Practice sting Wrong medicine prescribed

An easily made mistake when prescribing medicines is selecting the wrong medicine. The following message is a good example.

Notification

A general practitioner wants to prescribe a low dose of midazolam (Dormicum®) to an elderly woman. The GP types in the electronic prescribing system (EPS) 'DORM'. The GP clicks on Dormonoct® 1 mg with a dose of 2 tablets once a day. When checking the prescription, the pharmacist is not aware that loprazolam (Dormonoct®) is not a common sleep sedative and that the dose is very high for an elderly person. The pharmacy delivers Dormonoct® to the patient. The patient takes the medicine and finds the medicine to be much stronger than she expected. She contacts the GP.

Analysis

When prescribing drugs in an EPS, the prescriber often types in the first letters of the medicine's name. The prescriber can add letters and numbers for the dosage form and strength. A list of medicines appears on the screen from which the correct medicine in the correct strength is chosen. It is important that the GP checks whether he has selected the correct medicine before giving the prescription to the patient or sending it to the pharmacy. The GP should have been warned by the notification that the dose is too high. This notification appeared on the screen after the selection of Dormonoct®.
Also in the pharmacy, the pharmacist's assistant did not take any action while processing the prescription and the pharmacist did not take any action while checking the prescription. They did not take any action, because the maximum dose of 2 mg had not been exceeded.

In July 2021, a urologist appeared before the disciplinary judge for a similar error. The urologist wanted to prescribe Clomid®, an anti-estrogen, to a patient. The urologist typed in the letters "Clomi". Clomipramine, an antidepressant, was shown. The urologist prescribed this medicine. The disciplinary board gave a warning to the urologist. The board blames the urologist for not carrying out an extra check before sending the prescription to the pharmacy.

Recommendations

To prescribers

- Always check whether you have selected the correct medicine before giving the prescription to the patient or sending it to the pharmacy.

To pharmacists

- Discuss with the pharmacy team how to deal with the medication monitoring signal that the dose is high, but that the maximum dose is not exceeded.