


Use your library!

 Your public library has a lot of free information about health and medicines. Librarians are experts at finding this information for you. They can help you find trustworthy books, magazines, newspapers, and internet resources.

Here's just one example of how a librarian helped and possibly prevented a medication error. A man told a librarian that he had trouble reading because of dyslexia. (Dyslexia is a learning disability that makes it hard to recognize written words.) He had just been diagnosed with post-traumatic stress disorder (PTSD), and he wanted more information about his treatment. The man also brought a bag of medicine bottles with him. Together in a private library room, the librarian and the man reviewed the directions on each bottle. She read to him from a drug information book. She told him about each prescription and its side effects and interactions with other medicines. She also made photocopies of all the information so he

could take it home. The man returned to the library several times for more information about PTSD and his medicines.

It is always best to get information from a trusted source. At no time should the librarian take the place of your doctor, pharmacist, or nurse. But the librarian can lead you to additional reliable information

Along with your doctor and pharmacist, librarians can help you find reliable information about your medicines.

sources. For example, many television ads about medicines direct you to visit the drug company's website for more information. A librarian can guide you there and also help you look for impartial information (not from the drug company) about the medicine. He or she can also help you find information on vitamins, herbals, and over-the-counter medicines.

Your library is a valuable resource in your community—let your librarian work with you to learn as much as possible about your health and medicines. The more information you have, the better protected you are against errors with your medicines.

60 second safety tip

■ **Warfarin** may not mix well with other medicines. **Warfarin** (Coumadin) is a medicine that quite a few people take to prevent blood clots. Taking too much of it can cause unintentional bleeding. However, even taking the right dose can lead to bleeding problems if you also take certain antibiotics to treat an infection. Some antibiotics can cause higher levels of **warfarin** in the body. One 75-year-old woman learned this after she went to the emergency room with a very large, blood-filled bruise on her leg. She had been continued on page 2 ▶

Know your pharmacist...

Know your medicine

If you are like most Americans, you are on a first name basis with your hairdresser, barber, maybe even your car mechanic or your dry cleaner. But do you know the first name of your pharmacist?

A study done by the American Pharmacists Association (APhA) found that only 35% of consumers know their pharmacist's name.¹ This is surprising since your pharmacist is one of the easiest members of your healthcare team to reach.

The study found that people who know their pharmacist's name may be safer with their medicines. These people are more likely to:

- Tell their pharmacist the names of other medicines they take
- Read product labels all the time
- Know the main ingredients of the prescription medicines they are taking
- Use their pharmacist as a source of information on both prescription and over-the-counter medicines.

So take a simple step towards safer use of your medicines: Introduce yourself to your pharmacist and learn his or her first name; **no appointment or co-pay needed.**

Reference: 1. American Pharmacists Association. New National Consumer Survey Highlights Need for More Communication with Pharmacists [Press Release]. September 19, 2005. Washington, DC: APhA.

When too much “soda” is dangerous



You wouldn't think that a laxative or enema could cause harm.

However, there are reports of adults and children who have been hospitalized after taking too much of these seemingly safe treatments. In one case, an elderly woman in the hospital died. Her doctor had prescribed “1½ bottles” of a popular laxative, Fleet **Phospho-soda**, at 6 p.m. and again at 8 p.m. on the evening before a colonoscopy (a procedure to inspect the bowel for disease). A nurse obtained three bottles of the laxative and gave the woman one and a half bottles at each of the designated times. During the night, the patient developed pain and had great trouble breathing.

Until last summer, **Phospho-soda** laxative came in 1½ and 3 ounce bottles. The woman's doctor had wanted her to receive the smaller 1½ ounce bottles. At the time, this hospital only carried the larger 3 ounce bottles. So the nurse gave the woman one and a half of the larger bottles at 6 p.m. and then at 8 p.m. After taking twice as much **Phospho-soda** than the doctor had wanted, the woman became very ill. Sadly, she died a short time later.

Since last June, Fleet **Phospho-soda** only comes in 1½ ounce bottles. The company decided this was safer to prevent mistakes like this one. But even in smaller size bottles, too much **Phospho-soda** can harm you. The main ingredient in the laxative is **sodium phosphate**. An overdose of this can cause serious side effects. Your body can become too acidic and your heart may not beat properly.

There also have been several accidental overdoses from using enemas that contain **sodium phosphate**. In one case, a 5-month-old infant had to be hospitalized after his mother gave him an entire adult-sized Fleet enema. Children have also been given overdoses of **sodium phosphate**-containing laxatives.

If your doctor prescribes **Phospho-soda**, be sure to ask him the total volume (amount in ounces, Tablespoons, or mLs) of the laxative he wants you to take. If you purchase this product over-the-counter without your doctor's directions, ask a pharmacist to make sure you will be taking a safe dose. Also be sure to give children a pediatric-sized Fleet enema.

60 second **safety tip** continued

taking warfarin for several months and then started taking the antibiotic **Bactrim DS** (**trimethoprim** and **sulfamethoxazole**) for a bladder infection. The combination of medicines had caused the large bruise on her leg. If you take warfarin and then need antibiotics, remind your doctors about the **warfarin**. You may need more frequent blood tests (INRs), or even a dose change while you are taking the antibiotic. Also let your pharmacist know if you are taking **warfarin** when you pick up any other prescription medicines. This way he or she can check your medicine list for any other possible side effects from taking **warfarin** with other medicines.

Double Trouble

Too close for comfort. A mother discovered that her infant daughter had been taking an allergy medicine instead of an antacid for a month. The baby's doctor had prescribed the antacid **Zantac** (**ranitidine**) syrup to help with spitting up and crying. When the mother called the pharmacy for a refill, she requested the same grape flavor of medicine that her daughter had been taking. The pharmacist told her that **Zantac** did not come in a grape flavor. The mother took the medicine back to the pharmacy. The pharmacist discovered that the label read “**Zantac**,” but the bottle actually contained **Zyrtec** (**cetirizine**), an allergy medicine.

Zantac and **Zyrtec** have been mixed up frequently because their names look and sound alike. Medicines are often stored alphabetically on pharmacy shelves. So **Zantac** and **Zyrtec** also may be right next to each other, making it easy to pick up the wrong bottle. If your child's doctor prescribes either **Zantac** or **Zyrtec** syrup, it's a good idea to open the medicine bottle and sniff the contents before you leave the pharmacy. **Zantac** smells like peppermint and **Zyrtec** smells like grape candy. It's one more check you can do to help prevent a mistake.

Contact Information



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