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ISMP Institute for Safe Medication Practices
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ISMP Medication Safety Alert!®
Educating the Healthcare Community About Safe Medication Practices

Fixing the cracks—Good catch programs strengthen the safety foundation

Problem: Imagine a building with hairline fractures in its foundation. These cracks, though seemingly insignificant, represent underlying weaknesses that, if ignored, can lead to significant structural problems. If a building inspector overlooks a minor fracture, the underlying issue can worsen, leading to a major structural failure. Similarly, in healthcare, medication errors caught before they reach the patient can serve as warning signs. The problem? Often, these close calls (i.e., near misses, good catches) that do not reach the patient go unreported, just like those ignored cracks. Why the silence? Perhaps a "no harm, no foul" mindset exists, the reporting system is cumbersome, fear of repercussions looms, or the perception exists that leadership does not value these insights. This underreporting prevents us from learning from these close calls and reinforcing our systems, and may increase the risk of errors reaching patients, patient harm, or death.

Reasons Close Calls May Go Unreported

Several factors can hinder the reporting process. First, some practitioners may think that since the error did not reach the patient, it is not worth reporting and the practitioners will quickly move on to their next task. Some may think that correcting an error is just a routine part of their job.

Second, a lack of clear reporting channels and procedures can deter staff. The question becomes, "To whom should this information go? Is there a straightforward process?" This is akin to not knowing who to call when you spot a crack; is it the landlord, the building manager, or someone else? A lack of understanding about what constitutes a reportable close call or the proper method for documentation can contribute to underreporting. Given demanding workloads and staffing challenges, the prospect of completing yet another report can feel burdensome.

Third, fear of repercussions can significantly discourage transparency. Understandably, individuals may hesitate to highlight potential problems if they fear punitive action. Nobody wants to be blamed for the cracks, especially if they were only the ones who noticed them!

Finally, if leadership does not actively foster a culture of safety and respond to reports, the perception may arise that leadership does not value the reports, like leadership dismissing the cracks with a casual "They're fine, don't worry about it."

Good Catch Reported to ISMP

In a case discussed in our August 2020 article, Pharmacist Makes a Good Catch and Prompts System Improvement, a physician prescribed olopatadine (**PATADAY**) 0.2% ophthalmic solution with instructions to instill one drop into each eye twice daily. However, the approved administration frequency for the 0.2% solution is once daily. There is an olopatadine 0.1% ophthalmic solution for which the approved administration frequency is twice daily. Olopatadine ophthalmic solution is used to relieve ocular itching and redness associated allergic conjunctivitis. Noticing the mismatch between the ordered product concentration and frequency of administration, the pharmacist contacted the physician's office. The prescriber clarified the prescription to the intended olopatadine 0.1% ophthalmic solution with instructions to instill one drop into each eye twice daily. The prescriber also noted that they would update resources in their computer system to help guide the proper dosing of these products.

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SAFETY briefs

HIGH-ALERT

Avoid mix-ups between immediate- and extended-release cloNIDine oral liquids. A pharmacist reported events where a community pharmacy improperly substituted the 100 mcg/mL **ONYDA XR** (clo**NID**ine) extended-release oral suspension for prescriptions that had previously been prepared using a 20 mcg/mL compounded immediate-release oral suspension. Onyda XR, approved in 2024, is a once-a-day formulation with nighttime dosing, for the treatment of attention-deficit/hyperactivity disorder (ADHD) in pediatric patients 6 years and older. The immediate-release tablet formulation (used to prepare the compounded oral suspension) is approved to treat hypertension (typically twice daily) and has been used off-label for a variety of indications, including ADHD. For ADHD, the immediate-release formulation is initially administered at bedtime, but practitioners may titrate the dose and frequency to the maximum daily weight-based dose. In addition, Azurity has announced the approval of **JAVADIN** (clo**NID**ine) (0.02 mg/mL [20 mcg/mL] immediate-release oral solution) for hypertension in adults.

According to the Onyda XR prescribing information, immediate-release clo**NID**ine hydrochloride, extended-release clo**NID**ine hydrochloride tablets, and Onyda XR have different pharmacokinetic characteristics. Therefore, practitioners should not substitute doses of these drugs on a mg-for-mg basis.

Build order sets/sentences in the electronic health record (EHR) with dose range checking to guide prescribers to select the correct option based on the indication. Consider applying auxiliary labels to the medication containers to warn against potential dosing confusion. Staff may also circle the product's concentration on the container label to draw attention to it. Make practitioners aware of the potential for errors due to the difference in concentrations among commercial and

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Safe Practice Recommendations: Real change in medication safety requires a strong, proactive safety culture. By actively seeking out and addressing potential problems before they escalate—like spotting and repairing those initial "cracks in the foundation"—and rewarding staff who identify these vulnerabilities, we create a system where errors become opportunities for growth. This commitment to early detection allows us to reinforce our defenses and ensure a healthcare system that is truly "built on solid ground" for our patients. Organizations should prioritize good catch programs to help identify and address safety concerns before they cause harm, strengthening the foundation for everyone involved in patient care. Consider the following recommendations when implementing a good catch program.

