

What's New in the Patient Safety World

December 2016

Standardize 4 Safety and Just Bag It!

A couple nationwide medication safety campaigns have been in the news lately. Earlier this year ASHP (American Society of Health-System Pharmacists) was awarded a 3-year contract by the FDA to develop standardized concentrations for intravenous and oral liquid medications. ASHP has partnered with ISMP (Institute for Safe Medication Practices), AAMI (Association for the Advancement of Medical Instrumentation), and PPAG (Pediatric Pharmacy Advocacy Group) in this endeavor, the [Standardize 4 Safety](#) initiative. The coalition just announced one of its Phase 1 (of 3 Phases) outcomes: a [list of recommended standardized concentrations for adult continuous IV infusions](#). The list includes the standardized concentration(s), dosing units, status of commercial availability, and comments for over 30 of the most commonly infused drugs in adults.

Other activities in Phase 1 will be development and implementation of concentrations and dosing units for compounded oral liquids for adults. Phase II addresses concentrations and dosing units for pediatric continuous IV infusions and standard doses for oral liquid medications. Phase III addresses intermittent IV medications, PCA (patient-controlled analgesia) pumps, epidurals, and standard doses for oral chemotherapy agents.

Another collaborative medication safety campaign, the ***Just Bag It*** Campaign, was just launched by the National Comprehensive Cancer Network ([NCCN 2016](#)). Vincristine is a chemotherapy agent intended for intravenous use. Yet since the 1960's there have been numerous incidents where it has been administered intrathecally or via Omay reservoirs. The results are disastrous, with patients developing quadriplegia, encephalopathy, and usually death. In 2013 ISMP summarized the literature ([ISMP 2013](#)) and noted that virtually all cases involved vincristine being prepared in a syringe and that there were no cases when vincristine was prepared in an IV bag. There are, of course, other contributing factors in such incidents. ISMP noted the following contributing factors: mislabeling of syringes; bringing IV and intrathecal medications into a treatment area together; failing to administer vinca alkaloids in a specialty oncology unit or with only experienced, oriented staff familiar with current operational and clinical standards, procedures, or protocols; administering chemotherapy outside of normal hours; not conducting an independent double check or "time out" before intrathecal medication administration; and incomplete or missing warning labels. But, given that all reported incidents occurred when vincristine was in a syringe, ISMP recommended that vincristine instead be diluted in a minibag for infusion and syringes be avoided.

Now the NCCN *Just Bag It* Campaign has been launched for the safe handling of vincristine, calling for health care professionals to *always dilute* vincristine in a 50ml mini-IV drip bag and never in a syringe. The campaign comes with Christopher's Story, the sad story of a patient who died as the result of one of the above vincristine errors. All NCCN member institutions have already adopted this best practice for handling vincristine but the campaign calls on all other oncology providers to do the same.

References:

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