Practice Sting Who is the actual prescriber??

This Practice Sting is particularly relevant for prescribers, pharmacists, and nurses.

VMI is interested in your experiences regarding the modification of medication orders by nurses or within the pharmacy.

Incidents

1. A woman taking oxycodone reports severe nausea shortly after admission. A nurse pragmatically administers a 4 mg tablet of ondansetron without consulting a prescriber. After administration, the nurse requests a medication order from the physician. The physician notes that the patient is also using levomepromazine, which interacts with ondansetron. Combined use may lead to QTc interval prolongation.
2. A pediatrician prescribes midazolam nasal spray at a dose of 2.5 mg per administration for a child. This dosage is intentionally higher than the standard dosage listed in the Pediatric Formulary. The physician explains this deviation to the parents. At the outpatient pharmacy, the pharmacy assistant notices the higher-than-usual dose and assumes a prescribing error. Based on the Pediatric Formulary, the assistant adjusts the dose to 0.5 mg per administration with instructions to use one spray per dose. The pharmacy assistant does not contact the pediatrician. As a result, the child receives a significantly lower dose than intended by the physician. The reporter of the latter incident expresses concern that the outpatient pharmacy frequently modifies medication orders without consultation.

Question for Healthcare Professionals

To facilitate mutual learning, VMI invites Dutch health care preofessionals to complete a short questionnaire. This can be done until October 30 and will take no more than 10 minutes. VMI will anonymously share the results in the Practice Sting Extra. Thank you in advance for your cooperation.

Analysis

Nurses are not authorized to prescribe prescription medications. Exceptions apply to a limited group, including nurse practitioners and specialized nurses in diabetes mellitus, oncology, or asthma and COPD. These professionals have completed additional training and registered their prescribing authority in the BIG register. In daily practice, nurses without prescribing authority may administer medications not previously prescribed as 'as-needed' by a physician or other authorized professional. This can result in inappropriate pharmacotherapy, as illustrated in the first report.

Modifying medication orders in the pharmacy is a routine practice and falls under the professional responsibility of the pharmacist. In 1.8% of prescriptions, pharmacists alter the order due to a relevant medication safety alert to resolve a pharmacotherapy-related problem (FTP), such as dosage issues or drug interactions. However, such modifications may lead to incorrect pharmacotherapy, as seen in the second report where the physician intentionally deviated from the standard dosage.