Dispensing errors

When medication is dispensed to the wrong customer

A number of errors where medications are dispensed to the wrong customer are reported to Guild Insurance every year. Of note, many of these occurred when a pharmacist dispensed scripts for two or more members of the same family. For example, the pharmacist labelled the medications intended for a woman, with her husband's name.

Similar errors have also occurred when pharmacists dispensed medications via dose administration aids. For example, Webster packs were prepared correctly, but the pharmacist then put the wrong person's label on the pack.

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

A pharmacist was processing scripts for a customer and her husband. The pharmacist inadvertently labelled Carvedilol 12.5mg with 'Mr' instead of 'Mrs'. As a result, the woman's husband began taking the medication as directed. He experienced hypotension and dizziness, causing him to fall and suffer a fractured scapula.

A number of customers were waiting for their scripts to be dispensed. The pharmacist called out the customer's name and a woman stepped forward and collected the script. The customer left the pharmacy and commenced taking the medication as directed. Sometime later, the pharmacist realised that the wrong customer had taken the dispensed medication. The customer had claimed someone else's script for Karvea 300mg instead of the Chlorsig eye drops she had been prescribed. Unfortunately, by the time the customer had been located she had taken the medication and suffered severe hypotension requiring hospitalisation.

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.
- Use barcode scanning every time.
- Make use of the safety features available in your dispensing software. Set up different alerts to remind people to perform certain tasks. Likewise, make use of advanced scanning features that automatically print a barcode on the dispensing label.
- Use alert tags or signs to help distinguish between people with the same or similar surname.
- Don't process scripts 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 to tell you that the label is incorrect.
- Ask the customer to identify themself before handing over the dispensed item. It is not uncommon for the wrong customer to step forward and claim a script. Nor is it uncommon for a customer to say "yes" to the wrong name!
- When handing medications to a customer, point out all warnings and directions on the label and packaging. This not only helps with counselling but serves as a final check against any dispensing error.
- 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.

1800 810 213
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