Create a policy. A well-defined policy is the cornerstone of any successful program. The policy should clearly define what constitutes a good catch, emphasize the importance of reporting, and outline how leadership will analyze good catches to identify trends and implement system-wide changes, promoting transparency and building trust among staff.

Make it easy to report. Reporting mechanisms should be exceedingly easy, readily accessible, and require minimal training. Instead of asking the reporter broad, general questions, the report should prompt for key identifying information and a free-text description of the event.

Encourage staff to speak up. Bringing positive attention to those who report potential safety concerns sends a powerful message about the organization's culture of safety. One approach is to share good catches during huddles or staff meetings. Share the situation that occurred and how it was caught, highlighting the learning points for others, to foster a culture of shared knowledge.

Provide recognition. For particularly impactful good catches, consider offering the individual a small token of appreciation. A small gift card to a local coffee shop or movie theater can go a long way. Even better, feature their story in the organizational newsletter or on the organization's internal communication platform, sharing the lessons learned with a wider audience. Some organizations provide staff with a traveling trophy or offer a meet and greet with executive leadership. Gather feedback from staff to determine what motivates them and makes them feel most appreciated.

Detect errors through other means. To generate a more complete picture of the safety of the medication-use process, organizations must collect and analyze data beyond that gathered through voluntary error reporting. Include errors detected and/or averted by automation (e.g., barcode scanning data, alerts generated in order entry and verification systems). While time consuming, you can learn a lot about process variation through observational studies of critical or complex parts of the process. Staff are often very willing to suggest at what points in the process they are feeling vulnerable; all you have to do is ask.

Educate practitioners. Incorporate training about the good catch program into orientation and annual competency assessments. Education should include clear instructions on how to report close calls through the organization's reporting system, along with real-life examples of good catches and their positive impact on patient safety. Explain that reports do not go "into a black hole" but follow a structured review pathway, including by leadership and interdisciplinary groups. Consider creating easily accessible resources, such as posters and infographics, outlining the steps for reporting and the benefits of participation.

Report close calls and errors. Encourage staff to report close calls and errors that reach patients not only to the organization's internal system but to ISMP as well.

Learn and improve. Establish a regular forum, such as safety huddles and/or a dedicated section in the organizational newsletter, to share impactful good catch stories and the resulting system improvements. This demonstrates the value of reporting and encourages continued participation in the program. The goal is to enhance awareness about how fixing those little "cracks" can prevent bigger issues down the road, ultimately creating a safer environment for patients and staff alike.

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compounded preparations, with attention given during the medication reconciliation process to ensure accurate doses are documented, prescribed, and dispensed. If patients are transitioned to Onyda XR from a different clo**NID**ine formulation, educate them about changes in dose, dose volume, frequency, and concentration.

HIGH-ALERT

Single-dose vials are for single doses only. A patient was prescribed **ZEPBOUND** (tirzepatide), a glucose-dependent insulinotropic polypeptide (GIP) receptor and glucagon-like peptide-1 (GLP-1) receptor agonist used for weight loss and maintenance. The medication is available in both single-dose prefilled pens and single-dose vials. The patient was prescribed a lower starting weekly dose than indicated in the product's prescribing information, a dose of 1.25 mg once weekly. However, Lilly, the manufacturer of Zepbound, does not market a vial or prefilled pen with only 1.25 mg of tirzepatide; the lowest dose/vial size available is 2.5 mg/0.5 mL. As a result, the patient received a Zepbound 2.5 mg/0.5 mL vial. Since the patient was using only half of the vial for a dose, a healthcare practitioner from LillyDirect, a direct-to-consumer telehealth and pharmacy program by Lilly, told the patient that they could "save the other half of the vial for future use." When concerns about the reuse of a single-dose vial were raised, the practitioner indicated that "all our nurses tell their patients to do this."

Reuse of a single-dose vial, even for the same patient, places patients at risk for serious infection as the vial does not contain preservatives. This practice should **NEVER** be done or taught. Single-dose or single-use vials should only be used for one dose for one patient. Similarly, all staff should understand that any form of syringe and/or needle reuse could compromise sterility and should be avoided, and that syringes cannot be reused even if the needle is changed. Education on safe injection practices should be required during orientation and at ongoing intervals, and staff competencies should be assessed regularly. Patients using injectable products should also be taught these key safety principles.

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Sharing a Safety Mission: The 28th ISMP Cheers Awards — celebrating the winners

ISMP recently celebrated the 28th annual **CHEERS AWARDS**, which recognize individuals, organizations, and groups that have demonstrated extraordinary commitment to advancing the science and study of patient safety. Please join us in celebrating the impressive accomplishments of this dedicated group, who have helped advance our shared safety mission.

CHEERS AWARDS Winners

AdventHealth, based in Altamonte Springs, Florida, received a **CHEERS AWARD** for its adoption of a comprehensive infusion pump management strategy across a large health system. They have continuously improved their processes, meeting national and organizational benchmarks and achieving an impressive 95% pump library compliance rate.

