Common dispensing errors and how to avoid?

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Objectives

• Highlight common dispensing errors which occur in community pharmacies and learn from these
• Identify how the NPA can support you in the event of a dispensing error
• Help you to improve patient safety, by adopting procedures within the pharmacy which promote good dispensing practices
• Explain error reporting requirements
• Discuss NPA’s role as Medication Safety Officer for independents and how errors can be reported through the NPA
• Help you to identify and manage risks
Definitions

Medication error - an incident in which there has been an error in the process of:
- prescribing
- dispensing
- preparing
- administering
- monitoring, or providing medicine advice regardless of whether any harm occurred

• Near miss - an incident that did not cause harm but which is judged to have had the potential to cause harm
Causes of errors
1. Prescription errors

- Misreading the prescription
- Illegible handwriting
- Abbreviations ambiguous or misinterpreted
- Pharmacist unfamiliar with Latin abbreviations
- Units of measurement ambiguous or misinterpreted
- Incorrect calculations
- Dosing errors
Can you read these prescriptions?

ondansetron or candesartan?

Istin or Ismo?
2. Dispensing errors

- Medicines with similar names
- Medicines with similar packaging
- Incorrect picking of the medicine
- Transposing the label or labelling the medicine incorrectly
- Dispensing out-of-date medicine
- Not dispensing against the prescription
- Incorrect labelling
Similar name

Similar packaging
3. Other causes

- Busy workplace
- Stress
- Distractions
- Staff shortages
- Giving the wrong medicine to the wrong patient
- Omitting medicines
- Lack of concentration
- Lack of clinical knowledge
High risk medicines

• May cause serious patient harm if dispensed incorrectly:
  o Narrow therapeutic range
  o Serious adverse effects if dose or administration incorrect

• Examples:

<table>
<thead>
<tr>
<th>!Lithium</th>
<th>!Insulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>!Opioid medicines</td>
<td>!Oral anti-cancer medicines</td>
</tr>
<tr>
<td>!Methotrexate</td>
<td>!Anticoagulants</td>
</tr>
</tbody>
</table>

• NPA Standard Operating Procedures for dispensing certain high risk medicines following guidance issued by the NPSA
How to minimise dispensing errors
Keep interruptions in dispensary to a minimum

Important to have a clutter free and organised dispensing area
Maintain workload of pharmacy staff at safe and manageable level

Only allow competent pharmacy staff to put away dispensary stock
Dispensing process

- Verify name of medicine if unclear or badly written
- Clarify unclear or illegible doses before dispensing
- Check abbreviations of medicine names or dosage units
- Print dispensing label before selecting medicine from shelf
- Use prescription to select stock, not dispensing labels or patient medication record (PMR)
- Alert staff to medicines with similar names and packaging
Dispensing process

✓ Involve two people in dispensing process where possible
✓ Make final accuracy check against the prescription
✓ Calculations should be written down and double-checked
✓ Pharmacist should take a short mental break between assembly and final check if working alone
✓ Procedure should be in place to identify who was involved in dispensing and checking processes
✓ Patient identity must be confirmed before prescriptions are handed over
Clinical assessment of a prescription

1. Check that the medicine is not contraindicated or should be used with caution in specific patient groups, such as:
   - Children
   - Elderly patients
   - Pregnant or breastfeeding women
   - Immunocompromised patients
   - Patients of certain ethnic backgrounds
   - Female/male patients
Clinical assessment of a prescription

2. Check:
   - Interactions
   - Potential side effects
   - Dosage, form and route of administration
   - Duration of treatment
   - Other medical conditions
   - Monitoring requirements
Final accuracy check

For each item, check:

✓ Name on bulk pack or patient pack matches prescription
✓ Strength of item against strength on prescription
✓ Multiple packs are the same medicine and the same strength
✓ Expiry date
✓ Drug form of medicine against drug form on prescription
✓ Quantity on prescription against dispensed medicine
✓ Dispensed medicine against contents of bulk pack
✓ Patient information leaflet is supplied
Final accuracy check

