Incorrect prescription and application of medication for seizures
16HDC00163, 28 June 2019

Medical centre ~ Pharmacy ~ Disability service ~ General practitioner ~ Seizure ~Medication ~ Prescription ~ Rights 4(1), 4(2)

A woman in her late teens lived in a community house under the care of a disability service provider. Her mother was closely involved in the provision of her services.

The young woman had been a patient at her medical centre since she was a baby.

Her general practitioner (GP) prescribed "Midazolam 15mg/3ml plastic 1 ampule for a seizure applied to skin behind ear". Over a period of four years, the prescription was repeated nine times. Another GP signed repeat prescriptions for the midazolam (to be administered behind the ear) on two occasions. A number of pharmacists dispensed midazolam with the instruction to apply behind the ear.

The young woman experienced a seizure. Her caregiver went to get buccal midazolam, but the only midazolam available was an injection. She noted that the packaging of the medication stated: "Use one ampule for a seizure applied to skin behind the ear."

The caregiver called the disability service to attempt to clarify the medication instructions with a registered nurse, but that was unsuccessful, so she followed the instruction on the package and administered the midazolam to the young woman behind her ear. The seizures continued, so the caregiver called an ambulance.

The young woman's mother arrived shortly after the ambulance, and at that stage the seizures had settled. Her mother said that the ambulance officer was surprised that the pharmacist had instructed that midazolam be applied behind the ear.

The young woman's GP had altered the prescription instructions to refer to buccal use. She agrees that there is no evidence to support the administration of midazolam behind the ear for the acute control of prolonged seizures, and that this use was outside usual accepted practice.

From the date of the original prescription until the issue was discovered, there were discrepancies between the pharmacy labels (completed by the pharmacy), the medication administration chart (completed by the GP), and the young woman's seizure management protocol setting out the process to follow should she have a seizure (created by the disability service).

Findings

It was inappropriate for the GP to prescribe midazolam in a manner inconsistent with accepted practice. The GP continued to prescribe midazolam to be applied behind the ear whilst recording contrary instructions on the medication administration chart, which shows a concerning lack of critical thinking. It was held that the GP failed to provide services with reasonable care and skill, and breached Right 4(1).

The GP did not document the reasons for the change to the mode of administration of midazolam, why the particular mode was chosen, and whether there had been any discussion with the young woman's mother. By failing to keep appropriate clinical records,

the GP failed to provide services that complied with professional standards, and breached Right 4(2).

There was contradictory information in the records with regard to the manner in which midazolam was to be administered, and this was not questioned. In addition, there was a weakness in the manner in which medication was checked, and deficiencies in the policy and procedures for safe administration of medication. There was also a lack of recorded nursing assessments. It was found that the disability service failed to provide services with reasonable care and skill, and breached Right 4(1).

Multiple pharmacists failed to think critically, and relied on previous dispensing rather than contacting the prescriber, resulting in a pattern of behaviour by staff of non-compliance with the Standard Operating Procedures (SOPs). It was held that the pharmacy failed to provide services with reasonable care and skill, and breached Right 4(1).

Adverse comment was made regarding the second GP having signed repeat prescriptions for the young woman's midazolam, and regarding a pattern of behaviour by doctors at the medical centre not prescribing in accordance with accepted practice.

Adverse comment was also made about a pharmacist for not following the pharmacy's SOP, and having queried the instructions with the disability service rather than the prescriber.

Another pharmacist dispensed midazolam for the young woman with the instruction to apply behind the ear. The pharmacist noted that the instructions were unusual, and checked the young woman's history. Adverse comment is made about the pharmacist's failure to contact the prescriber when she recognised the unusual method of administration of the midazolam, and her actions once she was made aware of the incident.

Recommendations

The GP agreed to undertake further training on safe prescribing practice and record-keeping, and to apologise in writing.

It was recommended that the pharmacy (a) undertake training of all staff involved in dispensing prescriptions with regard to the Pharmacy Council of New Zealand's Code of Ethics, the steps to be taken if there is any uncertainly about a prescription, and the records that should be maintained; and (b) provide a written apology for the repeated failure of its staff to take appropriate steps with regard to the unusual mode of administration of midazolam.

It was recommended that the disability service (a) review its Safe Administration of Medication Policy and Procedures; (b) develop a process/policy to ensure that each client's records are reviewed regularly to ensure that instructions are consistent and correct; and (c) provide a written apology.