

Acute Care

ISMP Medication *Safety Alert!*[®]

Educating the Healthcare Community About Safe Medication Practices

Have a game plan—Setting a goal for medication safety during the World Cup



PROBLEM: With the United States, Canada, and Mexico hosting the FIFA (Fédération Internationale de Football Association [French] or International Federation of Association Football [English]) World Cup in multiple cities starting this June, and in planning for other upcoming large international events such as the 2028 Summer Olympics in Los Angeles, hospitals (including EDs), urgent care centers, pharmacies, and other healthcare organizations may see an influx of patients who need medications to treat chronic conditions or who require urgent treatment while traveling. International travelers seeking medical care during these large events face increased medication safety risks, which also pose challenges for healthcare organizations within those host cities. Additionally, several states with tourist attractions might experience international travelers regularly visiting the area, so there needs to be consistent processes in place for these potential patients.

Patients may present with both prescription and over-the-counter medications labeled in a different language or with different brand names or generic names, and with drugs and treatment regimens that do not align with hospital or pharmacy formularies and practices within the United States. Vulnerabilities may include the need for translating prescriptions, labels, and medication lists; unfamiliar brand or generic drug names and strengths; look-alike or sound-alike medication names compared to US products; and unfamiliar doses, dosing units, instructions, or formulations. These factors heighten the risk of selection errors, under- or overdosing, and unintentional duplication or omission of therapy. These situations may be particularly challenging when practitioners must make decisions with incomplete or unclear medication information. Community pharmacies must also ensure that patients receive prescription directions, warnings, and counseling in their preferred language.

We have written about similar problems in the past. For example, in our December 3, 2015 article, Same Name, Different Drug Outside US, we shared that a hospital pharmacist received an order for “Cartia 100 mg” along with instructions stating that the patient would bring in their own medication. The pharmacist assumed that the patient would be taking **CARTIA XT** (diltiazem), which did not come in a 100 mg strength. The prescriber insisted that the 100 mg was correct, so the pharmacist followed up when the patient brought the medication into the hospital. It turned out that the medication was actually aspirin, or acetylsalicylic acid, which is available under the brand name Cartia in Israel, the patient’s home country (**Figure 1**).



Figure 1. In multiple international markets, Cartia is aspirin.

Similar to situations that require emergency preparedness (e.g., unanticipated electronic health record [EHR] downtime), preparing for surges of international travelers requires proactive medication safety planning, clearly defined roles, readily available reference tools, and practice drills so staff can safely function when usual safeguards are limited.

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SAFETY brief



Look-alike calcitonin carton found in carboprost bin. A pharmacy technician inadvertently stocked a carton containing calcitonin 400 units/2 mL injection in the carboprost 250 mcg/mL injection bin in the automated dispensing cabinet (ADC) refrigerator. A vigilant nurse noticed the misplaced calcitonin upon opening the refrigerator and immediately alerted the pharmacy of the good catch. Both medications are made by Dr. Reddy’s and come in similar-sized cartons with the same orange and blue colors and graphics (**Figure 1**, page 2). Calcitonin is used to treat high levels of calcium and is administered via intramuscular (IM) or subcutaneous injection. It requires refrigeration, but can remain at room temperature for up to 14 days after removal. Conversely, carboprost is used for refractory postpartum uterine bleeding or termination of pregnancy. It is administered IM and requires refrigeration for storage and cannot be left at room temperature.

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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. Selected items from the **January – March 2026** issues of the **ISMP Medication Safety Alert! Acute Care** newsletters 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](#).

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SAFE PRACTICE RECOMMENDATIONS: Organizations need to establish a consistent process to safeguard medication use for international travelers and should consider the following:

Assess risk before the surge. Engage emergency preparedness teams and conduct a proactive risk assessment (e.g., failure mode and effects analysis) focused on medication history intake, prescribing, verification, dispensing, administration, and discharge counseling for patients with limited English proficiency (LEP) or whose medication lists may include non-US brand and generic drugs. Focus on high-alert medication scenarios where an error (e.g., name or strength mix-up) may have a higher chance of causing serious harm. Consider vulnerable steps in the medication-use process where interpreter services and additional international drug information resources may be required.

