Feedback from Datixes
Common Pitfalls when prescribing with Metavision

Real examples of prescribing errors that have been datixed BSUH Critical Care

Mis-selection of the drug from the list

This type of prescribing error is common with electronic prescribing and doesn't tend to happen with paper drugs charts.

- **Wrong drug selected as only first few letters of the drug name entered into Metavision**
  levofloxacin prescribed instead of levothyroxine
- **Wrong drug selected as prescriber not aware that the 2 drugs are different**
  Tetanus toxoid (vaccine) prescribed when tetanus immunoglobulin was intended
  Semisodium valproate prescribed when sodium valproate was intended
- **Wrong method of administration (but correct drug) selected from the list**
  IV bolus of omeprazole instead of continuous infusion of omeprazole in a post OGD patient

Drug prescribed without repeated set being selected

This causes the prescription to finish at the end of the set. This has led to missed doses when it has not been noticed that a prescription has not repeated

- Patient on long term steroids switched to IV hydrocortisone as nil by mouth. Hydrocortisone prescribed as 4 doses in 24 hours, but not a repeated set. Prescription finished after 24 hours. No further hydrocortisone prescribed. Patient became hypotensive during the day with no steroid prescribed.

Loading dose prescribed as a repeated set

When prescribing a loading dose, or a stat dose, 'Repeated Set' should not be selected as this will generate further doses after the initial dose.

- An elderly patient was to be loaded on digoxin and was prescribed 500mcg x 2 doses. The repeated set box was ticked, so after the 2 doses had been administered MetaVision generated another 2 doses. The patient received 6 doses of 500mcg before the error was noticed.

Additional dose added to the set when intending to prescribe an initial stat dose

When prescribing an initial stat dose for a repeated set, the 'Once Only' box must be checked. If this doesn't happen the additional dose becomes part of the repeating set. This increases the number of doses per day, so an od script becomes bd, bd becomes tds etc.

- Patient on Morphine Sulphate MR. Dose intended to be increased from 10mg bd to 20mg bd. Unintentionally prescribed 20mg tds as initial stat dose was not prescribed as Once Only. Patient became very drowsy on this much increased dose.
- Elderly patient initiated on Citalopram 20mg od. Intended to prescribe a stat dose to enable starting therapy as soon as possible prior to morning dose the next day. Stat dose not prescribed as once only. Citalopram unintentionally prescribed as 20mg bd which is double the maximum daily dose in this age group.
- Patient being converted from po to IV dexamethasone 12mg od. Stat IV dose of 12mg not prescribed as once only so patient was unintentionally prescribed 12mg bd. Patient became agitated which may have been due to double dose of dexamethasone.

Duplicate prescriptions

Always check that someone hasn't already prescribed what you are about to write up. If represcribing an item, always cancel the old prescription first before writing up the new prescription.

- Patient on ARVs needed their prescription adjusting. The new prescription was added but the existing prescription was not cancelled. The patient received a double dose of ARVs before the error was spotted.

Failure to double check your final prescription

When designing any prescription, even if using the default suggested by MetaVision, it is always important, after you have prescribed the item, to go to the Cardex and check that the prescription is as you had intended.

- Patient prescribed prednisolone for exacerbation of asthma. Intention was to prescribe 30mg om for 4 days to complete the course.
  MetaVision default prescription is 30mg om repeated set. In amending the prescription to create a defined course, the prescription was unintentionally changed to 19 doses in 4 days. 3 doses were given on the first day before the error was noticed. The patient required an insulin infusion for high BMs.

Incorrect prescribing using the default settings

MetaVision will present you with a default prescription on which to base the prescription for your patient. You will usually need to amend the default prescription to create the correct prescription for your patient.

- A patient was prescribed their usual intermediate acting insulin. The intention was to prescribe their usual dose of 60 units od. The default prescription for this insulin is bd, as this is how this insulin is usually used. The patient was prescribed 60 units bd which was double the intended dose.