More Barcodes Than Needed Cause Confusion

Figure 1. Example of a product that has multiple barcodes. (Image courtesy of the Institute for Safe Medication Practices)

As you have probably noticed, there are a number of medications with two or more barcodes printed on the package (Figure 1). The presence of multiple barcodes on products is confusing to staff that may use barcoding for dispensing as well as staff at nursing homes and in hospitals, particularly frontline staff who utilize bedside barcode medication administration (BCMA). Typically, the barcode associated with the national drug code (NDC) is intended for scanning during BCMA workflow. But often the manufacturer includes an additional barcode that is used in its production and quality control processes. When the pharmacist, technician, or nurse tries to scan one of these barcodes, it won't scan properly, leading to frustration. As a result, there have been instances where a practitioner has overridden the barcode system, leading to potential errors. We have seen multiple barcodes on products such as scopolamine and fentaNYL patches. We have asked the Food and Drug Administration to discuss this problem internally with their barcode work group to see if they can have manufacturers redeploy these barcodes elsewhere on the package, or at least clearly identify which barcode should be scanned during clinical use. Pharmacies should notify staff of this issue with certain medications and communicate this risk to facilities they provide with medications.

SPECIAL ATTENTION IS NEEDED DURING TRANSITIONS OF CARE

We recently received an error report about a resident who returned to an assisted living facility after a four-day hospital stay. The pharmacy was unaware the resident had been hospitalized and continued to dispense the resident's medications. Upon the resident's return, the medication orders remained the same except for the dose of DULoxetine (CYMBALTA), which was decreased from 120 mg (2 capsules) daily to 60 mg (1 capsule) daily. However, medication cards that were just delivered from the pharmacy were based on the old orders which included the higher dose of Cymbalta. The cards were placed in the medication cart before being verified with the new orders.

When the pharmacy received the transfer orders, the pharmacist did not send a replacement card with the lower dose of Cymbalta. The pharmacist assumed that the staff at the facility would just give the resident 1 capsule (60 mg) instead of 2 capsules (120 mg). However, facility staff did not notice the difference in dosing, and 2 capsules per dose were administered based on the directions on the medication card label rather than the directions on the medication administration record (MAR). The resident received five days of the higher dose before the error was noted. Fortunately, the resident was not harmed.

This case emphasizes the importance of performing medication reconciliation during transitions from one health care setting to another. The staff at the assisted living facility was reminded about the need to compare the medication cards to the MAR after a resident's return from a hospital stay, and to always use the MAR for reference and verification when administering medications. Good communication between the pharmacy and facility staff during transitions of care is also important. In this case, the facility should have notified the pharmacy of the resident's hospitalization. Once it was realized the patient's dose had changed, the staff at the facility and at the pharmacy should have communicated with each other to ensure the facility had the correct product labeled with the correct directions. ■

This article is from the Institute for Safe Medication Practices (ISMP). The reports described were received through the USP–ISMP Medication Errors Reporting Program. Errors, near misses, or hazardous conditions may be reported at www.ismp.org. ISMP can be reached at 215-947-7797 or ismpinfo@ismp.org.