Communicating Drug’s Purpose Can Prevent Errors

FOR A PATIENT WITH KNOWN DIABETES, A PHARMACY technician typed the medication order (Figure 1) as “Lantus inject 80 units at bedtime,” then retrieved three 10 mL vials to fill the order. The pharmacist read the order the same way while checking the technician’s work but said to herself, “This doctor doesn’t know how to spell Lantus” (insulin glargine). Then, thinking how easy it is to spell Lantus, she checked a little further. When she accessed the patient’s drug profile she saw that the patient was already on Levemir (insulin detemir [rDNA origin] injection) along with Latuda (lurasidone) 40 mg, an atypical antipsychotic drug. The prescriber intended to increase the Latuda dose to 80 mg.

Figure 1. Latuda prescription was mistaken as Lantus.

Serious harm could have occurred had the pharmacist not been suspicious enough to check further. This incident serves as a reminder about the importance of communicating the drug’s purpose. Prescribers should also properly write the dosing unit and the route of administration—in the Latuda order on the previous page, mg is expressed as just “m”, and the route is not indicated.

A 10-FOLD DECIMAL POINT ERROR
A prescription for risperiDONE 2.5 mL by mouth twice daily for a 4-year-old child was brought into a community pharmacy during its peak hours. RisperiDONE oral solution is an atypical antipsychotic agent used to treat autism, bipolar mania, or schizophrenia in the pediatric population. It is available in a 30 mL bottle at a concentration of 1 mg/mL. As the pharmacy technician was busy helping patients at the pick-up counter, the pharmacist decided to complete the entire prescription dispensing process herself. Without noticing, the pharmacist easily bypassed a drug utilization review (DUR) alert, which did not require an override with documentation.

The pharmacy did not have enough risperiDONE oral solution in stock to dispense a 30-day (150 mL) supply, so the pharmacist ordered five additional bottles. The next day the pharmacy received the additional risperiDONE. A different pharmacist labeled and dispensed the medication; the patient’s caregivers declined patient education. The patient was administered risperiDONE for seven days until the child experienced seizures and was hospitalized. It was discovered that the decimal point had been misplaced on the original prescription. The prescriber intended to write for 0.25 mL (0.25 mg) but instead wrote for 2.5 mL. As a result, the patient received 2.5 mg twice daily (5 mg total) for seven days.

RisperiDONE oral solution is considered a high-alert medication (www.ismp.org/communityRx/tools/ambulatoryhighalert.asp) in the pediatric population as it is a liquid that requires measurement. As such, special safeguards should be implemented to reduce the risk of errors. Modify alerts so that they clearly state the problem, are not easily bypassed, and require documentation to continue the dispensing process. When additional medication must be ordered to complete the prescription, pharmacies should consider implementing another double check before the additional medication is dispensed to the patient. Also, institute mandatory patient education for high-alert medications, including return demonstrations by caregivers and patients of how to measure and administer the medication, to ensure caregiver and patient understanding. aP

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