

# Acute Care

# ISMP Medication Safety Alert!®

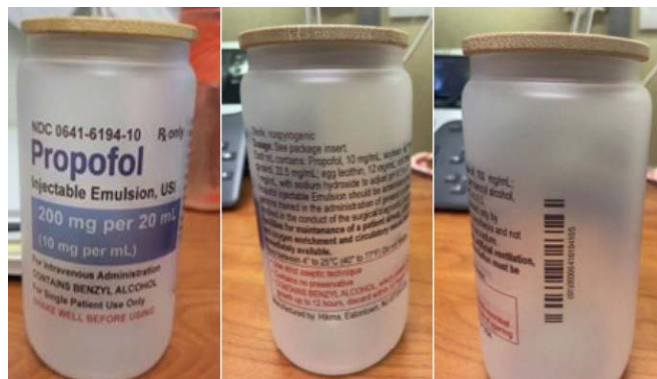
Educating the Healthcare Community About Safe Medication Practices

## Be wary of controlled and non-controlled medication replicas sold online



**PROBLEM:** A pharmacy technician was shopping online and purchased a plastic drinking cup that resembled a propofol vial (**Figure 1**). She brought the cup into the pharmacy to use as a decoration. The pharmacy director was concerned to see this type of product, so took a closer look. It turns out, the label included a national drug code (NDC) and barcode. The pharmacy director then attempted to scan the barcode into an electronic health record (EHR) and, shockingly, found that it actually scanned and documented propofol!

We found that several similar products are available for purchase on the Etsy and Amazon websites, including drinkware designed to look like controlled substance medication vials such as fenta**NYL**, **HYDRO**morphine, ketamine, **LOR**-azepam, and midazolam. There were ornaments, candles, and even sippy cups (**Figure 2** and **Figure 3** [page 2]). While some items appear to be crafts using copies of drug labels, the ornaments appear to be made from actual medication vials, or nearly identical replicas. In fact, one propofol ornament even has a plastic hanger attached!



**Figure 1.** A water bottle designed to look like a propofol vial includes the proper national drug code (NDC) and a scannable barcode on the label.



**Figure 2.** Medication vials or replicas made into ornaments (left), candles (middle), and drinking cups (right).

Not only do these replica products look like the real drug, but it is alarming when practitioners can scan the barcode on a drinking cup and document the administration of a medication on the medication administration record (MAR). With controlled substances, this could also be a potential diversion issue. For example, a practitioner could scan the barcode on a replica product (e.g., a drinking cup stored in the patient care unit) to falsely document in the MAR that a medication had been scanned and administered to a patient, and then keep the drug for personal use or distribution.

Rarely do you see something promote the “drug culture” as this does. In fact, it is rather disturbing

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## SAFETY briefs



### No, not three lidocaine patches at a time!

A prescriber ordered a lidocaine 5% patch for an elderly patient with instructions to “apply 1 patch daily, for 12 hours on and then remove for 12 hours.” However, the patient applied three patches daily instead. Rather than following the instructions on the prescription label, the patient followed the “usual dosage” information on the outer package, which states “Apply up to 3 patches. See package insert for complete prescribing information.” While the manufacturer was not reported, there are several lidocaine patch products that have similar statements on the label (**Figure 1**, page 2). The organization did not report if there was any patient harm. However, excessive dosing or prolonged exposure to lidocaine patches may lead to

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## IMPORTANT! Read and utilize the Acute Care Action Agenda

One of the most important ways to prevent medication errors is to learn about problems that have occurred in other organizations and to use that information to prevent similar problems at your practice site. To promote such a process, selected items from the **October – December 2023** issues of the **ISMP Medication Safety Alert! Acute Care** newsletter have been prepared for use by an interdisciplinary committee or with frontline staff to stimulate discussion and action to reduce the risk of medication errors. Each item includes a brief description of the medication safety problem, a few recommendations to reduce the risk of errors, and the issue number to locate additional information.

