Patient Safety Alert

March 4, 2021

Anticonvulsants During Admission and Transitions of Care

The Patient Safety Authority is aware of an increased risk for life-threatening outcomes resulting from medication errors involving anticonvulsants.

We have noted several serious events involving omitted or incorrect dosages of anticonvulsants when the patient is admitted and during transitions of care.

Omissions or errors in dosages related to anticonvulsants can result in seizures or other adverse conditions, and we are aware of a least one recent death potentially related to this type of error.

Strategies to reduce these types of medication errors involving medication reconciliation are highlighted in a recent article in *Patient Safety*.

Key points:

- Consider additional triggers for alerts, monitoring, or laboratory testing when anticonvulsants are ordered.
- Review facility lists and processes for high-alert medications. Consider adding anticonvulsants to your facility high-alert medication list and incorporating high-leverage error reduction strategies into management of these medications.
- Develop standardized processes to ensure clinicians follow consistent procedures (including medication reconciliation) throughout the continuum of care, including admission and discharge procedures.

- Include the medication indication on the home medication list and all documentation systems for medication orders, care planning, and discharge planning.
- Consider a dedicated pharmacy role to assist with various medication reconciliation processes.
- Develop technology for shared electronic medication lists and processes.