Category: Medication

Preventing: Unintentional switching of brands for antiepileptic medicines.

Key words: Medicine, Dispensing, Brand Prescribing, Dosette Box, Labelling, Anti-Epileptics.

Sharing Learning Points

LOCALLY

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What happened?

A patient with epilepsy, who had multiple hospital admissions over a short period of time for varying medical conditions not related to epilepsy, received the wrong brand of phenobarbital during their multiple admissions and on discharge.

The patient receives a dosette box from their community pharmacy which contains phenobarbital, a Class 1 anti-epileptic which must be prescribed by brand. For Class 1 anti-epileptics, switching between manufacturer's products can potentially cause a loss of seizure control and increased side effects. Therefore, the MHRA advises that patients on these medications should be maintained on a specific manufacturer's product.

Dosette boxes are medication compliance aids used to support people who find taking medication difficult. They are usually supplied weekly and contain an information sheet giving a description of the medicines in the box such as the dose, administration instructions, the colour of tablet/capsule and whether it has any markings.

The patient's Emergency Care Summary (ECS) did not specify which brand of phenobarbital the patient was on and neither did the dosette box. The hospital pharmacy team confirmed with the patient's community pharmacy that the patient was on TEVA brand and this was documented on HEPMA throughout the multiple admissions. However, on all of the admissions, the Accord brand of tablets was prescribed on the inpatient chart. This was recognised as incorrect by the pharmacy team but the prescribing had not been rectified. The patient therefore received the Accord brand of tablets as an inpatient and these were dispensed in the dosette box on discharge.

The patient's phenobarbital dose was 120mg which was normally achieved using the 60mg tablets. HEPMA did not have a prescribing file available for TEVA 60mg tablets which may have contributed to the error. Fortunately, the patient did not suffer any seizures as a result of this error.

What went well?

- The error was identified and brand was confirmed with community pharmacy.
- HEPMA team have now added 60mg strength of TEVA phenobarbital, so this brand can be prescribed on HEPMA.
- Communication with the patient's practice pharmacist and community pharmacy following the event.
- The brand of phenobarbital has been added to the ECS and dosette box information.

What, if anything, could we improve?

- Ensuring errors are escalated and prescribing rectified on the first admission to prevent errors on subsequent admissions.
- Ensure documentation on all software (Trakcare, HEPMA) is complete.
- More awareness around anti-epileptic brand prescribing.
- Class 1 anti-epileptics should be prescribed by brand.

What have we learnt?

- There is potential for loss of seizure control if the incorrect brand of phenobarbital is prescribed.
- Escalating appropriately when encountering errors and ensuring they are rectified will drastically reduce incidents similar to this in future.
- Staff should never assume that a previous admission's medicines are 100% correct, and reiterates the need for obtaining a second source when completing a medicines reconciliation.

If you have any comments about this or any similar adverse event please send them to rebecca.richards@nhs.scot or murray.burns@nhs.scot