



THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

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To: New York State Licensed and Registered Pharmacists

From:

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Deputy Commissioner, Office of the Professions and Office of Higher Education

Lawrence Mokhiber  
Executive Secretary, New York State Board of Pharmacy

Date: November 30, 2004

Re: Important information regarding medication error prevention and patient counseling

We are writing to every licensed and registered pharmacist in New York State in a continuing effort to help protect your patients from the consequences of medication errors, and to help you, the pharmacist, avoid instances of professional misconduct.

One of the most important professional roles of a licensed pharmacist is patient education, commonly referred to as counseling. Counseling is beneficial to both patients and pharmacists. Communicating with patients is an important way to avoid medication errors and to help patients understand the intended effects as well as the side effects of their drugs. In fact, an estimated three-quarters of pharmacists who attended continuing education sessions presented by the State Board for Pharmacy, including a session at a recent meeting of the Pharmacists Society of the State of New York (PSSNY), indicated that errors have been prevented as a result of patient counseling. Studies have shown that the professional expertise provided by a pharmacist during counseling can save money, unnecessary hospitalization, and in some cases, prevent patient harm/death.

Often during counseling either the pharmacist or the patient realizes that a wrong drug was originally prescribed or a prescription was misunderstood. Because many drugs have names that sound-alike or look-alike, drug names are sometimes miswritten, misheard, and misread. Attached are examples of medication errors involving sound-alike and look-alike drugs and how they occurred or were avoided. It is important that you are aware of drugs with sound-alike and look-alike names, and take extra precautions within your practice to prevent and avoid medication errors often associated with these drugs.

Carefully reviewing a patient's medication therapy with the patient helps to avoid potentially dangerous situations; careful review has helped to avoid countless mistakes and errors each year.

The following are actual cases of medication errors reported to the State Education Department. Some involve sound-alike and look-alike drugs. These errors may have been identified and avoided through counseling or through a more thorough review of the patient profile:

- A six-day old infant received 35mEq of Potassium Chloride, rather than the prescribed dosage of 3.5mEq. This error had a fatal result.
- An elderly patient stabilized on Coumadin 1 mg daily received a new prescription for continued therapy at the same dose. A pharmacist mistakenly filled the prescription, providing for 6 mg daily. The pharmacist did not review the patient's profile, and did not provide the required counseling to the patient on what would have been a change in dosage. In retrospect, the prescription was clearly written for 1 mg. This error resulted in several days of unnecessary hospitalization for the patient, and is but one of many recent errors reported involving this drug.
- Several infants received Zyrtec liquid rather than the prescribed Zantac liquid. There is no indication for Zyrtec in this population. As a result, the desired therapeutic response was delayed. This situation resulted in a number of unnecessary trips to the physician and caused great concern to the parents.
- A non-diabetic patient received chlorpropamide rather than the prescribed chlorpromazine. The patient sustained permanent impairment.

### COUNSELING REQUIREMENTS:

To positively influence patient compliance with medication therapies and to help ensure patient safety, the pharmacy community has strongly supported patient counseling requirements. Leadership within the pharmacy profession worked with the Education Department to develop the counseling requirements that are in place today. According to rules and regulations affecting the practice of your profession and your professional license, a pharmacist or pharmacy intern **must** provide counseling:

- **Before dispensing a medication to a new patient** of the pharmacy,
- **Before dispensing a new prescription\*** for an existing patient of the pharmacy, and
- **Every time the dose, strength, route of administration, or directions for use has changed** for an existing prescription previously dispensed to an existing patient of the pharmacy.

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\* New is defined as an order for a drug that the patient has not been currently and continuously taking. It does not mean a reauthorization for an existing drug therapy.

An **offer** to provide counseling must also be made every time a patient has a prescription refilled or has a prescription filled for a medication therapy that has been reauthorized by a prescriber. While interns, clerks, “technicians”, or other members of the pharmacy staff can inform the patient of the availability of counseling by a licensed and registered pharmacist or a pharmacy intern, it is important that a bona fide counseling offer be made, as opposed to asking patients general questions such as, “you don’t have any questions, do you,” or asking patients to sign a “log” waiving counseling before the actual offer is made. If a patient accepts the offer to provide counseling or requests to be counseled, a pharmacist or pharmacy intern must provide the counseling.

#### WHAT COUNSELING INCLUDES:

Depending on the situation, you may choose to discuss among the following with your patient:

- The name and description of the medication and known indications;
- Dosage form, dosage, route of administration and duration of drug therapy;
- Special directions and precautions for preparation, administration and use by the patient;
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
- Techniques for self-monitoring drug therapy;
- Proper storage;
- Prescription refill information;
- Action to be taken in the event of a missed dose.

