Practice sting Other strength delivered

Supplying a medicine in a different strength than prescribed can lead to an incident, as shown in the notification.

Notification

In the palliative ward of a nursing home, a geriatric specialist decides, in consultation with the patient and her family, to switch to palliative sedation with midazolam and pain relief with morphine via a syringe pump. The geriatric specialist issues an order for 1 ml morphine ampoules with a strength of 10 mg/ml. The doctor completes a form for this administration. This form states, among other things, that the nurse must withdraw 6 ml from the morphine 10 mg/ml ampoules for the syringe pump.

Due to availability problems, the pharmacy cannot supply morphine 10 mg/ml ampoules. The pharmacy supplies morphine 20 mg/ml ampoules. The pharmacy assistant adjusts the administration form accordingly. The pharmacy assistant also reports the change to a nurse from the department who is not directly involved with the patient. The nurse forgets to inform the doctor and the nurse directly involved with the patient due to the busyness on the ward.

Subsequently, a nurse prepares the syringe pump solution accordingly to the doctor's form. Not realizing that the strength of the morphine ampoule is different, she draws up 6 ml. The nurse who performs the double check does not observe the mistake either. Both sign the form and the administration form.

The nurse places the syringe in the syringe pump and administers the solution. The patient becomes restless. This can be a result of the too high dose of morphine. The geriatric specialist prescribes additional midazolam. This gives a good effect.

Analysis

Due to availability problems of medicines, the pharmacy may be forced to supply the medicine in a different strength. It is important that the pharmacy communicates this clearly with the nursing staff of the department, so that there are no surprises. The pharmacy must also ensure that the administration list is adjusted.

As the above report shows, more action from the pharmacy is needed for medicines that are prepared for administration in the department. The form that is available in the department for this purpose must also be adapted.

Finally, this notification shows that close monitoring is necessary when administering medicines. The double check by a second person must also be done meticulously.

Recommendations

For healthcare institutions and pharmacists

- Make agreements about how the pharmacist will inform the (department of a) healthcare institution about the dispensing of a different strength of a medicine, but of course also in the case of a different form (e.g. retard) or an alternative medicine.
- Also make explicit agreements for medicines that are used in preparing solutions for syringe pumps, infusions and the like for administration and for which the forms used in the healthcare

institution must be adapted. Also agree who will adjust the form if the strength or medicine changes.

- Discuss the importance of accurate checks with healthcare workers.