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ISMP
An ECRI Affiliate

Community/Ambulatory Care
ISMP Medication Safety Alert!®
Educating the Healthcare Community About Safe Medication Practices

Personal practice changes practitioners would make after learning firsthand about medication errors at ISMP

Awareness about medication errors and their causes prompts change. One lesson we have clearly learned is that the most effective strategies to prevent medication errors often lie outside the direct control of individual practitioners, particularly strategies related to technology, the environment, and the design of systems and processes. But there still are many things individual practitioners can do in their own practice—changes in their behavioral choices when carrying out the tasks associated with medication use—to reduce the risk of a medication error.

During their experience at ISMP, students and fellows have seen firsthand the devastation that medication errors have wrought, and they know that medication errors could happen to them, too. We repeatedly hear that the experience at ISMP has changed their practice. ISMP staff and other practitioners associated with ISMP echo similar sentiments. In January 2022, we asked more than a dozen past and present ISMP fellows and staff to answer the following question: *After being at ISMP, if you returned (or have returned) to frontline patient care, what three things would you do (or have done) differently?* Described below are changes practitioners would make (or have made). We hope the insight from our past fellows and the current ISMP staff is an inspiration for change.

Make error reporting a priority. It is only through insightful information from those who have made errors that we learn about their underlying causes and strategies for prevention. Thus, reporting hazards, close calls, and other errors was a frequently cited priority for practitioners associated with ISMP. Some practitioners were very specific in their survey response, indicating that they would report more hazards and close calls, describe errors more fully in narrative reports, make it easier for staff to report errors internally, and follow-up more closely with the reporter. Many said they would actively seek feedback about reported errors or hazardous situations to spark change, as well as support colleagues who have made errors. Of course, practitioners would make (or have made) a commitment to report notable errors or potentially hazardous conditions externally to the ***ISMP National Medication Errors Reporting Program*** or the ***ECRI and the ISMP Patient Safety Organization*** (www.ismp.org/MERP).

More comprehensive event investigation. Many practitioners associated with ISMP would develop (or have developed) investigative depth behind why human errors, at-risk behaviors, and reckless behaviors occur, uncovering the deep system-based causes of events, or latent failures. These practitioners said they would try to steer clear of the common pitfalls when conducting an event investigation (www.ismp.org/node/803). For example, they would avoid making assumptions and instead investigate all questions or concerns, and they would routinely employ systems thinking, always searching for upstream factors that contributed to the event.

Share risks with colleagues. Practitioners who spent time at ISMP felt it was important to share known and suspected risks (hazards) with their colleagues to enhance awareness. For example, several pharmacists previously associated with ISMP had improved communication with prescribers upon returning to practice, noting they were

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SAFETY briefs

Poor fax quality leads to specialty pharmacy error. A specialty pharmacy received a new prescription for a somatropin pen injector for a current patient with growth hormone deficiency. The prescription had a lower dose than what had been dispensed previously, and the patient's parent was not aware of the dose reduction. While confirming the new dose, the pharmacist realized that the previous prescription was dispensed incorrectly. The previous prescription had been faxed to the pharmacy, but the quality of the fax was poor with significant fax noise. The intended dose of "0.6 mg" indicated in the Sig field had been misread and dispensed as 0.8 mg. Even the start date was entered incorrectly as 12/8 instead of 12/6. You can see in **Figure 1** how the numeral 6 in the Sig field and start date field looks like the numeral "8." The pharmacist called the provider to report the error, and the patient's parent was advised to follow up with the provider. Thankfully, the incorrect dose of 0.8 mg daily did not harm the patient as it still fell within an acceptable dose range based on the patient's weight.

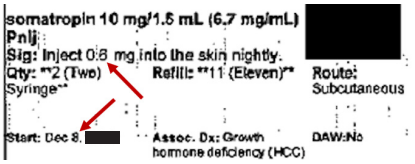

Figure 1. The numeral 6 in the Sig field and start date field (indicated by the red arrows) were misinterpreted as the numeral 8 due to the poor quality of the faxed prescription.