Establish clear roles and escalation pathways. Designate an interdisciplinary response team to develop interim processes when risk is elevated. Define an escalation trigger for pharmacy consultation (e.g., unclear product name or strength, non-English label with no translation services available, suspected therapeutic duplication, high-alert medications). Ensure there is an escalation pathway (e.g., on-call leadership coverage after hours) so frontline staff know who can quickly triage safety issues and mobilize additional resources if needed.

Offer language services. Make formal interpreter services available, including in-person, video call, or via telephone. Avoid using interpretation services from multilingual teammates or family members, who are not professionally trained in healthcare translation.

Document in the EHR and pharmacy dispensing systems. Build required fields to document preferred patient language and interpreter service needs in the EHR. Ensure this information is easily accessible to staff. Hospital and ambulatory care settings should automatically schedule interpreters at clinical points of service for patients who are identified with LEP.

Create a communication “triage” process. Create a policy and procedure for “unknown medication” situations: gather information, engage interpreter services, contact the pharmacy, and document what was verified and how it was verified. Standardize how unclear medication information is communicated and documented in the EHR, including when a practitioner will need further clarification.

Develop an easily accessible medication verification resource. Create a curated packet (electronic and hard copy) that is easy to find, prominently version-dated, and reviewed at least annually. Include a step-by-step guidance for: available resources that can be used for identifying international brand- and generic-named single ingredient and combination products; converting strengths/concentrations; and documenting equivalencies (what was verified, by whom, and which source was used). Focus on any important clinical dosing/monitoring/goal differences for high-alert medication classes (e.g., insulin, antithrombotics) as well as a “crosswalk” for common generic/brand names. List internal and external resources with phone numbers/workflows. This may include interpreter services, toxicology/poison centers, and medication databases (e.g., Lexidrug, Micromedex) that provide international drug information.

Strengthen medication reconciliation for international travelers. Request original medication containers, photos of labels, and a written medication list when available. Use qualified medical interpreters to obtain a medication history. Build in a “two-source verification” expectation for high-alert medications (e.g., label/photo plus a trusted drug information source; or patient’s container plus pharmacist verification). When substitution to a US drug is needed, include the indication in the order and provide education before starting the medication and prior to discharge to ensure patient understanding, and to prevent duplication when the patient resumes their usual home medications.

Collaborate with community pharmacies. When proactively planning for an international travel surge, hospitals and clinics should reach out to local community pharmacies to collaborate. Notify

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Figure 1. Similar-looking cartons of carboprost (left) and calcitonin (right), made by Dr. Reddy's.

Upon investigation, the hospital found that the technician had scanned the barcode on only one of the carboprost cartons to access and refill the carboprost bin (following their pharmacy's restocking process to only scan one product) and then placed a calcitonin carton in the carboprost bin in error. The pharmacy stored these medications next to each other in their main pharmacy refrigerator, possibly contributing to the error.

A second hospital also reported to us the same concern with these two products. We reached out to the manufacturer to notify them of this concern and recommended differentiating the carton's packaging and labeling.

When the pharmacy receives a new product, conduct a review to identify potential risks with the product's design, including look-alike labeling and packaging concerns with other products in use. When the pharmacy recognizes potential risks, consider purchasing the product (or one product of a problematic pair) from a different manufacturer. Use barcode scanning technology in the pharmacy when placing products in storage, and when confirming that medications chosen for distribution to the ADC match the medications listed on the ADC fill report, and ensure each individual product (e.g., each vial or carton) is checked. Determine if your ADC has the functionality for practitioners to scan each individual product when refilling the ADC, and consider requiring scanning of each medication before placing it in the ADC. Additionally, consider

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them of the steps your organization has taken and communicate identified risks and mitigation strategies. Community pharmacies should complete similar risk assessments to ensure there is a standard process for medication labeling, translation, and interpreter services. In addition, community pharmacies should consider flagging these prescriptions in their system to ensure patient counseling is done and in the patient's preferred language.

