FOCUS ON ERROR PREVENTION

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NEW DRUG THERAPY

Patients with chronic medical conditions are often taking multiple medications. With increasing age and progression of their medical condition, patients may receive new drug therapies. It is therefore critical that steps be taken to prevent the dispensing of drugs that the patients should no longer be taking.

CASE:

A sixty-six year old diabetic patient has been taking metformin for an extended period of time.

During a recent visit to his physician, the patient was asked to discontinue metformin and was given a new prescription for Jentadueto® (linagliptin/metformin hydrochloride 2.5 mg/500 mg) to be taken twice daily. The prescription was taken to the patient's regular pharmacy for processing. The patient received the correct medication and was counselled appropriately.

Approximately one month later, the patient called the pharmacy and asked a pharmacy assistant to "renew his diabetic medication." The pharmacy assistant reviewed his medication profile and saw both Jentadueto® and metformin. However, the pharmacy assistant was not aware that Jentadeuto® was a "diabetic medication" and therefore assumed that the patient was asking for a refill of metformin.

Metformin was therefore prepared for checking by the pharmacist. The computer's Drug Utilization Review (DUR) indicated a potential duplication of therapy with metformin and Jentadueto®. The DUR also indicated that the patient was "late" in refilling the metformin. Both notations were missed by the pharmacist. Hence, metformin was dispensed and placed in a sealed bag for pick up.

When picking up the medication later in the day, the patient indicated that he had been taking the medication and did not require counselling. The patient therefore took the metformin and left the pharmacy. Upon arriving home, the patient opened the bag and identified the error. He was very upset that he was given a medication that he should no longer be taking.

POSSIBLE CONTRIBUTING FACTORS:

- When ordering his medication, the patient did not specify the name of the drug and the pharmacy assistant did not take the time to confirm.
- The pharmacy assistant was unfamiliar with the drug Jentadeuto®.
- On receiving the new prescription for Jentadeuto®, the pharmacy staff failed to deactivate the metformin prescription which should no longer be dispensed due to the change in therapy.
- When dispensing the metformin, the pharmacist failed to read and act upon the DUR notes.

RECOMMENDATIONS:

- Remind staff to always confirm the name of the medication the patient is requesting when processing refills.
- Whenever a new medication is added to the pharmacy inventory, all staff should be educated about the product.
- Consider placing information regarding newly marketed products in an appropriately labelled binder to be reviewed by all staff on a regular basis.
- If there is a change in a patient's drug therapy or dosage, establish a system to deactivate or discontinue all previously dispensed medications which should no longer be dispensed. Add a notation to the patient's profile to link these deactivated prescriptions to the new prescription.
- Remind all pharmacy staff to carefully review and act upon all DUR notes. If necessary, contact your software vendor to ensure the information is prominently displayed and easy to read.

Please continue to send reports of medication errors in confidence to Ian Stewart at: ian.stewart2@rogers.com .

Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.