The **Action Agenda** is available for download as an Excel file ([www.ismp.org/node/118962](http://www.ismp.org/node/118962)). **Continuing education** credit is available for nurses at: [www.ismp.org/nursing-ce](http://www.ismp.org/nursing-ce).

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how these products seem to be making light of the dangers of these drugs.

### Mix-ups with promotional or demonstration (demo) products

We have previously shared that manufacturers sometimes promote medications with items that look like the drug product itself but serve another purpose, which creates a potential for errors. For example, we have several reports of confusion between supposed medical products that were actually promotional materials, including candies and body lotions. One case (February 9, 2006 newsletter) involved a dermatologist who gave a patient what he thought was a sample tube of a company's ointment, but it was a magic marker that looked like the ointment container. A young woman then applied the "ointment" (actually purple ink) all over her face for treatment of facial contact dermatitis/eczema. She was seen later in an emergency department to treat a local reaction to the ink. In another case, when **GLIADEL** (carmustine implant) was first marketed, we received complaints about a marketing campaign in which chocolate candy was packaged to look like the real Gliadel wafer, which is implanted intracranially to treat malignant glioma.



Figure 3. A sippy cup imitating a propofol vial.

Errors involving demonstration (demo) products have also been reported. For example, in 2015, ISMP ([www.ismp.org/node/552](http://www.ismp.org/node/552)) and the US Food and Drug Administration (FDA) alerted healthcare professionals not to use Wallcur simulated (demo) intravenous (IV) products in human or animal patients. More than 40 patients received these nonsterile products that were distributed to medical clinics, surgical centers, and urgent care facilities intended for medical training purposes only. Some patients developed chills and/or sepsis. One patient died.

Given that patients and healthcare practitioners could be confused by online merchandise that looks like real medications, these types of products should not be permitted in healthcare organizations.

**SAFE PRACTICE RECOMMENDATIONS:** We have notified the US Food and Drug Administration (FDA) of this issue and recommend that non-drug products should not be allowed to have active NDCs and scannable barcodes. Organizations should be aware of the potential for drug diversion and the risk of patient harm if these products are mistaken or scanned surreptitiously in place of real drugs. Please consider the following recommendations.

**Set expectations.** Prohibit merchandise products that resemble actual medications (especially those with NDCs and barcodes) from being brought into or stored in the pharmacy or on patient care units. Review recommendations in our previous newsletter, *Managing visits from pharmaceutical sales representatives* ([www.ismp.org/node/860](http://www.ismp.org/node/860)), to ban these types of products from being brought into the organization and distributed to staff.

**Do not reuse drug vials.** Used or unused medication vials should never be removed from organizations for the purpose of using them as crafts or to be sold as merchandise.

**Educate staff.** Help staff understand the risk of purchasing these products online and bringing them to work. Discourage staff from making or selling these products outside of work. As healthcare practitioners knowledgeable about the risks, we should not be promoting or making light of the use of controlled substances in this manner.

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lidocaine toxicity, with dose-related adverse effects such as central nervous system excitation and/or depression, as well as bradycardia, hypotension, and cardiovascular collapse.



Figure 1. Example of a lidocaine patch with "DOSAGE" instructions that state, "Apply up to 3 patches. See package insert for complete prescribing information."

The lidocaine 5% strength is available only by prescription; therefore, patients should refer to the specific instructions on the pharmacy prescription label rather than the product's outer package. We have notified the US Food and Drug Administration (FDA) about this concern and recommended removing the dosage instructions from the outer package label. If your organization or pharmacy purchases this product, use the teach-back method to educate patients about their prescribed dosage, which may differ from the instructions on the outer package labeling.

**Incomplete verbal order leads to wrong dose.** An intensive care unit patient required conscious sedation. An intensivist asked a nurse to administer "one and twenty-five" of midazolam and fenta**NYL**, intending to order 1 mg of midazolam and 25 mcg of fenta**NYL** for the patient. The nurse reported that she had administered 100 mcg of fenta**NYL**, perhaps thinking "one" signified one hundred mcg of fenta**NYL**. The patient was monitored and did not require additional intervention. In the error report, the physician stated that "one and twenty-five" is common

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**Educate patients.** If patients bring in replica drug products, inform them that your organization does not allow the use of these products due to the concern of mix-ups with real medications.