Educate staff and improve after each event. Provide just-in-time refreshers before major events, focusing on units that may be most impacted (e.g., admissions, ED, inpatient units, inpatient and outpatient pharmacy), on how to access interpreter services and the medication verification resource packet, and when to escalate to leadership. Run brief tabletop exercises or simulations using realistic “international label” and “unfamiliar brand name” scenarios to practice the workflow and identify gaps in the process. After the event surge, review safety concerns, including delays, close calls, and errors. Update tools/forms and share lessons learned with frontline teams to continuously improve the process.

Engage and educate patients. During discharge counseling and community pharmacy dispensing, ensure interpreter services are available if needed, implement the teach-back method, and have patients show and tell how they plan to take their medications. Avoid closed-ended questions and never assume patients understand how to take their medications. Emphasize if a new drug replaces a home medication, whether the home medication should be resumed or stopped after discharge or upon return to their home country, and how to avoid unintentional duplication when returning to the usual home medication. Share resources such as those found on the ISMP consumer website, [Medicine Safety Tips While Traveling](#).

We thank Donald McKaig, RPh, from Brown University Health, for helping to write this article.

Beware of TikTok trend—Live goldfish found in IV bag

Both adults and children use social media platforms like Facebook, Instagram, TikTok, and X (formerly Twitter) to share videos about new trends or to “challenge” others to participate in a specific act. Sometimes, these trends or challenges support a charitable cause (e.g., Ice Bucket Challenge for amyotrophic lateral sclerosis [ALS]) or are shared just for fun. But sometimes these trends can be dangerous as they can lead to serious injuries or health concerns. In fact, the US Food and Drug Administration (FDA) has warned about the dangers of challenges involving medications—one involving an [over-the-counter cold medicine](#), and one known as the “[Benadryl Challenge](#)” which resulted in several teens needing emergency care, and in some cases was fatal.

Just recently, a trend involving patients in the hospital setting was reported to us. A nurse entered a patient's room to find a live goldfish swimming in a 0.9% sodium chloride intravenous (IV) infusion bag! The nurse quickly confirmed that the bag's tubing was not attached to the patient. Upon interviewing the patient and family, it was discovered that a family member had brought the fish into the room, opened the IV fluid bag, placed the fish in it, and sealed the bag with tape. This trend appears to be circulating on social media (TikTok). This incident caused a lot of concern regarding the serious infection risk had the IV tubing been connected to and infused into a patient.

Everyone needs to recognize that participating in social media trends of this nature can lead to harm, especially in hospitals or healthcare settings where patients' health can be impacted. Healthcare practitioners are essential in educating patients and their families about the dangers associated with these trends. Patients must recognize that engaging in viral challenges with medications, fluids, or medical equipment in any setting is unsafe and inappropriate. Healthcare organizations should monitor for these emerging social media trends and take steps to protect patients, including disconnecting and removing medications and IV bags when they are no longer needed. Counsel patients and families about the dangers of replicating behaviors seen on social media.

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storing the medications separately within the refrigerator(s) when look-alike sound-alike situations like this may occur. Employ bedside barcode scanning technology to confirm that medications selected for administration match those included on the patient's medication administration record. This speaks to the importance of reading the product label three times (when obtaining the item, just prior to use, and when discarding it or returning it to stock).

Contributing author Kara Jensen, PharmD, BCPS; 2025-2026 ISMP Safe Medication Management Fellow, supported by the US Army

Special Announcement

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- **Ochsner Children's and ISMP Safe Medication Management Fellowship:** This opportunity is for a pharmacist to work onsite at Ochsner Health in New Orleans, LA and remotely with ISMP throughout the year.
- **ISMP Safe Medication Management Fellowship:** This opportunity is for a healthcare practitioner (e.g., pharmacist, nurse, or physician) to work remotely with ISMP.

For more information, click [here](#).

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