes do not contain any markings. Instead, the markings appear on the plunger (**Figure 2**). To measure a dose, patients pull back the plunger until their dose marking aligns with the flange of the barrel. Even though these dosing devices are different from the oral syringes normally seen, the package inserts for these products do not provide detailed, clearly illustrated instructions on how to read the graduations when measuring a dose. We learned of a patient who may have received an excessive dose of risperi**DONE** due to the different labeling of these devices. When dispensing risperi**DONE**

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Patients should be discouraged from reusing old medication vials to prepare their daily medications or to contain anything different than what the vial label indicates.

oral solution, be sure to educate patients on how to use the dosing device and accurately measure the intended dose. This will require opening the carton with the patient at the point-of-sale or counseling area. Use a teach-back method to verify the patient can accurately measure the prescribed dose.

Overdoses Related to "Pill Dumping" Into a Spare Medication Vial

Pharmacists from the Maryland Poison Center published several cases of what they refer to as "pill dumping" where patients use a spare medication vial to hold multiple medications taken from different labeled prescription vials (Leonard & Klein-Schwartz, 2019). For example, "pill dumpers" may store all their morning or evening medications in a spare medication vial to make it easier to take all their medications at once. However, sometimes they mistake a look-alike prescription vial for the "pill dumping" vial and swallow any remaining contents in the prescription vial.

Figure 2. The dosing devices packaged with risperiDONE oral solutions may contribute to dosing errors because the measurement graduations are on the plunger unlike most oral syringes that have the graduations on the syringe barrel.

Looking at the data, the Maryland team identified 88 patients who "pill dumped." Although all exposures happened in the home, these patients were already in or had been referred to a healthcare facility at the time of the call. Most wound up in the emergency department or critical care unit. One patient died when he accidentally swallowed pills remaining in a prescription vial containing oral colchicine. We have also observed patients who use a spare vial to hold multiple different medications instead of taking all the individual prescription vials with them when traveling. Patients should be discouraged from reusing old medication vials to prepare their daily medications or to contain anything different than what the vial label indicates. Also, according to the authors, pill boxes or pill organizers might reduce the occurrence of "pill dumping."

Please, Please, Open the Bag!

Patients continue, at the point-of-sale, to receive medications intended for a different patient. Just recently ISMP received another report of this type of error. A parent of a 16-year-old picked up what was supposed to be the child's prescription for the antibiotic minocycline. The next month, when looking at the bottle to order a refill of the medication, the mother realized the pharmacy label listed a different patient's name and drug. **XARELTO** (rivaroxaban), a direct oral anticoagulant, was printed on the label. No injury had been noted at the time of the report, but the risk of bleeding from taking Xarelto for a month is certainly significant.

One of the most effective ways to prevent this error is to open the bag of filled prescriptions at the point-of-sale and verify with the patient that the medications are correct and for the right patient. Always ask the patient to provide at least two patient identifiers—their full name and full date of birth—when picking up prescriptions. Talking with the patient about their medications can further reduce the risk of errors. ■

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