Dispensing errors

Wrong quantity of medication

A growing number of dispensing errors involving the medication wrong quantity are reported to Guild Insurance. These errors occur when a pharmacist dispenses a quantity of medication that differs to the amount prescribed. For example, the doctor prescribed ten (10) diazepam tablets, but the pharmacist dispensed fifty (50) in error.

While over supply of a medication can cause serious clinical effects, under supply can be equally problematic. 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.

Case

A woman was prescribed a two-week course of Ciprofloxacin 500mg to treat a chest infection. However, the pharmacist only dispensed a one week supply by mistake. The woman claimed she developed pneumonia as a result of the pharmacist's error.

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…."
- Seek help if you are feeling intimidated or uneasy about contacting the prescriber to clarify a script.
- 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.
- Be careful with zeros and abbreviations. Transcription or interpretation errors involving a zero, decimal point or abbreviation are common causes of serious dispensing errors.
- Consider placing flags or warnings in the dispensing basket when handling a script for an unusual quantity of medication. For example, a simple card stating '**RISK WARNING – different quantity**' could reduce the chance of you automatically selecting a standard quantity.
- Review the dispensary layout to ensure workflow supports each step of good dispensing.
- 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.

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