

Who's looking out for your safety? The Joint Commission and you!

The Joint Commission on Accreditation of Healthcare Organizations is an independent agency that sets standards for US hospitals and other healthcare organizations. The Joint Commission visits most of these organizations regularly to see if they're meeting the standards. This agency is especially concerned about your safety. Since 2002, it has gathered safety experts to help set specific goals to protect patients, called National Patient Safety Goals.

Many of these goals deal with medicine safety. Summaries of just three of the goals are provided below as examples, along with suggestions on how you can also help healthcare workers achieve these goals.

Goal: Make sure medicines are given to the right patient by checking two forms of identity. (Two forms of identity must also be checked before lab tests or medical procedures.)

What you can do: Expect to be asked for two forms of identity often, even by doctors, nurses, or lab workers who know you well. For example, your doctors and nurses should check your wristband and ask your name and birth date every time before giving you medicine. If they don't, speak up! Some patients have identical or nearly identical names.

Goal: Make a list of medicine names that look alike when written or sound alike when spoken. Take steps to prevent mix-ups with these medicines.

What you can do: In most cases, medicines with names that look or sound alike are used to treat different conditions. So always ask the nurse or doctor the name of each medicine and why it is being given to you. Make sure the reason makes sense to you. Speak up if the name of the medicine sounds different than you expected, or if the medicine looks unusual. Before you leave the hospital, ask the doctor or nurse if your medicine has a name that looks like another medicine's name. If so, check your prescriptions carefully when you have them filled. Also make sure the medicine and reason for taking it match what the doctor or nurse has told you.

Goal: Obtain an accurate list of medicines the patient has been taking at home. Have the doctor look at this list when prescribing medicines in the hospital. Compare the list of medicines taken at home with the medicines prescribed in the hospital to make sure there are no mistakes. Send a list of the medicines the patient will be taking after leaving the hospital to the patient's family doctor.

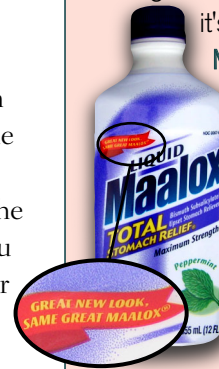
What you can do: You may forget to tell your doctor or nurse about certain medicines you take, especially eye drops, inhalers, medicine patches, and birth control pills. To remember all your medicines, think about the doctors you visit and the medicines each one has prescribed for you.

Then think about your health condi-

continued on page 2 ▶

60-second safety tip

Change in Maalox. A new type of Maalox is in your pharmacy. The banner on the bottle says "Great new look. Same great Maalox" (see picture). But



it's really not the same Maalox. The Maalox you know contains both **aluminum** and **magnesium hydroxides**, and **simethicone**. The newer version, called **Maalox Total Stomach Relief**, only contains **bismuth subsalicylate**.

This medicine is related to **aspirin**.

This means that **Maalox Total Stomach Relief**:

- Should not be taken if you're allergic to **aspirin** or have an ulcer.
- Should not be given to children or teens who have a cold, flu, or chickenpox. Taking **aspirin** products under these conditions has been linked to Reye's Syndrome, a disease that injures the liver and brain.
- Requires your doctor's approval if you take medicines for diabetes, gout, arthritis, and blood thinning.

This new **Maalox** causes temporary blackening of the tongue and stools. You may have to peel back the medicine's label to see this information. People who do not notice this side effect may worry because black stools are often a sign of bleeding.

Always read the entire medicine label, and don't hesitate to ask your pharmacist questions so you know what you are taking.

Did you know...**Children may be at risk for strangulation in hospitals**

Earlier this year, a 10-month-old baby in a Finland hospital accidentally strangled on the tubing from her intravenous (IV) fluids. The baby had been asleep just an hour before a nurse found her with the tubing tightly wrapped around her neck. Attempts to save the baby failed.

In 2002, two babies in Canada were also found with IV tubing wrapped around their necks. An 8-month-old boy was thankfully revived, but an 11-month-old boy died. The day before, his mother and nurses had noticed the tubing tangled around his legs and belly. Sadly, no one thought about the risk of strangulation. Two fatal accidents were also reported in the US.

These tragic events seem to be rare. However, children between 3 months and 3 years are particularly vulnerable to such accidents. They are not mature enough to understand the risk, call out for help, or rescue

themselves from potentially threatening situations. Also, sick children of this age often receive fluids and medicines through their veins (intravenously) instead of by mouth.

Other types of medical tubing and wires can also cause strangulation. For instance, one baby was found with wires around her neck from an apnea monitor (a machine that alarms if a child is not breathing). Luckily, she was not harmed, even though strangulation in children can occur with very little pressure to their necks.

If your young child is hospitalized, ask a nurse about the risk of becoming tangled in the various tubing. If at risk, ask to have your child moved to a location where he or she can be observed frequently. Some hospitals may also have hard plastic sleeves that can be placed over the tubing closest to the child. This prevents the tubing from wrapping around the child.

Joint Commission continued
tions and the over-the-counter and prescription medicines you take for each one. Finally, think about the vitamins and herbal products you take to stay healthy. Keep a written list of all these medicines. (Go to: www.ismp.org/consumer/ISMP_MedForm.pdf for a form you can use). If you follow these suggestions, you will be less likely to forget to mention a medicine that you take at home.

During your hospitalization, ask for a copy of your medicine record. This lists all the medicines that you are getting. Check it for accuracy. If you move to a different room, check your medicine record again. If you are not well enough to do this, ask a friend or relative to help. When you are ready to leave the hospital, ask your nurse to add any new medicines to your list, and to cross off any medicines that you should stop taking. When you visit your doctors, always take your list of medicines with you.

To learn more about the National Patient Safety Goals, visit the Joint Commission's website at: www.jcaho.org/general+public/index.htm. You can also see how well hospitals are meeting these goals, and learn if your hospital is meeting all the Joint Commission's standards.

allergy alert Soy in Benadryl Fastmelt

Children with a severe allergy to peanuts or soy usually need to have **diphenhydramine (Benadryl)** liquid and an **Epipen (epinephrine)** Auto-Injector nearby at all times, including at the child's school. These medicines can lessen the effects of an allergic reaction. One mother bought a product known as **Benadryl Fastmelt** to restock her soy-allergic child's school supply of **Benadryl**. This medicine comes as a tablet that dissolves quickly in the mouth without water. These work well for children who can't swallow pills. They are also easier to carry around than a bottle of liquid medicine. Before the mother sent the medicine to school, she checked the ingredients. She was surprised to see that soy was one of the ingredients in the medicine. Soy was the reason her child might need to take **Benadryl**! Her child might have had a serious allergic reaction just from taking the **Benadryl** alone. This important information is not easy to find on the carton. In fact, most people would not even look at the added ingredients listed on the label. And why would they if they are used to buying **Benadryl** products for their allergies? Pfizer, the maker of **Benadryl Fastmelt**, has been asked to make the information about the soy protein ingredient more visible on the label, or better yet, to remove soy from the medicine. But this is a good example of why it is important to read all the ingredients in medicines listed on the labels.

Contact Information

Safe Medicine (ISSN 1550-6282)
©2005 Institute for Safe Medication Practices (ISMP). Reproduction is prohibited without written permission from ISMP.
Editors: Judy Smetzer, RN, BSN; Nancy Tuohy, RN, MSN; Michael R. Cohen, RPh, MS, ScD, Russell Jenkins, MD.
ISMP, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Email: consumer@ismp.org. To subscribe, visit: www.ismp.org/consumerarticles.