Med Safety Minute

Prescribe Safely...
Every Patient, Every Time

e-medication safety

10:00 hrs: The Pain Team reviews your patient & recommends reducing the dose of OxyContin® from 10 mg bd to 5mg bd.

11:58 hrs: You cancel the OxyContin® 10 mg bd & order a new prescription for 5 mg bd.

13:30 hrs: You get a call from the ward – the patient has developed signs of opioid toxicity. But you have just reduced the dose – so why is this happening?

Answer:

The patient was administered a duplicate dose of OxyContin®

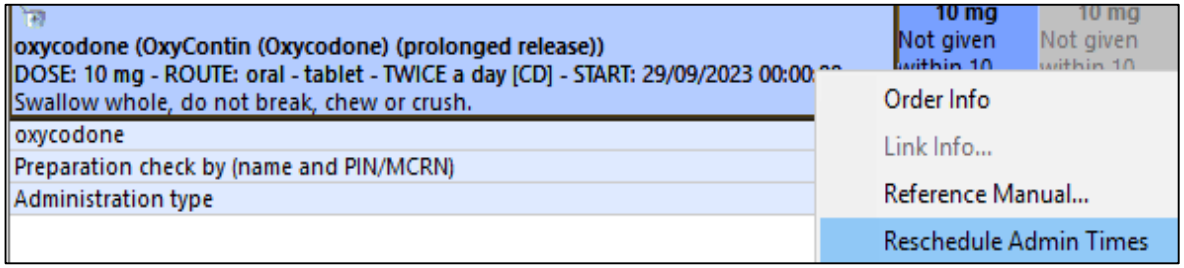
Avoid the unpleasant surprise of default duplications

How did this happen?

- The default administration times for MDAs on EPR in SJH are midday & midnight.
- The dose of 10 mg had been administered slightly earlier than scheduled – at 11:55 hrs – just before you cancelled the prescription at 11:58 hrs.
- When you ordered the new prescription for 5 mg bd at 11:58 hrs, the first dose defaulted to 12 midday, i.e. just 2 minutes later.
- This 5 mg dose was then administered shortly afterwards, just 20 minutes after the 10 mg dose had been given.

Reducing the risk

- If cancelling & reordering a medication, check when the previous dose was administered to prevent dose duplication.
- When prescribing, check what the default administration times are & adjust the schedule from the drug chart if required.



- Discuss your prescribing intentions with nursing staff so that they are aware of the plan.
- Always refresh & review the drug chart after prescribing to check the administration schedule is as you expected