


# Practice Sting Working with a Fragmented Patient Record.

This Practice Sting is relevant for prescribers and healthcare professionals who use different systems for documenting and prescribing medication.

**Be sure to update medication changes across all systems.**

## Incident

A patient is treated with 40 micrograms (mcg) of darbepoetin alfa every three weeks. During dialysis, the patient's haemoglobin (Hb) level is found to be too low. The prescriber notes in the dialysis report that darbepoetin alfa should henceforth be administered weekly instead of once every three weeks.

Approximately three weeks later, the patient's Hb level remains too low. Although the medication change was recorded in the dialysis report, it was not updated in the treatment plan on which the medication administration is based. As a result, the new administration frequency was not implemented, and the patient continued to receive darbepoetin alfa once every three weeks.

## Recommendations

**For the medication safety committee**

- Establish and implement procedures on documenting medication changes so that all parties (prescriber, pharmacist, and administering nurse) are informed.
- Periodically draw attention to these agreements, including the consequences of deviating from them.
- Determine which organisational or technical measures can be implemented to prevent similar incidents in the future.

**For prescribers**

- Make sure all medication changes are recorded in all the intended places, including the prescribing system and administration records.

**For nurses/care staff**

- Be alert to discrepancies between the clinical report, prescribing system, or administration record.

## Analysis

This report highlights the risks associated with having to document medication changes in multiple locations. Prescribers record considerations and decision-making information in the reporting system. Nurses administer medication based on a treatment plan or administration record. Pharmacies dispense medication based on prescriptions from the electronic prescribing system. These systems are often not (fully) interconnected. As a result, prescribers are required to enter information in multiple places.

To ensure correct medication and dosage, prescribers must therefore enter changes in multiple systems. This enables nurses to administer the medication in the correct dose. If discrepancies arise between sources, it is important to determine which information is accurate. The administering healthcare professional has a key role in verifying this.

The duplication of tasks regarding medication changes increases the risk of errors. To mitigate this risk, organisations can explore ways to better align the involved systems, for example through (partial) system integration or other forms of data exchange. Until such integration is achieved, a clear and standardised workflow can help ensure that all professionals know which system is used for which purpose, and can prevent inconsistencies in documentation.