Colecalciferol Significant Event Audit

Datix Ref	WEB/14812
Description	31/40 pregnant lady who was found to have vitamin d deficiency and came in for review with me. I checked the guidleines via LHP, and issued a weekly course of vitamin d tablets. I subsequently realised that the dose recommended in pregnancy was lower than this and called her to explain, by which time she had already taken the first dose.
Immediate action taken	I called the lady to establish if she had already taken the medication, and she had. I then called the endocrinologist on call to ask for advice, who reassured me that the dose would be fine. I also looked at the information on medicines.org.uk, which reiterated the best practice is to use the lower dose in pregnancy. I called her back to explain and apologise for my mistake, and offered reassurance as per the endocrinologist advice, as well as agreeing ongoing treatment.
Findings of investigation	SEA investigated by the prescribing GP and SEA Meeting held on 4.2.16 with the practice clinical team.
Why did it happen?	There were individual factors that contributed to the prescribing error: - 1 The doctor was running late, putting pressure on the surgery and consultation which may have contributed to making clinical decisions in a more rushed manner than would be most safe and ideal; 2 The doctor checked the local clinical guidelines during the consultation, and prescribed on the basis of the adult dose of medication. Only afterwards did the doctor re-check the guidelines to ensure it was the correct dose in pregnancy, which then led to him making a number of enquiries to discover the correct dose in pregnancy. There were also system errors contributing to the error: - 1 The local guidelines do not given any advice on the dose of the medication in pregnancy. They only point towards the medicines.org.uk website to review the manufacturer's recommended dose, but no recommendation about dosing is made here either. 2 By the time the doctor contacted the patient, she had already taken the first dose of the medication. There would have been an opportunity for the dispensing pharmacist to review the recommended dose in pregnancy, had they realised the lady was pregnant, but it was issued as prescribed by the doctor.
Lessons learned	1 Time pressures can impact upon clinical decision-making, and the clinician may be susceptible to making prescribing errors if they are running behind or feeling under stress due to clinical demand. 2 There are limitations to the usefulness of guidelines, which can be confusing and at times difficult to interpret. If they are not clear, they may actually increase the risk of prescribing error, which may have contributed in this case. 3 Doctors'prescribing errors will not always be picked up by the dispensing pharmacist, though often are. It is not certain what processes the pharmacists go through when issuing medication, including whether they routinely ask people if there are any special prescribing issues e.g. pregnancy (when an exemption certificate is likely to be presented). This should in particular be the case when any high dose therapies are prescribed.
Shared learning	1 The doctor will reduce the risk of prescribing errors when running behind by not issuing medication at the time unless the dose is specific and clear. The mistake could have been avoided had the doctor completed the consultation without prescribing the medication, instead checking the correct dose and then calling the patient later on and issuing the prescription at that stage. This is good practice for all prescribing, but particularly in specific prescribing issues e.g. pregnancy. 2 The current guidelines for the prescribing of this medication in pregnancy are inadequate, and will continue to pose a risk of contributing to prescribing errors. The doctor involved will feed back to the medicines team at the local Trust (who produce the guidelines) in order to ensure this is clarified, thus reducing risk of error. 3 There may be training issues for dispensing pharmacists when this medication is prescribed, or more broadly for checking safety when particular prescribing circumstances arise, such as during pregnancy.