Dispensing errors.

Wrong frequency.

An increasing number of dispensing errors involving the wrong frequency are reported to Guild Insurance. Typically, these errors occur when a pharmacist directs a customer to take a medication more or less frequently than prescribed. For example, the customer was prescribed a daily dose, but the pharmacist labelled the medication to be taken twice a day.

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 examples

A man was hospitalised with Amiodarone toxicity as the result of a dispensing error. The pharmacist misinterpreted a hand-written script for Amiodarone 400mg BD and dispensed 400mg TDS instead. While the pharmacist recognised that the script had been written in "an unusual and misleading way", he failed to verify his interpretation with the prescriber or another pharmacist.

A young man's claim for compensation was successful after he experienced significant side effects as a result of a dispensing error.

The pharmacist had inadvertently dispensed Prednisolone 25mg TDS, rather than the prescribed frequency of Prednisolone 25mg for three days.

An elderly woman died from renal failure, allegedly resulting from a dispensing error. While the woman had been prescribed Methotrexate 5mg weekly, the pharmacist's labelling instructions were unclear, and she took a daily dose instead.

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.
- Take the time to look up the medication if you are unfamiliar with the dosage or frequency.
- Seek help if you are feeling intimidated or uneasy about contacting the prescriber to clarify a script.
- Reduce ambiguity when labelling medications prescribed as a weekly dose by providing very specific instructions. For example, consider replacing '*Take one tablet daily on the same day every week*', with '*Take one tablet every FRIDAY only*'
- 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.
- Promote a culture where all staff are confident to point out risky practices when they occur.
- Reducing distractions when a pharmacist is dispensing is everyone's responsibility. Agree to strict rules for minimising interruptions and distractions in your `pharmacy.
- 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.

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