

What's New in the Patient Safety World

May 2023

ISMP Medication Safety Best Practices for Community Pharmacy

ISMP recently released its "Targeted Medication Safety Best Practices for Community Pharmacy" ([ISMP 2023](#)). The 5 best practices included are:

BEST PRACTICE 1:

Use a standard protocol to verify a patient's identity, utilizing at least two patient identifiers, when receiving a prescription to be filled, responding to patient-specific questions, providing filled prescriptions to patients at the point-of-sale, when delivering prescriptions to the patient's home, and prior to administering vaccines or other treatments.

BEST PRACTICE 2:

Install and use barcode verification during production (i.e., the prescription filling process) to scan each drug or vaccine package or container (e.g., bottle, carton) used to fill a prescription, including manufacturer cartons or bottles that may be dispensed to a patient.

BEST PRACTICE 3:

A series of recommendations regarding methotrexate (see below for details).

BEST PRACTICE 4:

Standardize to the use of the milliliter (mL) unit of measure when prescribing, dispensing, and measuring oral liquid medications.

BEST PRACTICE 5:

Seek out and use information about medication safety risks and errors that have occurred in organizations outside of your pharmacy, including other affiliated pharmacies, and take action to prevent similar errors.

We are really glad to see the **recommendations regarding methotrexate**. Our many columns on methotrexate issues are listed below. The main problem is that the dosing regimen for methotrexate differs whether the indication is for oncological conditions or autoimmune conditions like rheumatoid arthritis. Weekly dosing is used for the latter but sometimes patients are erroneously given daily doses of methotrexate, leading to serious consequences. The ISMP recommended best practices for methotrexate are:

a) Use a weekly dosage regimen default for oral methotrexate in electronic systems when medication orders are entered.

b) Require verification and entry of an appropriate oncologic indication in order entry systems for daily orders.

- Require a hard-stop verification of an appropriate oncologic indication for all daily oral methotrexate orders.
- For systems that cannot provide a hard stop, clarify all daily orders for methotrexate if the patient does not have a documented appropriate oncologic diagnosis.
- Work with software vendors and information technology personnel to ensure that this hard stop is available. Software vendors need to ensure that their order entry systems are capable of this hard stop as an important patient safety component of their systems.

c) Create a forcing function (e.g., electronic stop in the sales register that requires intervention and acknowledgement by a pharmacist) to ensure that every oral methotrexate prescription is reviewed with the patient or a family member when a prescription is presented or refills are processed.

d) Provide specific patient and/or family education for all oral methotrexate prescriptions.

- Specifically ask the patient which day of the week they plan to take this medication.
- Provide clear written instructions AND clear verbal instructions for oral methotrexate that specifically review the dosing schedule, emphasize the danger with taking extra doses, and emphasize that the medication should not be taken “as needed” for symptom control.
- Require the patient to repeat back the instructions to validate that the patient understands the dosing schedule and toxicities of the medication if taken more frequently than prescribed.
- Provide all patients with a copy of or hyperlink to the free ISMP high-alert medication consumer leaflet on oral methotrexate (found at: www.ismp.org/ext/221).

We are a bit surprised at the absence of one important recommendation that we and ISMP have made in the past: **limiting the number of doses available to patients with non-oncological indications**. While pharmacies are likely required to fulfill the ordered

number of pills, we'd like to see them call the ordering clinician when a patient is given a supply which is large enough to cause harm if taken inadvertently.

Our prior columns related to methotrexate issues:

- July 2010 “[Methotrexate Overdose Due to Prescribing Error](#)”
- July 2011 “[More Problems With Methotrexate](#)”
- February 2016 “[Avoiding Methotrexate Errors](#)”
- June 21, 2016 “[Methotrexate Errors in Australia](#)”
- October 18, 2022 “[Methotrexate Again, With a Twist](#)”

References:

ISMP (Institute for Safe Medication Practices). Targeted Medication Safety Best Practices for Community Pharmacy. ISMP 2023; April 3, 2023
<https://www.ismp.org/guidelines/best-practices-community-pharmacy>

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