

The Patient's Role in Safe Medication Use

A nurse had an order to administer a 200mg depot injection of zuclopenthixol decanoate. She had no previous experience with the drug and misunderstood the vial's label. Instead of giving the patient his usual dose of 1ml of a 200mg/ml solution, she interpreted the entire vial to contain 200mg. Five times the normal dose was given (the vial was only half full). The patient experienced very unpleasant extrapyramidal symptoms for weeks as the drug was very slowly eliminated from the body.

A pharmacist took a telephone order from a doctor. Instead of Zyprexa 20mg HS (an antipsychotic) she heard Celexa 20mg HS (an antidepressant) and dispensed this to the patient. The patient took the drug and a month later experienced a relapse of psychosis.

These are examples of medication errors that occur in mental health settings. Despite having medication delivery systems with numerous redundancies, errors can still occur during prescribing, dispensing and administration stages. An important last line of defense against errors is the patient's knowledge of his or her therapies. However this defense can be compromised, making patients more vulnerable to medication errors. Those who have not been told about their medication or who have cognitive deficits associated with schizophrenia that interfere with their understanding of medication, may be unaware that a drug is about to be administered or dispensed in error. If the patient does detect an error, their protestations may be dismissed as a symptom of their illness, such as a persecutory delusion.

Unpleasant outcome resulting from errors can result in a fear of medication. In those with schizophrenia, non-adherence with prescribed medication for other reasons such as stigma, complicated medication regimens and lack of insight is already a common problem and is a leading cause of relapse and re-hospitalization in this population. Errors may result in a loss of trust in health care providers, making it even more difficult to convince patients of the relative benefits of medication.

Medication errors are less likely to occur if the consumer has the information to actively participate in their detection. At a minimum, both inpatients and outpatients should know:

- Drug names (generic and brand names)
- What each drug is used for
- What each drug looks like
- How each drug should be taken
- Side effects, including those to report immediately to a doctor
- Important drug interactions (including interactions with over-the-counter medication and herbal products)
- What to do if a dose is missed
- Proper storage of medication

Pharmacists, nurses and physicians need to take the time to teach patients this information. The health care team must also communicate with one another to ensure

consistency of the facts being delivered. Patients with cognitive impairment may need this information repeated regularly. The same factual details coming from a variety of sources - from health care professionals and family - reinforces learning and understanding.

Patients should be encouraged to question a medication they feel is being administered or dispensed in error. The medication should not be given until the nurse or pharmacist is able to verify that the drug, dose, route, etc. is correct. This may involve contacting the doctor or double-checking with another staff member. To avoid errors in self-administration of medications at home, patients struggling with complicated medication regimens can benefit from compliance aids such as blister packs. They should also be encouraged to return old medications to the pharmacy to avoid confusion with current drugs.

Errors can occur at any stage between the time the medication is ordered and the time the patient receives the drug. Most hospitals actively monitor errors and near misses and work to improve the medication delivery system to reduce the chance of the same types of errors occurring again in the future. Despite constant improvements in error prevention, the patient still has an important defensive role in the system. Health care providers have a duty to ensure that patients have the required information to actively participate in safe medication use.

Providing adequate information for patients is a good medication error prevention strategy. For more information about helping patients become informed consumers refer to www.ismp.org and click on 'Alerts for Patients'.

Caroline Warnock, B.Sc.Pharm.
Centre for Addiction and Mental Health
Special Consultant to ISMP Canada