**Reinforce.** Consider incorporating this issue into the checklist when pharmacists and pharmacy technicians perform monthly unit inspections. Share concerns with nurse managers, physician leadership, Pharmacy & Therapeutics committee, and supply staff. If replica drug products are found, coach staff about the risks and the organization's policies.

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nomenclature used within the organization when referring to "1 of midaz and 25 of fenta**NYL**." This cultural assumption, acceptance of an incomplete verbal order, and lack of read back contributed to the misinterpretation of the order and administration of an incorrect dose.

Educate practitioners to never accept these types of verbal orders and explain the danger of this at-risk behavior. At-risk behaviors are behavioral choices that are made when individuals have lost the perception of risk associated with the choice or mistakenly believe the risk to be insignificant or justified. Teach practitioners who give and receive verbal orders about the need for a complete order (i.e., full drug name, dose, unit of measure, route), and to perform (or expect) a read back of the verbal order to the prescriber for verification to ensure that what was heard and transcribed is correct. Do not use or accept drug name abbreviations or unnecessary jargon that can easily be misunderstood. Identify any barriers (e.g., cultural norms, intimidation, staff competency) discouraging staff from speaking up when receiving unclear orders.

## Just Culture Scholarship recipient and runners-up announced

▶ ISMP has awarded the 2024 **Judy Smetzer Just Culture Champion Scholarship** to a team from **Great River Health**, a regional healthcare system with three hospital campuses and more than 40 ambulatory clinics serving residents of southeast Iowa, west-central Illinois, and northeast Missouri. The scholarships, which are being offered in cooperation with The Just Culture Company, include enrollment in a certification course that helps healthcare practitioners work to advance fair accountability and system improvement.

Great River Health has demonstrated full organizational commitment to building an infrastructure that can support the tenets of a Just Culture and move them toward greater reliability and safety. One example is the establishment of tiered safety huddles to improve patient safety, communication, and collaboration among all departments.

Huddles have encouraged safety event reporting at Great River Health as well as advanced staff participation in process improvement initiatives. This increased reporting has most notably helped reduce medication events resulting in patient harm and preventable patient falls while showing steady increases in staff-reported safety concerns, close calls, and great catches.

With high reliability as an end goal, they also have completed or have in process more than 20 interdisciplinary Lean projects in response to hazards and issues that deter organizational reliability and safety. The Quality Improvement Teams that lead those projects help to resolve barriers and concerns and reach key performance indicators.

The recipient was selected from a large pool of qualified teams looking to become stronger champions of the model in their organizations. Teams were judged on leadership and infrastructure, interdisciplinary collaboration efforts, dedication to broaden staff education on the tenets of a Just Culture, and potential to impact culture throughout their organization.

This year for the first time two runner-up teams also were chosen in recognition of their outstanding applications and will receive free tuition for The Just Culture Company's *Just Culture Conduct Course for Healthcare Managers and Influencers* and a 50% discount on the certification course. The 2024 runner-up teams were **St. Luke's Hospital** in Kansas City, MO, and **UCI Health Medical Center** in Orange, CA.

For more about the scholarship benefits, candidate requirements, and application process, visit: [www.ismp.org/node/30840](http://www.ismp.org/node/30840).

## Special Announcements

### IV medication webinar

Join us on **February 6, 2024** for a **FREE** webinar entitled **Improving Safety, Efficiencies, and Reducing Waste with Ready-to-Administer IV Medications: A Roadmap to Success**. Please visit: [www.ismp.org/node/108857](http://www.ismp.org/node/108857).

### Virtual MSI workshop

Join us for our first **ISMP Medication Safety Intensive (MSI)** workshop in 2024. The unique 2-day virtual program will be held **March 7 and 8, 2024**. Please visit: [www.ismp.org/node/127](http://www.ismp.org/node/127).

To subscribe: [www.ismp.org/node/10](http://www.ismp.org/node/10)



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