Fax noise, the random marks and streaks on faxes, is an inherent problem with this technology, and it may be more common in old or poorly maintained fax machines. ISMP has received many reports of errors related to the presence of extraneous lines, markings, or interference on prescriptions caused by old or poorly maintained equipment. Carefully review faxed

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no longer fearful about reaching out to prescribers to clarify unfamiliar or unusual orders. One practitioner pointed out that he often shares known or suspected risks with other practitioners in person, asking them if they were aware of the risk and if they have any ideas for improvement. Another practitioner noted that she had taken pictures of problematic packaging and sent them to internal colleagues as well as to ISMP.

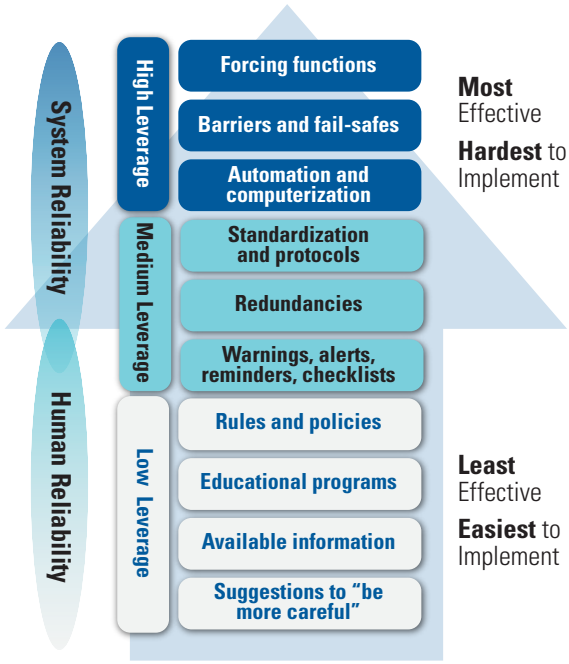
Conduct targeted education to staff and patients. After being at ISMP, several practitioners told us they would provide targeted education to new staff members, including students and residents, about critical medication safety initiatives, particularly surrounding the use and dispensing of high-alert medications. One practitioner said he would team with risk management to present targeted training programs based on past hazards, errors, and claims. Another practitioner, a pharmacist, would provide patient counseling more frequently; instead of asking patients whether they have any questions for the pharmacist, she would counsel all patients who pick up a new prescription.

Promote a Just Culture. Practitioners associated with ISMP expressed a sincere desire to work within a Just Culture. Recognizing the leadership-driven cultural transformation that must occur to truly implement and maintain a Just Culture, some practitioners provided unique examples of how they would pique (or have piqued) the interest of leadership to further explore what Just Culture could mean for their organizations and how it would help them achieve better outcomes:

- Hold discussions with leaders, human resource staff, and other influencers to reach the tipping point for executive commitment to a Just Culture
- Be far more aware of at-risk behaviors and workarounds, get managers and leaders to collaborate with frontline staff to better understand the reasons for at-risk behavioral choices, implement high-leverage system changes based on these collaborations, and coach at-risk behaviors before errors occur
- Teach managers what good system design looks like and how to help employees make safe behavioral choices

Fully utilize ISMP resources. Many practitioners associated with ISMP reported that they would utilize the ISMP newsletters as well as the ***Action Agenda*** more fully by bringing reports of errors that have occurred elsewhere to staff or safety meetings, discussing the likelihood of it happening at their practice site, identifying possible causes, and making suggestions for proactive risk-reduction and prevention. The survey respondents also mentioned utilizing the framework of the ISMP ***Key Elements of the Medication Use System*** (www.ismp.org/node/895; www.ismp.org/node/541) to identify the contributing factors and underlying causes of medication errors; and referencing the ***ISMP Hierarchy of Error-Reduction Strategies*** (**Figure 1**) (www.ismp.org/node/18343).

