Gaps Remain in Communicating Cancelled e-Prescriptions

A pharmacist recently told us of an error in which a patient received two separate prescriptions for warfarin. The patient was being discharged from the hospital and was to take warfarin 3 mg daily at home. The prescriber initially sent an electronic prescription (e-Rx) to the pharmacy for warfarin 1 mg, with instructions to take three tablets daily. After sending the e-Rx, the prescriber realized that a warfarin 3 mg tablet was available and electronically discontinued or cancelled the first prescription. He sent a new e-Rx for the 3 mg tablet, to be taken daily, to the same pharmacy. The pharmacy never received notification that the first e-Rx was discontinued and dispensed both prescriptions to the patient. Subsequently, the patient took double the dose (one 3 mg tablet and three 1 mg tablets) daily for several days before presenting to an anticoagulation clinic with an elevated INR. It is not hard to imagine that this patient would have suffered serious harm if the overdose was not identified as soon as it was.

This is not the first time we have heard of issues when prescribers try to discontinue or cancel an e-prescription. Most times, pharmacy systems do not successfully receive cancellation communications. However, prescribers, including the one involved in the case described above, are not aware of this communication barrier. The safety and efficiency gains provided by the electronic communication of health information and prescriptions continue to be limited by gaps in interoperability. It's about time that pharmacies, prescribers, health information network operators, pharmacy computer system vendors, e-prescribing/electronic health record vendors, and regulators take action to improve the interoperability of these systems. As we move toward that goal, technology vendors and systems that transmit prescriptions must make all prescribers aware of this shortfall.

CONFUSED DRUG NAMES: CLOMIPHENE AND CLOMIPRAMINE

A consumer reported that his wife received the wrong medication from a community pharmacy. The physician's office telephoned a prescription to the pharmacy for the fertility drug clomiPHENE 50 mg, take three tablets by mouth daily. However, the pharmacy dispensed clomiPRAMINE 50 mg, a tricyclic antidepressant used to treat obsessive-compulsive disorder, with directions to take three capsules (150 mg) by mouth daily. After taking the first dose, the patient reported feeling sick and very sleepy. Later, she developed a headache, dizziness, and nausea. It is not known if any computerized alerts were generated for the high dose of clomiPRAMINE—the starting dose for clomiPRAMINE is 25 mg daily with a gradual titration over two weeks to 100 mg daily in divided doses.

We received four other reports involving this look- and sound-alike name pair dating back to 2002. The fact that both products are available in 50 mg dosage strengths increases the risk of confusion. To help differentiate these drug names, the Food and Drug Administration applied tall man lettering to the pair as part of the FDA Name Differentiation Project (www.fda.gov/Drugs/DrugSafety/MedicationErrors/ucm164587.htm).

Continued on page 55 ▶

▶ *Continued from page 10*

To prevent these errors, prescribers should include both brand and generic names as well as the purpose of the medications on prescriptions, and limit the use of telephone orders. If used, pharmacies should document telephone orders on a pharmacy prescription blank and read back, spelling the drug name(s) and stating its indication(s). Differentiate these drug names on computer screens. Explore adding computer alerts to verify the indication for these drugs. Use tall man letters and other strategies (such as bold face, color) to differentiate these drug names. Consider storing products with look-a-like names in different locations; use shelf stickers to help locate products that have been moved. Investigate implementing mandatory counseling when dispensing medications from a known problematic name pair. ■

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 on the ISMP website at www.ismp.org. ISMP can be reached at 215-947-7797.