Practice sting 2022-16

Practice sting Contraceptive injection at the wrong injection site

The contraceptive injection is available as Depo-Provera®, an injection for intramuscular administration and as Sayana®, an injection for subcutaneous administration. This notification reports a case where it went wrong with the administration: Depo-Provera® was injected subcutaneously, although the general practice and the pharmacy paid attention to administration via the correct route of administration.

Notification

A woman receives Sayana® for several years in the general practice. Due to supply problems of Sayana®, the GP prescribes Depo-Provera® with the free text "until Sayana® is available again". When the GP hears that Sayana® is available again, he prescribes Sayana® once again to this woman. The pharmacist's assistant assumes that this prescription is a mistake of the GP because the patient has already had Depo-Provera® three times. She changes the prescription to Depo-Provera®.

In the general practice, a GP's assistent in training administers the contraceptive injection. She was told by an experienced colleague that the contraceptive injection should be injected subcutaneously. She therefore injects Depo-Provera® subcutaneously. After injecting, the GP nurse reads the text on the box and realizes that she has made a mistake. She explains the situation to the GP, who consults the pharmacist. Their decision is not to inject again, because the risk of overdose is too great. Because of the risk of an unwanted pregnancy, non-hormonal contraception is advised to the woman.

Analysis

During supply problems of Sayana®, the GP and the pharmacist have agreed that the GP will prescribe Depo-Provera®. When the GP prescribed Sayana®, the pharmacy assistant did not realize that Sayana® was available again. The pharmacy assistant incorrectly assumed that - because the patient had already had Depo-Provera® three times before - the GP meant Depo-Provera®. She had forgotten that Depo-Provera® only had to be used during the period when Sayana® was not available.

The GP did not communicate with the pharmacist that when Sayana® was available again, the GP only wanted to administer Sayana®. The reason was that in the past an administration error has been made in general practice by using the two injections - which differ in administration route - next to each other.

In order to prevent administration errors with the two different routes of administration, the pharmacist has specially created two codes for the prescription processing. By these codes, i.m. (for intramuscular) with Depo-Provera® or s.c. (for subcutaneous) with Sayana® are put on the pharmacy label. It also went wrong because the GP and the pharmacist were not aware of each other's precautions to prevent errors in administration.

Recommendations

For general practitioners and pharmacists

- Make agreements about the substitution of medicines by the pharmacy in the event of supply problems. Also agree whether the doctor needs to adjust the medicine on the prescription.
- If a medicine is available again, discuss whether the patients should be switched back to the original medicine.

For pharmacists and pharmacy assistants

- Make sure that the text on the label is understandable for the collaborator who administers the medicine. Avoid jargon and abbreviations.

For general practitioners, practice nurses and GP's assistants

- Always read the pharmacy label before administering and for unfamiliar products, always read in the package leaflet how the medicine should be administered.