Figure 1. ***ISMP Hierarchy of Error-Reduction Strategies***



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prescriptions for fax noise. If the transmission has fax noise in the area of the prescribed medication and directions for use, call the prescriber to confirm the prescription. Check the faxed order against the original, if available. Maintain fax machines, scanners, and printers according to the manufacturers' recommendations to ensure clear prescription images. Schedule regular maintenance of both the sending and receiving fax machines. If maintenance fails to improve fax quality, the machine should be replaced. Notify the prescriber if it appears their equipment may be contributing to the poor fax quality and encourage them to electronically prescribe and transmit prescriptions in the future.

Paxlovid drug interactions. A physician prescribed **PAXLOVID** (nirmatrelvir and ritonavir) for a 34-year-old patient with flu-like symptoms who tested positive for coronavirus disease 2019 (COVID-19). On day three of treatment, the patient visited the prescribing physician and presented with fatigue and bradycardia, with a heart rate below 40 beats per minute. The physician referred the patient to the emergency department (ED) for further evaluation, where it was discovered that the patient had been taking ivabradine for premature ventricular contractions. Ivabradine is metabolized by the CYP3A4 enzyme, and the ritonavir component of Paxlovid is a strong cytochrome P450 (CYP) 3A4 inhibitor. Thus, concomitant use of Paxlovid and ivabradine is contraindicated due to the risk of ivabradine accumulation and toxicity, which could lead to bradycardia, hypotension, and heart failure. Increased plasma concentrations of ivabradine may also exacerbate bradycardia and conduction disturbances. Fortunately, the patient was monitored in the ED for 24 hours, recovered, and was discharged home.

The practitioner who reported this event to ISMP mentioned that the prescriber was not familiar with the patient's medical history. Paxlovid is not a drug that should be prescribed without reviewing the patient's current medication list for potential drug-drug interactions. Prescribers and pharmacists should test their computer systems to ensure they provide alerts for this and

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Pen injectors need pen needles!

Autoinjectors and pen injectors are commonly used for patient self-administration of medications. Autoinjectors, which already have an attached needle, provide a single medication dose for onetime use prior to disposal. Autoinjectors help some patients overcome the hesitation with injecting themselves. **EPIPEN** and **AUVI-Q** (both **EPINEPHR**ine), **TRULICITY** (dulaglutide), and **BYDUREON BCise** (exenatide) are examples of medications available in autoinjectors.

Unlike autoinjectors that already have a needle attached, pen injectors require patients to manually attach a pen needle, which is often sold separately. **HUMALOG KWIKPEN** (insulin lispro) and **FORTEO** (teriparatide) are examples of pen injectors that require purchase of separate pen needles. Some states require a prescription to obtain pen needles, which are available in multiple lengths and gauges. When pen needles need to be purchased separately, the US Food and Drug Administration (FDA) encourages manufacturers to include a statement, "Needles not included," on the carton (**Figure 1**). Please note that some pen injectors, including **OZEMPIC** (semaglutide), may come with an included supply of pen needles.

Figure 1. FDA recommends that manufacturers of pen injectors include the statement, "Needles not included," on the outside carton as a reminder to provide pen needles to the patient when the medication is being dispensed.

Both FDA and ISMP have received reports of missed medication doses and reuse of needles when the correct pen needles were not dispensed to patients prescribed a pen injector (www.ismp.org/node/31803). Most of these errors were attributed to not offering patients the required pen needles, dispensing the incorrect type of pen needles, unfamiliarity with the pen injector, and patients with an inadequate supply of the pen needles.

