The Importance of Clarity in Medication Instructions

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PROBLEM: We received a report at ISMP that a three-month-old infant had been discharged from a hospital after surgery for a ventricular septal defect. At discharge, the child’s mother was handed a copy of instructions that called for the administration of 25 micrograms (25 mcg, or 0.5 ml) of digoxin (Lanoxin Pediatric Elixir®, GlaxoSmithKline) (50 mcg/ml) twice a day. Because the mother had difficulty reading the form, she rewrote the instructions. Unfortunately, she incorrectly transcribed the dose as 2.5 ml instead of 0.5 ml. Consequently, the child received 150 mcg (0.15 mg) of digoxin for each dose, or 300 mcg (0.3 mg) daily.

On the evening of the seventh day, the mother found the infant unconscious. She brought her to a hospital emergency room, where the infant suffered a cardiac arrest soon after admission. She was resuscitated, placed on life support, and ultimately resuscitated, placed on life support, and resuscitated, placed on life support, and resuscitated, placed on life support, and resuscitated, placed on life support, and resuscitated. The drug-delivery device, or a mock-up.

A limited vocabulary or difficulty following complex sentence structure can leave patients or caregivers unable to understand spoken instructions. Even minor misunderstandings about medication instructions or care plans can result in increased hospital admissions and deteriorating health. One possible reason for this lack of understanding might be that people who have difficulty reading or understanding health information are too embarrassed or ashamed to acknowledge their deficits. Instead, they refuse to ask questions and often pretend to understand instructions.

Here are some recommendations to help ensure that patients receive clear instructions:

• Always ask patients and caregivers to demonstrate their knowledge and comprehension by having them accurately repeat the instructions in their own words.
• For safety, have patients or caregivers demonstrate how they will measure the dose and administer the drug by using the actual product, the drug-delivery device, or a mock-up.
• Finally, give patients professionally printed or original handwritten instructions—not photocopies, carbon copies, or mimeographed copies—and never give patients copies of copies!

Computer-based instructions that are frequently updated and freshly printed offer the safest solution for providing useful and accurate information to patients.

REFERENCES

ISMP, a nonprofit organization located in Huntingdon Valley, Pennsylvania, provides independent practitioner review of medication errors submitted to the national MER program, operated by the U.S. Pharmacopoeial (USP) Convention, Inc., of Rockville, Maryland, in cooperation with ISMP. ISMP also reports on progress made in correcting medication errors and problems. Call ISMP at 215-947-7797 or at 800-FAIL-SAF(E). Visit www.ismp.org, or write to us at ismpinfo@ismp.org.