



HOSPITAL
PHARMACY
ADMINISTRATION



Special points of interest:

- Clinical Pharmacy Implementation
- Medication Errors Reporting & Prevention
- Pharmacists Continuous Education
- HPA News & Achievements

Inside this issue:

- HPA latest updates 1
- Sound-alike Medication Errors 2
- Ischemic Stroke, Atrial fibrillation and HTN - Case 3
- Environmental Factors Incriminated in the Development of End Stage Renal Disease in El-Minia Governorate, Upper Egypt 4

HPA Newsletter

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HPA Latest Updates

There are newly activated areas in clinical pharmacy services that emphasize the important role of pharmacists in providing patient health care and therefore more job vacancies are needed in hospital pharmacy practice.

Therefore, HPA finalized CAPA "job description and carrier pathway documents for pharmacists working in governmental hospital" that contains:

1. Structure of pharmacist carrier pathway in hospitals.
2. Job description proposed models to each of the following:
 - Head of Clinical pharmacy department and clinical pharmacy specialist.
 - Head of DIC department and DIC specialists.
 - Head of outpatient, inpatient pharmacy department and outpatient, inpatient pharmacy specialists.

- Head of I.V admixture preparation and TPN department and I.V admixture preparation and TPN specialist.

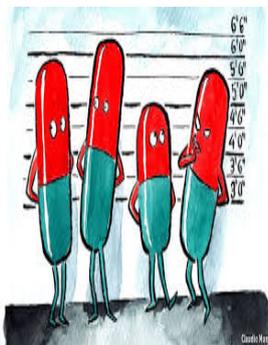
In two consecutive meeting in CAPA at 21/2/2016 and 28/2/2016 in co-operation with the following head of pharmacy department sectors and directorates:

- General Authority for Hospitals and Educational Institutes.
- Secretariat of Specialized Medical Centers.
- General Secretariat of Mental Health and Addiction Treatment.
- Curative Organizations
- Cairo health affairs directorate
- Alexandria health affairs directorate





Sound-alike Medication Errors



**“look-alike/
sound-alike
names (LASAs),
are among the
most common
reasons for
medication
errors
worldwide.”**

NO HARMe received a report of medication error when the nurse mistakenly gave the patient ALDACTONE® (Spironolactone) instead of the prescribed ALDOMET® (Methyldopa). The error actually reached the patient and monitoring was required to ensure there is no harm.

Discussion:

1- This kind of errors occurs due to sound-alike drug name confusion. Sound-alike, Look-alike (LASA) errors is a very common cause of errors all over the world. Each year, an estimated 1.5 million Americans are harmed from medication errors, one-quarter of those errors occur when health-care workers mix up similarly named drugs.⁽¹⁾ The consequences of these errors to patients range from being given a medicine that is ineffective for their condition to potentially fatal adverse reactions to a medicine that they were not prescribed.

2-The same error of name confusion between ALDACTONE® and ALDOMET® has been previously reported to the Australian national drug authority (NSW Pharmaceutical Defense Limited error statistics, January 2009 - January 2011). This error along with other similar cases lead the Australian Commission on Safety and Quality in Health Care to endorse the use of Tall Man lettering to reduce the risk of selection errors by health professionals associated with look-alike, sound-alike medicines names.^(1, 2)

How to Avoid This Medication Error:⁽³⁻⁶⁾

1- Always clarify with the prescriber if you are unsure which drug was ordered, or should be ordered.

2- Make sure that medications with similar sounding names are separated into separate sections or shelves.

3- Use both brand and generic names when prescribing drug name pairs known to be similar. Print both names on unit-dose packaging, if used.

4- Prescribers should specify the dosage form, drug strength, complete directions, and the purpose on prescriptions to help differentiate drugs. Pharmacists and nurses should match the drug's indication to the patient's condition.

5- Use TALL MAN lettering to emphasize the spelling of drug names (AIDOMET® and AIDACTONE®). Tall Man Lettering (TML) is the practice of writing part of a drug's name in uppercase letters to help distinguish look-alike drugs from one another to avoid medication errors. ISMP, FDA, the Joint Commission, and other safety conscious organizations have promoted the use of tall man letters as one means of reducing confusion between similar drug names.

6- Pharmacies should educate staff about the

potential for LASA errors and even identify a list of LASA products dispensed at their site.

7- Use verbal or telephone orders only when absolutely necessary. If used, verbal or telephone orders should be documented on the patient's record and read back, spelling the drug name and stating its indication.

8- Encourage patients to question nurses or pharmacists about medications that look or sound different than expected.

9- When such errors (or near misses) occur, this should be reported and shared between sites for awareness/education of staff.

10- Consider the risk of name confusion when adding a new drug to the formulary.