To help prevent errors associated with pen injectors, FDA recommends healthcare providers do the following:

- Check your state laws to determine if a prescription is required to dispense pen needles.
- Hospitals and physician practices should work with their electronic medical record vendor and/or information technology department to create order sets that include providing a prescription for pen needles when ordering medications in pen injectors.
- Prescribers and nurses should educate patients to pick up both the pen injector and pen needles from the pharmacy.
- Prescribers who provide samples of pen injectors should consider maintaining a supply of the correct pen needles to dispense with the samples.
- If there is no prescription for pen needles and/or it is unclear in the patient's pharmacy profile if they have received pen needles, enter a counseling note in the pharmacy computer system (or on the prescription receipt) to trigger patient education when the patient picks up the prescription. Ask the patient if they have an adequate supply of pen needles without reusing them.
- Use the teach-back method to educate patients regarding how to correctly use the pen injector, including setting up the device, using the pen needle (standard pen needle or safety pen needle; www.ismp.org/node/44), changing the needle for each injection, administering the medication, and disposing of the pen needle safely.
- Educate patients not to share pen injectors, even when the needle has been changed.
- Educate patients to never use the pen injector cartridge as a vial.

For providing this FDA Advise-ERR, ISMP thanks the FDA Division of Medication Assessment and Medication Errors Surveillance (DMAMES), Postmarket Medication Error Team (PMET): BarbraKaryne N. Nchinda Fobi, PharmD, MPH, CPPS, FISMP; Niloofar Rezvani, PharmD; and LCDR Zachary Oleszczuk, PharmD, MSPharm, BCGP.

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other drug-drug interactions. The US Food and Drug Administration's (FDA) ***Paxlovid Patient Eligibility Screening Checklist Tool for Prescribers*** (www.ismp.org/ext/921) can be used for screening but does not currently list ivabradine as a drug with potentially significant interactions.

Educate prescribers, pharmacy staff, and patients about the potential for Paxlovid drug-drug interactions. In addition to FDA's *Paxlovid Patient Eligibility Screening Checklist Tool for Prescribers*, other resources that practitioners can use to learn about Paxlovid drug-drug interactions include: *Management of Drug Interactions with Nirmatrelvir/Ritonavir (Paxlovid): Resources for Clinicians* (www.ismp.org/ext/915) from the Infectious Diseases Society of America; *COVID-19 Drug Interactions* (www.ismp.org/ext/916) from the University of Liverpool; and *Drug-Drug Interactions Between Ritonavir-Boosted Nirmatrelvir (Paxlovid) and Concomitant Medications* (www.ismp.org/ext/917) from the National Institutes of Health.

HIGH-ALERT

Eprontia oral solution concentration conversion. A new oral solution, **EPRONTIA** (topiramate), was recently approved for the treatment of certain seizure disorders in patients 2 years and older, and for the prevention of migraines in patients 12 years and older. The concentration of this new product is 25 mg/mL, which differs from commonly compounded concentrations prepared by pharmacy. The American Society of Health-System Pharmacists' (www.ismp.org/ext/922) Standardize 4 Safety initiative recommends 20 mg/mL as the standard concentration. However, some organizations also compound 6 mg/mL for smaller children to make doses easier to measure; the Michigan Pediatric Safety Collaboration (www.mipedscompounds.org) also recommends a compounded concentration of 6 mg/mL. We are concerned about the risk of errors as pharmacies transition patients to the new commercially available 25 mg/mL topiramate concentration. This is especially concerning for patients prescribed the 6 mg/mL concentration, as an error could lead to a significant overdose.

Organizations should establish a proactive plan to convert to the commercially avail-

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Worth repeating...

More patients have swallowed the desiccants in everolimus blister cards

In a **SAFETY brief** in the March 2022 issue of this newsletter, we alerted readers to patient confusion and accidental ingestion of the desiccant tablets that are packaged within blister cards holding everolimus tablets from Biocon Pharma. At the time, we published two cases. One that involved a patient who had ingested one desiccant tablet and the other in which a non-English speaking patient almost ingested a desiccant tablet but had reached out to the pharmacy before ingesting and avoided the error.