MiKaela Olsen, DNP, APRN-CNS, AOCNS, FAAN, Clinical Program Director-Oncology, Johns Hopkins Hospital and Johns Hopkins Health System, Baltimore, MD, and **AnnMarie Walton, PhD, MPH, RN, OCN, CHES, FAAN**, Dorothy L. Powell Term Chair of Nursing and Associate Professor, Duke University School of Nursing, Durham, NC, were honored for their leadership to improve the safe handling and administration of hazardous drugs for healthcare workers and caregivers. Among their many accomplishments, they co-edited the 4th edition of *Safe Handling of Hazardous Drugs* for the Oncology Nursing Society, a resource that is utilized by nurses all over the world. Drs. Olsen and Walton also each co-led the development of a Joint Position Statement on Safe Handling of Hazardous Drugs for the Oncology Nursing Society and Hematology/Oncology Pharmacy Association and have contributed to numerous other standards and guidelines.

LIFETIME ACHIEVEMENT AWARD Winner

One of the highlights of the evening was the presentation of the 2025 **MICHAEL R. COHEN LIFETIME ACHIEVEMENT AWARD**. This award is given in honor of ISMP Founder and President Emeritus Michael R. Cohen to individuals who have made ongoing contributions to patient safety throughout their careers. This year's honoree, **Martin J. Hatlie, JD**, is a pioneer who has advanced the role of patients and caregivers as essential partners in improving safety across the healthcare continuum. Hatlie has been active in the field for more than 25 years. He served as the Founding Executive Director of the National Patient Safety Foundation (NPSF), helping to establish patient safety as a recognized discipline in healthcare, and is the cofounder of Patients for Patient Safety US (PFPS US), the United States branch of the World Health Organization's Patients for Patient Safety international network.

In his acceptance remarks, Hatlie reflected on how patient stories helped launch the modern patient safety movement and credited ISMP for creating a national medication error reporting program for patients and families. He emphasized that learning from medication safety events, advocacy, and collaboration remain essential for future efforts to advance patient safety.

Thanks and Looking Forward

We would like to express our gratitude to all of the organizations and individuals who attended and/or supported this year's **CHEERS AWARDS**. Visit the Cheers Event webpage for a list of contributors and winners, and you can also make a Donation to help support ISMP's lifesaving efforts. We look forward to continuing to work together on preventing errors and keeping patients safe in 2026.

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ClomiPRAMINE dispensed instead of clomiPHENE, again. A patient received clomi**PRAMINE** (**ANAFRANIL**) 50 mg, a tricyclic antidepressant used to treat obsessive-compulsive disorder, instead of the prescribed clomi**PHENE** (**CLOMID**) 50 mg, an ovulation stimulator. At the time of the error, generic clomi**PHENE** tablets were back ordered and only the brand name Clomid was available. When making the switch to Clomid, the pharmacist picked the wrong medication (i.e., clomi**PRAMINE**). The pharmacy dispensing system provides an alert when a different medication has been selected during substitution; however, it is easy to overlook as the alert is not prominent, using the same font and color as the rest of the text on the computer screen.

ISMP has received multiple reports involving this look- and sound-alike name pair dating back to 2002. It is likely that name similarity contributed to this recent event. The fact that both products are available in 50 mg dosage strengths only increases the risk of error.

Prescribers should include the purpose of the drug on prescriptions. Differentiate these drug names (e.g., tall man [mixed case] letters with bolding and color backgrounds) on computer screens for e-prescribing and in the pharmacy computer system. Explore adding computer alerts to verify the indication for these drugs. Differentiate these medication names on storage shelves. Consider implementing mandatory counseling when dispensing medications of a known problematic name pair.

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Report medication and vaccine errors to ISMP: Please visit www.ismp.org/report-medication-error or call 1-800-FAIL-SAF(E). ISMP guarantees the confidentiality of information received and respects the reporters' wishes regarding the level of detail included in publications.

Editors: Michael J. Gaunt, PharmD; Shannon Bertagnoli, PharmD; Ann Shastay, MSN, RN, AOCN; Rita K. Jew, PharmD, MBA, BCPPS, FASHP. ISMP, 3959 Welsh Road, #364, Willow Grove, PA 19090. Email: ismpinfo@ismp.org; Tel: 215-947-7797.

Special Recognition...

Our 2025 Community/Ambulatory Clinical Advisory Board

Production of this peer-reviewed newsletter would not be possible without the assistance of a reliable and talented clinical advisory board. As 2025 nears an end, we want to thank each of the following members of the advisory board for their dedication to making this newsletter a valuable medication safety resource for clinicians.

2025 ISMP Medication Safety Alert! Community/Ambulatory Care Clinical Advisory Board

Happy Holidays from the staff, Board of Directors, and Advisory Boards at the Institute for Safe Medication Practices (ISMP).

We wish you joy, health, and happiness this holiday season!