11- Manufacturers have also been strongly encouraged to evaluate potential brand names before they register a new drug.

References:

1. How to Prevent Sound-Alike, Look-Alike Errors - University of Utah Health Care - [Internet]. Healthcare.utah.edu. 2016 [cited 10 March 2016]. [\(Click Here\)](#)
2. similar names or commonly confused medication names [Internet]. safetyandquality.gov.au. 2016 [cited 10 March 2016]. [\(Click Here\)](#)
3. Reducing Look-alike/Sound-alike (LASA) Drug Errors | RelayHealth [Internet]. Relayhealth.com. 2016 [cited 10 March 2016]. [\(Click Here\)](#)
4. Top 10 Sound-Alike & Look-Alike Drugs [Internet]. downstate.edu/. 2016 [cited 10 March 2016]. [\(Click Here\)](#)
5. Progress with preventing name confusion errors [Internet]. Ismp.org. 2016 [cited 10 March 2016]. [\(Click Here\)](#)
6. Schmidt B. Look-Alike Drug Name Errors [Internet]. Psqh.com. 2016 [cited 10 March 2016]. [\(Click Here\)](#)



Ischemic Stroke, Atrial fibrillation and HTN - Case

Embaba hospital

Presenting Complaint:

GA. is a 70 years old female patient, 80 kg, She was admitted to the ICU on 23/2/2016 suffering from disturbed conscious level and right sided hemiplasia

Diagnosis:

Ischemic stroke

Patient History:

Having Medical History of AF, bronchial asthma and HTN

Medication History:

Capoten[®], Ator[®], Atrovent[®] inhaler and Atenolol[®]

Subjective:

The patient was suffered from: confusion, trouble speaking, right side hemiplasia, Aphasia.

Objective:

1. Laboratory Investigation:

Hb 11 u/L, WBCs 17×10^3 μ L, Platelets 232 μ L, Na 140 mEq/L, K 3.3 mEq/L, S. Cr 0.8 mg/dL, Alb : 2.8 g/dL, Urea 23 mg/dL

2. Physical Examination:

Vital Signs: BP: 150/100, HR: 86, R.R: 17 breath/min.

3. C.T scan:

Brain: ischemic stroke

4. ECG: AF

5. Diagnosis:

Ischemic stroke, AF, HTN

Assessment:

Pharmaceutical related problems:

1. Ischemic stroke
2. AF
3. HTN
4. Bronchial asthma

Problem I: Treatment of AF:

Etiology:

Atrial fibrillation (AF) is strongly associated with Atrial ischemia, Genetic factors, Noncardiovascular respiratory causes . ([Click Here](#))

Current Therapy:

Ceftriaxone [®]	2gm/24hr
Cerebrolysin [®] 5mg	2amp./12hr
Atenolol [®]	50mg/day
Zantac [®] amp.	Amp./8hr
Aspocid [®] 75mg	2 tab./24hr
Marevan [®] 5mg	1tab./24hr
Fraxiparin [®]	0.6ml/24hr
Potassium chloride	4 amp./500ml ringer
Aminoliban [®]	/12hr
Potassium syrup	/8hr

Therapy Indicated: ([Click Here](#))

Plan:

Problem I: Treatment of AF:

Therapeutic Objective:

- The cornerstones of atrial fibrillation management are rate control and anticoagulation and

rhythm control for those symptomatically limited by AF .

- Long-term management of atrial fibrillation is focused on reducing the likelihood of AF recurrence, reducing AF-related symptoms, control of ventricular rate, and reducing stroke risk .⁽¹⁾

Interventions:

The 2006 American College of Cardiology (ACC)/American Heart Association (AHA)/European Society of Cardiology (ESC) guidelines on anticoagulation for patients with nonvalvular AF include the following :

- No risk factors: Aspirin 81-325 mg/day
- Moderate risk factor: Aspirin 81-325 mg/day or warfarin (international normalized ratio [INR] 2-3)
- Any high-risk factor or >1 moderate-risk factor: Warfarin (INR 2-3) ⁽²⁾

Monitoring Parameters:

- C.T scan, ECG

Clinical Pharmacist Intervention:

Problem I: Treatment of AF:

- Ischemic stroke converted to hemorrhagic stroke due to fraxiparin[®] so decrease dose of fraxiparin[®] to 0.3ml/24hr.

- Measure INR to adjust warfarin dose.