Everolimus is available in 2.5 mg, 5 mg, 7.5 mg, or 10 mg tablets. Each strength is packaged as a carton of four blister cards, and each blister card has seven blisters containing everolimus tablets and four blisters containing desiccant tablets. The desiccant blisters are labeled with "DESICCANT DO NOT EAT," but this warning is only printed on one side of the blister card; the other side contains no wording (**Figure 1**). Patients viewing the blank side of the blister may push a desiccant tablet through without realizing it. Although the desiccant tablets look different than the everolimus tablets, these can still be easily mistaken for medication-containing tablets.

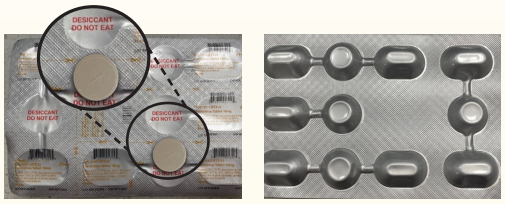

Figure 1. Front (left) and back (right) of everolimus 10 mg blister card, which holds seven medication tablets (oblong) and four desiccants (round). The desiccant removed from the blister looks like an oral tablet. The blister card is labeled on the front, but not on the back.

Since the publication of the **SAFETY brief**, we are now aware of a total of 13 reports related to this issue that have been submitted to ***ISMP National Medication Errors Reporting Program*** (ISMP MERP) and the US Food and Drug Administration (FDA) Adverse Event Reporting System (FAERS) since February 1, 2021. Two patients almost ingested the desiccant, including the patient mentioned above. The other 11 patients ingested the desiccant, often for several doses. In two cases, parents administered the desiccants to their children. One mother questioned whether her child's recent erythematous face was related to ingesting the desiccant after discovering she had administered the desiccant to her child at least six times. Another patient took all four desiccants in the blister pack and went to the emergency department for chest pain.

Although at least eight manufacturers provide everolimus tablets in blister packaging, all of the reports submitted to FDA and ISMP involve the product from Biocon Pharma, which is the only company that packages desiccants with the tablets in blister cards. The cases frequently involved elderly patients for whom poor vision may have contributed to the confusion. Furthermore, the font size and light tan color of the drug name and dose on the labeled side of the card are difficult to see on the foil blisters (**Figure 1**). Also, the everolimus product labeling and the information that accompanies the medication dispensed to patients provide NO information about the desiccants and what to do if they are swallowed.

Biocon Pharma told us that the desiccants in everolimus blisters are chemically inert, non-toxic, and non-hazardous. Also, the desiccant tablets are not absorbed or digested, and should pass through the body as is. Still, keep in mind that patients swallowing a desiccant tablet may miss a dose of their scheduled cancer or immunosuppressant medication.

Many practitioners will never open the Biocon Pharma everolimus carton to see the individual blister cards, so it is important to alert them to the blister card labeling issue so they are aware of the potential for patients to ingest the desiccant tablets. When educating patients, it is critical to let them know that these blister cards contain desiccants that might be mistaken as tablets. Consider opening the carton to show patients the blister cards. Patients should be warned to never swallow or eat a desiccant.

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able product, which should include identifying patients currently receiving an extemporaneous formulation of topiramate to ensure all active patients are converted to the new concentration in a defined period of time. Conversion charts should be prepared and checked, and the new strength and volume of each dose should be communicated to providers and patients/families before any prescription conversion. Eprontia doses should be prescribed in mg, not mL doses, and practitioners should clarify and discuss Eprontia doses based on the mg dose. Consider tagging prescriptions for Eprontia for mandatory patient education, especially if the patient previously was using a different concentration. Educate patients and/or caregivers about the new concentration, the corresponding volumetric dose, and how to measure each dose with an oral syringe.

Special Announcement

Virtual MSI workshops

Don't miss the opportunity to register for one of our unique 2-day, virtual ***ISMP Medication Safety Intensive (MSI)*** workshops being offered in 2022. Our next workshops are scheduled for **June 9 & 10, 2022** and **August 4 & 5, 2022**. For more dates in 2022 and to register, visit: www.ismp.org/node/127.