To help pharmacists internalize new safety strategies and to develop process improvement systems for their practice, all pharmacists in New York State are now required to complete three hours of continuing education on medication error reduction during each registration period. Despite many positive efforts, however, much remains to be done to insure patient safety. As a professional, it is your responsibility to make patient safety a priority. For example, it is important to continuously consider how to make systems within your practice safer, particularly given the number of sound-alike and look-alike drugs. In addition to being actively committed to avoiding medication errors, you should have a response plan in place in case an error occurs. Prompt response can make a significant difference on the ultimate impact on the patient.

The State Education Department, with the assistance of the State Board of Pharmacy, has worked with individual pharmacists and professional associations on an on-going basis to support enhancements in an evolving practice environment. We understand that laws, rules and regulations must be interpreted and re-interpreted in light of emerging technologies and needs. Some of our efforts to assist practicing pharmacists include adopting regulations to allow for the electronic transmission of prescriptions. We have also clarified which non-judgmental duties may be delegated to unlicensed staff

(technicians). As a result of feedback from the field, we changed the allowable technician to pharmacist ratio from 1:1 to 2:1. We have also provided guidelines and clarification on your rights to lunch and rest breaks to reduce daily stress. We encourage the proper use of new technologies, including robotic dispensing machines and bar-code readers. In the end, however, with or without the involvement of technicians and the use of technology or other staff, all prescriptions are ultimately the responsibility of the licensed pharmacist.

We hope this information is helpful to you. We appreciate the collaborative relationships we have with professional associations, individual practitioners, consumers of professional services, and others, as we all work to make the pharmacy practice environment as safe as possible. If you have any questions or need more information on creating a safer practice environment, please contact the New York State Board of Pharmacy at (518) 474-3817 ext. 130 or by e-mail at [pharmbd@mail.nysed.gov](mailto:pharmbd@mail.nysed.gov). Information for pharmacists and consumers of pharmacy services is also available on our Web site at [www.op.nysed.gov](http://www.op.nysed.gov).

The pharmacists of our State are critical to the provision of quality health care. Millions of patients rely on your professional expertise and experience. Thank you for your continued commitment to reducing medication errors and ensuring patient safety.

Attachment

**SOUND ALIKE DRUGS**

<b>Products Involved</b>	<b>Therapeutic Class</b>	<b>Description</b>
Advicor™ Altacor™	Antihyperlipidemic Antihyperlipidemic	Prescriber wrote a prescription for Advicor but intended to write Altacor.
DiaJect® (diazepam) injectable – pending approval Diastat® (diazepam) rectal gel	Anticonvulsant Anticonvulsant	Potential for error (wrong route) due to same active ingredient and administration via a syringe.
Levaquin® Levsin SL®	Fluoroquinolone Anticholinergic/ Antispasmodic	Verbal order for Levaquin documented as Levsin.
Sertraline Soriatane®	Antidepressant Retinoid	Prescriber wrote illegible order for Soriatane. Pharmacist entered and dispensed order as sertraline. Unit secretary and nurse also transcribed order as “serlatane” and sertraline.
Vicodin® Visicol™	Narcotic Analgesic Laxative	Prescriptions for Visicol (preprinted script in one case) filled with Vicodin. One patient noticed error by name and indication. Another patient was not so fortunate and experienced severe nausea, protracted vomiting, and hematemesis.
Tamoxifen Tamsulosin	Hormone (Antiestrogen) Antiadrenergic/ Sympatholytic	Order was written for Flomax® (tamsulosin) and faxed to the pharmacy. Pharmacy dispensed tamoxifen due to the close proximity of the two products (e.g., stored next to each other).
Topamax® Toprol-XL®	Anticonvulsant Antiadrenergic/ Sympatholytic	Prescription for Topamax was filled with Toprol XL. Patient took wrong medication for three weeks. Patient began experiencing hallucinations again.
Zebeta® Zetia™	Antiadrenergic/ Sympatholytic Antihyperlipidemic	Order for Zetia was dispensed with Zebeta. Both products are available in 10 mg, are packaged in small bottles, and may be stored next to each other if stocked by brand name. Illegible orders for Zetia may be interpreted as Zebeta, as both names contain the letters “Z,” “E,” “T,” and “A.”
Zantac® Zestril® Zyrtec®	Gastrointestinal agent ACE Inhibitor Antihistamine	Zantac interpreted as Zyrtec or Zestril; some due to illegible handwriting or verbal orders. Similar letters, dose, and dosage forms may lead to a mix up.