Patient Education:

Patient counseling for the following:

- Diet is lower in saturated and trans fats, and includes plenty of vegetables, fruit, fibre and lean protein
- Get regular exercise, Stop smoking ⁽³⁾

Quiz:

1. Which of the following medication should be omitted?

- A. Zantac
- B. Atenolol
- C. Ceftriaxone

2. Why the previous medication should be omitted ?

- A. Bronchial asthma
- B. This drug should not be given in 48 hrs .
- C. A & b

3. Do you have any further recommendations?

Please, contact us at:
hosprx@eda.mohealth.gov.eg

References:

1. Atrial Fibrillation Treatment & Management: Approach Considerations, Risk-Management Decisions, Management of New-Onset AF [Internet]. Emedicine.medscape.com. 2016 [cited 9 March 2016]. ([Click Here](#))
2. Atrial Fibrillation: Practice Essentials, Background, Pathophysiology [Internet]. Emedicine.medscape.com. 2016 [cited 9 March 2016]. ([Click Here](#))
3. Heart Disease, Stroke, and Healthy Living-Heart and Stroke Foundation of Canada [Internet]. heartandstroke.ca. 2016 [cited 9



“Atrial fibrillation is the most frequently encountered cardiac arrhythmia.”



Last Month Quiz Answers

1. B
2. B

Egyptian Scientific Publication: Environmental Factors Incriminated in the Development of End Stage Renal Disease in El-Minia Governorate, Upper Egypt

Emad G. Kamell^{1*}, Osama El-Minshawy²

ABSTRACT Background and Aims: End Stage Renal Disease (ESRD) has various causes that differ according to patient's country. In Egypt it is a huge health problem with high prevalence in El-Minia governorate as 308 per million population suffer from it. The aim of the work is to investigate the possible causes of ESRD with an unknown etiology in El-Minia Governorate.

Methods: A total number of 216 patients with an unknown etiology of ESRD as well as 220 controls were interviewed using a structured questionnaire including information about environmental factors predicted to cause ESRD such as occupation, pesticide handling, and source of drinking water.

Results: Distribution of patients by residence showed that most patients lived in rural areas (76%), compared to 57% in controls ($p < 0.001$). Drinking unsafe water was reported by 72% of patients and 48% of controls ($p < 0.001$). Family history of renal disease was found among 10% of

patients and 4% of controls ($p < 0.001$).

Exposure to pesticides and using herbs for the treatment were more among patients than controls (52% Vs 14% respectively) and (34% Vs 6% respectively) ($p < 0.001$).

Conclusions: ESRD with an unknown etiology may be attributed to environmental factors such as drinking unsafe water, exposure to pesticides and using herbs for treatment. Educational programs for common people should be strengthened. Lead pipes water supplies should be changed. Use of any herbs should be prohibited except under the supervision of Ministry of Health.

Keywords: ESRD, Unknown Etiology, Environmental Factors

To read the full article, please [\(Click Here\)](#)



“ESRD is when the kidneys stop working well enough for you to live without dialysis or a transplant.”



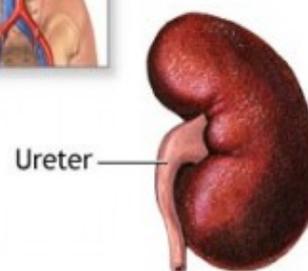
Normal kidney



- healthy function
- proper size
- low urine protein



Kidney disease



- granular surface
- decreased function
- smaller size
- high urine protein



HOSPITAL PHARMACY ADMINISTRATION



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HPA

Our Newsletter

The Hospital Pharmacy Administration Newsletter aims to publicize up-to-date news, information, resources, and recent healthcare topics that have an impact on the patient's quality of care in addition to practices serving physicians and pharmacists. A main goal of this publication is to send our news and updates on health care drug related issues, recently reported and have direct impact on Clinical and Hospital Pharmacy practice in Egypt.

Hospital Pharmacy Administration (HPA)

Vision

To implement and spread clinical awareness among our hospital pharmacists to ensure better patient quality of care.

Mission

To manage and assure that hospital pharmacists meet each individual patient's drug-related needs through provision of pharmaceutical care services.

Goals and Objectives

Increase awareness of hospital Pharmacists on the importance of applying clinical knowledge in their pharmacy practice through:

- Plotting an appropriate pharmaceutical care plan for each patient according to his medication use strategy.
- Helping healthcare team through promptly responding to drug information requests.
- Integrating patient counseling into the process of dispensing.

NO HARMe

NO HARMe is a national voluntary medication error and 'near miss' reporting program founded for the purpose of sharing the learning experiences from medication errors. Implementation of preventative strategies and system safeguards to decrease the risk for error-induced injury and thereby promote medication safety in healthcare is our collaborative goal.

To report a medication error to NO HARMe:

- Visit our website: www.eda.mohealth.gov.eg

or,

- Email us at:
medication.errors.system@gmail.com

NO HARMe guarantees confidentiality
and security of information received



**WHEREVER THE ART OF
MEDICINE IS LOVED,
THERE IS ALSO A LOVE
FOR HUMANITY**