To subscribe: www.ismp.org/node/126

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

ISMP Medication Safety Alert!® ActionAgenda

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, the following selected agenda items have been prepared for you and your staff to stimulate discussion and collaborative action to reduce the risk of medication errors. These agenda topics appeared in the *ISMP Medication Safety Alert! Community/Ambulatory Care* between January 2022 and April 2022. Each item includes a brief description of the medication safety problem, recommendations to reduce the risk of errors, and the issue to locate additional information. The *Action Agenda* is also available for download in Excel and Word formats at: www.ismp.org/node/31927.

Key: ⚠ — ISMP high-alert medication

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
Practitioners should respond to errors with empathy and honesty					
02/22	When patients report pharmacy dispensing errors to ISMP, they are often more upset with the response, or lack of response, from pharmacy personnel versus the actual error. Too often pharmacy staff and managers (including corporate leaders) are leaving patients dissatisfied. For example, in a recent event, a patient reported that "I was given the wrong birth control. I called to let the pharmacist know and she argued with me that it was right, I KNEW it was not." Fear of litigation may cause healthcare practitioners to view the patient as an adversary or threat, which can alienate patients and stifle an opportunity to learn from the event.	Plan ahead and prepare staff to respond to victims of errors with transparency and empathy. Develop and regularly update procedures for handling medication errors. Policies on disclosure and apology to patients and caregivers are also a must. Be specific regarding what to do and say, what not to do or say, and who should be contacted when an error occurs. Practice and role-play possible scenarios using established procedures and guidelines. Assure the patient reporting a potential or actual error that it is important and a priority. Document the event and response. Establish a continuous quality improvement (CQI) program to detect and assess errors as a means to determine the causes, develop appropriate responses, and implement strategies to prevent future errors.			
Cardiovascular events associated with stopping and restarting cloZAPine					
01/22	An outpatient had not taken clo**ZAP**ine 500 mg daily for 2 weeks due to a prescribing delay. Upon hospitalization, she was restarted on clo**ZAP**ine 400 mg daily but was found pulseless after the first dose. A boxed warning describes the risk of severe cardiovascular events during the initial titration period. A similar risk exists when the drug is stopped and restarted after 2 days or more, but this is not effectively communicated to practitioners.	When restarting clo**ZAP**ine after a break in therapy of 2 days or longer, begin at a dose of 12.5 mg once or twice daily. Educate providers about the potential for adverse cardiovascular events, especially during initial dose titration and re-initiation of therapy. Confirm the patient's dose and date of the last administration prior to prescribing and/or dispensing therapy. Investigate options to develop clinical decision support to help ensure practitioners check the date and time of the patient's last dose and to restart therapy according to manufacturer guidelines.			

