

FOCUS ON ERROR PREVENTION

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VISUAL, HEARING OR COGNITIVE IMPAIRMENT MEDICATIONS

Many patients exhibit varying degrees of visual, hearing or cognitive impairment, and may therefore require specialized care to ensure the appropriate use of medications. CNIB estimates that approximately half a million Canadians are living with significant vision loss that impacts their quality of life¹. In a recent survey, 5% of Canadians aged fifteen years and older reported having a hearing limitation². Pharmacists must therefore be cognizant of the unique limitations and needs of these patients when providing pharmaceutical care.

CASE:

A twenty-seven year old patient with severe visual impairment has been taking Levetiracetam for epilepsy for an extended period of time. The initial dose prescribed was 1000mg in the morning and 1500mg at bedtime. The tablets are available in both the 500mg and 750mg strengths. The patient was therefore given the 500mg tablets and advised to take two tablets in the morning and three tablets at bedtime.

Her physician later increased the dose to 1500mg in the morning and 1500mg at bedtime. The 500mg strength tablets were again dispensed and the patient advised to take three tablets in the morning and three tablets at bedtime.

Following a visit to her physician, the patient was given a new prescription stating 1500mg to be taken in the morning and 1500mg at bedtime. The prescription was taken to her usual pharmacy for dispensing. On this occasion, the pharmacy assistant selected the 750mg strength tablets in an effort to reduce the number of tablets taken by the patient. The instructions on the prescription vial therefore indicated that the patient should take two tablets in the morning and two tablets at bedtime. The pharmacist checked the prescription and dispensed the 750mg tablets. No documentation was made regarding the change in tablet strength.

The patient later returned to pick up the medication. No counselling took place. It is believed that the patient indicated that she has been taking the medication for an extended period of time and did not require any additional information. However, no documentation was made.

Not being aware of the change in tablet strength, the patient continued to take three tablets twice daily. That is, a daily dose of 4500mg instead of the 3000mg prescribed daily dose.

After completing the dispensed tablets early, the patient requested a refill of the Levetiracetam tablets. Though the refill request was early, the pharmacist did not question the patient regarding the reason.

At some point, the patient's parents with whom she resides, noticed the change in tablets and contacted the pharmacy to discuss the issue.

Though the patient did not suffer any adverse effects, the patient and her parents were unhappy that the change was made without discussing the issue with either the patient or her parents.

POSSIBLE CONTRIBUTING FACTORS:

- The change in tablet strength was made by the pharmacy assistant without highlighting the change and the need to inform the patient.
- The pharmacist either did not notice the change in strength or did not take steps to ensure that the patient was made aware of the change.
- The visual impairment of the patient likely contributed to her inability to notice the change in the labelled instructions and the change in appearance of the new strength.
- The pharmacist did not inquire and/or document the reason for an early medication refill.

RECOMMENDATIONS:

- Always document changes in drug therapy and the reasons for making the change.
- Establish standards to ensure that all changes to a patients' medication regimen be discussed with the patient or caregiver. Document that the communication took place.
- Ensure patient counselling takes place or document why it did not occur.
- Always attempt to establish the reason for early or late refills. Document your findings. **Pc**

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.

REFERENCES

1. Fast Facts about Vision Loss. Available at: <http://www.cnib.ca/en/about/media/vision-loss/pages/default.aspx> (Accessed August 9th, 2015).
2. Facts on Hearing Limitations. Available at: <http://www.statcan.gc.ca/pub/89-628-x/2009012/fs-fi/fs-fi-eng.htm> (Accessed August 9th, 2015).

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