Dispensing errors

Wrong route of administration

There has been a steady increase in errors reported to Guild Insurance involving the wrong route of administration. These errors occur when a pharmacist dispenses a medication that has been manufactured for administration via a different route. For example, the pharmacist dispensed ear drops instead of eye drops, or the patient was prescribed injections, but was given tablets. Errors also include pharmacists directing customers to take the correct medication, but via the wrong route. For example, a customer was prescribed oral capsules, but the pharmacist labelled the medication to be used as a suppository.

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 infant was prescribed Egozite scalp lotion to treat a skin condition. On the same script, it was recommended her parents also obtain Infacol drops to help treat infant colic. However, during the dispensing process, the labels were transposed and as a result, the Egozite lotion was given orally and the Infacol drops used topically.

A pharmacist inadvertently dispensed Ciloxan ear drops instead of Ciloxan eye drops. While the customer didn't suffer harm, the same error with a different medication may have resulted in serious consequences.

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.
- Seek help if you are feeling intimidated or uneasy about contacting the prescriber to clarify a script.
- Consider placing flags or warnings in the dispensing basket when handling a script for a different route of administration. For example, a simple card stating 'RISK WARNING – injection' could reduce the chance of you automatically selecting an oral dose.
- 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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