



Practice sting 2023-15

Practice sting Incorrect conversion of Calci Chew D3®

this practice sting is particularly interesting for healthcare professionals working in or for elderly care institutions, disability care institutions and mental health institutions

Communication remains an important point when processing medication orders, as is also evident from the following notification.

Notification

A patient in a nursing home has a feeding tube due to severe swallowing problems. The speech therapist recommends administering the medication through the feeding tube. The geriatric medicine specialist, pharmacist and nurse include the speech therapist's advice in the medication review. The pharmacist recommends, among other things, converting the Calci Chew D3® chewable tablets (500 mg/800 IU) into Cad® effervescent granules (500 mg/880 IU). The geriatric medicine specialist adjusts the medication accordingly in the electronic prescription system (EVS) and states in the medication order that the Cad® effervescent granules must be administered via the tube. When processing the medication orders, the pharmacy assistant observes that Cad® is not in stock and changes the effervescent granules to Calci Chew D3® chewable tablets that are in stock. According to Oraliala VTGM of the Dutch Pharmacy Organization KNMP, this medicine can be administered through the tube. However, the assistant forgets to mention on the administration list that the chewable tablets must be made suitable for administration by tube. Forgetting this automatically puts the chewable tablets on the administration list as oral medication. Due to the lack of administration information for the tube, the nurse at the nursing home does not administer the Calci Chew D3® through the tube.

Analysis

In this notification, several steps in the medication process went wrong:

1. The pharmacy assistant did not indicate that by substituting back the patient continued to use the Calci Chew D3® chewable tablets, while the pharmacist had advised the geriatric specialist to prescribe Cad® effervescent granules. The reason for this advice was that making the chewable tablets suitable for administration through a tube is very laborious. The tablets are difficult to grind and dissolving of the tablets in a syringe takes several minutes.
2. The pharmacy assistant forgot to adjust the method of administering the chewable tablets after conversion, so they remained on the administration list as oral medication.
3. The prescriber had not entered the contraindication 'tube' or 'swallowing disorder/swallowing problem' in the patient data in the EVS or the pharmacist had not seen that one of these contraindications had been entered for this patient. As a result, the pharmacist missed the signal that it was necessary to check whether all medication the patient received was suitable for administration through the tube.

Recommendations

For the committee that deals with medication safety

- Make clear agreements about who will record and maintain the contraindication for a tube/swallowing problem in the EVS.

For prescribers

- Inform the pharmacy when a patient can only take medication through a feeding tube.

- Add the contraindication 'tube' or 'swallowing disorder/swallowing problem' in the EVS for the relevant patients.
- Avoid using notes in medication orders as a means of communicating essential information that applies to the patient's entire medication regimen.
- If there is any doubt or uncertainty about medication use in patients with a feeding tube or swallowing problems, always consult the pharmacist.

For pharmacists and pharmacy assistants

- Only restart stopped medicines if the reason for stopping allows it or if you have permission from the prescriber.
- Check whether the contraindication 'tube' or 'swallowing disorder/swallowing problem' has been entered for patients with a feeding tube or if a prescriber asks for advice because of the feeding tube. If not, inform the prescriber of this.
- For patients with a contraindication 'tube' or 'swallowing disorder/swallowing problem', check using Oralia VTGM whether the prescribed medication can be administered via the tube.
- Check whether the administration list contains correct and complete information.
- Be extra alert to changes in pharmacotherapy in vulnerable patient groups, such as patients with a feeding tube.

For nurses, carers and supervisors

- If there is any doubt or uncertainty regarding medication use in patients with a feeding tube or swallowing problems, always consult the pharmacist.