# Dispensing errors

## Dose administration aids

Guild Insurance regularly receives claims relating to errors with Dose Administration Aids (DAA). Errors often involve pharmacists filling and dispensing DAAs for the correct patient but based on an obsolete medication profile. Such incidents provide a timely reminder to pharmacists that the accuracy of any DAA, filled on site or remotely, is primarily dependent on the accuracy of the customer's medication profile.

Another common error occurs when a pharmacist prepares two or more DAAs at the same time and inadvertently transposes the labels resulting in significant harm to one or both customers.

These errors can and do happen, even to experienced pharmacists who've never made a mistake before. They *can* happen to you and they *can* have serious consequences for you and your customers.

### Cases

An elderly lady experienced a prolonged period of hospitalisation for renal failure as a result of a dispensing error. Although she was prescribed Methotrexate weekly, the pharmacist inadvertently packed a daily dose into her 'webster pack'. Her claim for compensation was successful as the pharmacist had failed to demonstrate due care in the dispensing process. While he usually followed the computerised 'webster care' program, he chose not to on this occasion stating he was "too busy".

An elderly man was admitted to intensive care with hyperkalaemia because of a dispensing error. The pharmacist had mixed up the labels for two 'webster packs'. As a result, this man received another person's medications, including a potassium supplement. Unfortunately, the patient had a history of renal failure and required many months of haemodialysis as a result.

### Reduce the risk of dispensing errors

- Adhere to the PDL 'Guide to good dispensing' every time. Don't be coerced into rushing or cutting corners. When errors occur, pharmacists often say "if only I'd taken the time to…"
- Display posters or reminders in the dispensary to promote compliance with dispensing procedures.
- The importance of checking that the customer's medication profile is current cannot be overstated. While it can be time consuming to do, the consequences can be catastrophic if you don't.
- Make sure there are robust procedures in place for ensuring new medication profiles are filed correctly. Emphasise the importance of this to all staff, not just pharmacists. Make people aware of the potential consequences of dispensing from an obsolete profile.
- Don't prepare DAAs for two or more customers at once. Many errors occur when the wrong person's labels are affixed to a medication. Don't rely on the customer or their carer to tell you that the label is incorrect.
- Adhere to the PGA's Quality Care Pharmacy Program – Dose Administration Aids source checklist. **www.guild.org.au/qcpp**
- Use *alert* tags to help distinguish between people with similar names.
- Make use of the safety features available in your dispensing software. Set up different alerts to remind people to perform certain tasks.
- Reducing distractions when a pharmacist is dispensing is everyone's responsibility. Agree to strict rules for minimising interruptions and distractions in your pharmacy.
- Promote a culture where all staff are confident to point out risky practices when they occur.

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