

Stay Alert for Demo Meds That Look Like Actual Meds

You can help **prevent mix-ups between demonstration, or “demo,” products and actual meds.**

In a recent report, demo albuterol inhalers, which don't contain medication, were dispensed to patients instead of the actual inhalers.

It's not surprising...since demo inhalers, auto-injectors, and other devices used for patient education often look like the real thing.

In this case, the demo inhaler and the actual albuterol inhaler appeared nearly identical. The demo inhaler carton had NDC numbers and a scannable barcode...and nothing on the inhaler indicated it was a demo.

Use this as an opportunity to improve safety with demo products...and help ensure they don't get dispensed by mistake.

Work with your team to identify what demonstration or training devices you have in your pharmacy. Check for demos of epinephrine auto-injectors, insulin pens, inhalers, blood glucose meters, etc.

Use labeling such as “For demonstration only” or “For simulation only”...to differentiate these products from actual meds.

Don't mix demo products in with regular pharmacy inventory.

Store demos in teaching areas only...such as in a designated bin or labeled container by the pickup window or in a patient consultation area.

Take care not to inadvertently select demo products when ordering meds. Review item descriptions for phrases such as “training product.”

Examine product packaging closely when preparing Rx's as another check. For instance, *Ozempic* training devices say “Demonstration pen.”

Avoid work-arounds with barcode scanning. If you have trouble scanning a product or it's missing a barcode, investigate if it's a demo.

Be aware that promotional products from drug manufacturers or other items found online may also cause confusion...such as ink pens made from the “shell” of an actual pen injector.

If patients get a demo from their prescriber or the product manufacturer to practice with, encourage storing it away from the actual med...and discarding the demo when it's no longer needed.

Share issues involving demo products with your manager ASAP. They can report the problems...to alert colleagues nationwide.

Use our resource, Preventing Med Errors, to brush up on ways to ensure patients always get intended meds.

Key References:

- ISMP. Medication Safety Alert! February 2024. <https://www.ismp.org/communityambulatory/medication-safety-alert-february-2024> (Accessed July 26, 2024).
- Consumer MedSafety.org. Demonstration Devices Mixed Up with Real Devices. <https://www.consumermedsafety.org/safety-articles/demonstration-devices-mixed-up-with-real-devices> (Accessed July 26, 2024).
- ISMP. Medication Safety Alert! August 2023. [https://www.ismp.org/acute-care/medication-safety-alert-august-10-](https://www.ismp.org/acute-care/medication-safety-alert-august-10-2023)

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-ISMP. Medication Safety Alert! August 2023. <https://www.ismp.org/acute-care/medication-safety-alert-august-24-2023> (Accessed July 26, 2024).

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