

This is the first in a series of bimonthly columns that **RN** will offer on preventing drug errors. It will feature actual cases reported to the Center for the Advancement of Patient Safety (CAPS) at the U. S. Pharmacopeia, along with analysis and recommendations by CAPS staff.

Error Watch

A Series Of Slips Led To This Drug Mix-up

Borrowing drugs, not confirming a verbal request, and not knowing a weekend protocol paved the way for this “Serzone/Seroquel” mix-up reported anonymously to the U. S. Pharmacopeia’s Medication Errors Reporting (MER) Program.*

A patient’s dose of the antidepressant nefazodone HCl (Serzone) was being gradually reduced. On a Friday, a 200 mg tablet was dispensed, along with two 100 mg tablets to be used as the tapered doses for the weekend, when the pharmacy was closed. The patient was inadvertently given the two 100s on Friday, leaving the weekend nurse with only the (unscored) 200 mg tablet.

Forgetting that extra Serzone was kept in the night cabinet on weekends, the nurse asked a colleague to borrow a 100 mg Serzone tablet from another unit. The colleague thought she said “Seroquel”—which is the antipsychotic agent quetiapine fumarate. Seroquel (in 100 mg tablets) is what she borrowed, and that’s what the patient got for two days. Come Monday, the colleague called the pharmacy to get more Seroquel for the patient—and the error was caught. The patient suffered no harm, but the drug could have caused seizures and excessive orthostatic hypertension, among other reactions.

This mishap teaches the importance of several safety measures, such as having a “no borrowing” policy, posting reminders on procedures when the pharmacy is closed, alerting staff to easily confused drug names, and rechecking verbal requests for medications.

*MER is presented in cooperation with the Institute for Safe Medication Practices.

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