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
Top 5 medication errors and hazards from 2021					
01/22	The top 5 safety concerns in our 2021 newsletters included three associated with the coronavirus disease 2019 (COVID-19) vaccines (i.e., preparation errors; mix-ups between adult and pediatric formulations, and mix-ups with flu vaccines); responding to consumers' error concerns; and the need to increase error reporting.	These safety concerns warrant your attention and priority in 2022 given the serious consequences of an error. Review the list of errors and hazards in detail and implement the recommended actions to mitigate these risks. Include strategies to prevent similar errors in your 2022 strategic medication safety improvement plan.			
Barcode scan to prevent errors with look-alike packaging					
04/22 ⚠	A patient was supposed to receive lamo**TRI**gine extended-release 200 mg tablets. However, she received a mix of manufacturer bottles of lamo**TRI**gine extended-release 200 mg tablets and lamo**TRI**gine extended-release 300 mg tablets. The bottles look similar and the drug strength is printed to the right of the drug name, around the curve of the bottle.	Utilize barcode scanning during production and scan each bottle used to fill a prescription, including each manufacturer bottle that may be dispensed to a patient. At the point-of-sale, open the bag and have the patient check what has been dispensed to make sure it is correct.			
Do not use nonspecific PRN (as needed) frequencies for medication administration					
02/22	Nonspecific frequencies such as BID PRN, TID PRN, and QID PRN do not provide clear directions regarding the time interval between doses. They lead to variability in interpretation, which may cause patient harm.	Eliminate the use of nonspecific PRN frequencies. Prescribers should define the minimum time between PRN doses, such as "every 8 hours PRN," and include the indication. Computer systems should not allow nonspecific PRN frequencies as part of an order.			
Wrong directions—mL instead of mg—provided on the prescription label					
04/22 ⚠	Oral propranolol liquid was prescribed for a 7.2 kg 3-month-old baby with infantile hemangioma. However, the dosing directions provided on the pharmacy label were incorrect. The maintenance dose listed on the pharmacy label was much higher than the typical daily oral maintenance dose for infants and children for this indication. When the pharmacist called for clarification, the dosing directions were mistakenly communicated to the pharmacist in mL, not mg.	Propranolol oral liquid doses should be prescribed in mg. Prescribers should include the patient's weight in metric units on the prescription. Pharmacists may need to calculate and transcribe the mL dose; an independent double check of the calculation should be required. Pharmacy labels should specify the dose in mL in the instructions for use for the patient/parent to measure each dose and list the product's concentration elsewhere on the label. Use the "teach-back" method when counseling patients.			

Issue	Problem	Recommendation	Organization Assessment	Action Required/Assignment	Date Completed
Safeguards needed when linking or copying old prescriptions to new prescriptions					
02/22	When copying a prescription for chlordiaze**POXIDE**, the pharmacist did not notice that the dose was changed from 25 mg to 10 mg. The prescription was filled with 25 mg capsules and dispensed to the patient. The computer system's functionality that allows the person conducting order entry to copy or link to a previous prescription for the same drug contributed to this error.	Review the workflow and prompts when copying or linking to old prescriptions. Design computer systems to guide the person to verify that each piece of information on the new prescription matches the one already on the patient's profile. If the original prescription is placed on hold, this same verification should occur again when the prescription is eventually dispensed.			
Errors with injectable specialty medications such as STELARA (ustekinumab), DUPIXENT (dupilumab), and HUMIRA (adalimumab)					
01/22	Some specialty medications have been associated with errors due to confusion with selecting the correct quantity or billing unit (i.e., mL or each) to enter for billing purposes (www.ismp.org/ext/817). Selecting the correct billing unit may be challenging because the pharmacy staff may not be aware of the exact contents inside a medication carton.	Use dispensing software notes to alert the team to the correct package size for specific products (e.g., quantity of 1 = 2 syringes). Add a default package size to the dispensing software, clarify the billing unit in the system, and set the system to print labels to match the required number of packages. Prescribers should include the units (mL vs. each) with the quantity.			
Help patients navigate the path to out-of-stock specialty medications					
04/22 ⚠	A patient was prescribed **XATMEP** (methotrexate) oral solution to treat leukemia. However, the pharmacy did not have the drug in stock and discovered it was on backorder and thus unavailable. While a technician called the patient's mother to say that due to supply issues they could not provide the refill, they did not give any resolution options to the mother. Also, neither the pharmacist nor prescriber was notified.	Establish procedures, which should include alerting pharmacists, on how to handle drug and supply shortages. Create a checklist to help staff navigate and communicate issues when medications are unavailable. Develop electronic communication tools to alert practitioners to critical changes in a prescription's status as well as the reason for the change. Communicate with the prescriber and patient to find the best way for the patient to access the medication.			
Hidden pork content in COLACE (docusate sodium) capsules					
04/22	Some Colace capsules have ingredients sourced from pigs in their gelatin capsule. The container and product labeling do not specify the pork content. This increases the risk of patient harm if a patient has an allergy to pork.	Alert colleagues and patients to this situation. If practitioners or patients have concerns about the inactive ingredients contained in a medication, they should contact the manufacturer for more information.			