✓ Check prescription against label for:
  - Patient name
  - Name of medicine
  - Strength
  - Quantity
  - Dosage form
  - Dose/instructions

✓ Check label against product

✓ Mark ‘checked by’ box
Near miss incidents

- Dispensing mistakes can be minimised if near misses are regularly reviewed and actions taken
- Ensure that all staff can access the near miss log when needed
- The NPA ‘Near miss register’ is available from NPA Sales

Types of near miss
- Incorrect drug
- Out of date product
- Incorrect form
- Incorrect label
- Item not given to patient/representative
- Prescription misread
- Incorrect quantity
- Incorrect strength
Dealing with a dispensing error

• Provide patient/representative and patient’s GP with any required information immediately if patient has been harmed
• Inform patient/representative that a thorough investigation will be conducted and an action plan prepared to minimise the risk of re-occurrence
• If patient has taken any of the incorrect medicine, ascertain whether they have been harmed
• Always inform patient’s GP if an incorrect medicine has been taken
Dealing with a dispensing error

- Apologise to the patient/representative
- Supply the correct medicine, if appropriate
- Ascertain the patient’s/representative’s expectations
- Carry out a root cause analysis
- Follow pharmacy procedures for reporting the incident
- Record, review and learn from the error(s) made
Root cause analysis

- Finds out
  - What happened
  - How
  - Why

- Putting into place recommendations should reduce chance of incident recurring

- Focuses on system that has gone wrong rather than the individual who has made the error
Patient safety alerts

- **Medicines & Healthcare products Regulatory Agency (MHRA)** may issue advice, often in conjunction with manufacturers
  - Information also in Drug safety Updates
  - Sale of products may change
- **European Medicines Agency (EMA)** is responsible for European marketing authorisations and may issue advice
- **Marketing authorisation (MA) holders** may issue guidance, such as new dosing recommendations or contraindications
Dealing with patient safety alerts

- Pharmacists need to be aware of any alerts or guidance issued and take appropriate action
- When patient safety alerts are received, pharmacists should:
  - Implement all the actions relevant to them
  - Ensure all relevant staff are aware of the information and/or required changes
  - Where appropriate, contact doctors or refer patients to doctors to discuss treatment
Keeping up to date with patient safety alerts

- Sign up to NPA alerts
- Check the NPA website
- Sign-up to information email alerts from the MHRA
- Sign-up to email alerts from the Central Alerting System
- Check the European Agency website
- Ensure the fax machine is always switched on and contains paper
Medication Safety Officer (MSO)

- NPA’s Head of Pharmacy Services is MSO for all independent community pharmacies in England with fewer than 50 branches
- Responsibilities include:
  - Promoting safe use of medicines
  - Implementing local and national medications safety initiatives
  - Improving patient safety
  - Submitting medication error reports to National Reporting and Learning Systems (NRLS)
  - Improving reporting and learning from medication incidents
  - Responding to requests from NHS England and the MHRA for further information about medication errors
MSO page on NPA website

• Dedicated Patient Safety/MSO page on NPA website - https://www.npa.co.uk/Advice-Support/Patient-Safety-Medication-Safety-Officer/

• Links to:
  o Patient Safety Incident Report Form
  o SOPs for high risk medicines
  o Patient Safety Alert Factsheet
  o Patient Safety Alert Audit Sheet
  o Recent patient safety alerts and news stories
Patient Safety / Medication Safety Officer

MSO role

The NPA’s Head of Pharmacy Services is acting as the Medication Safety Officer (MSO) for all independent community pharmacies in England with less than 50 branches. Read the full press release about this new role.

Responsibilities for supporting pharmacy businesses and superintendents include:

- Promoting the safe use of medicines across the pharmacies
- Implementing local and national medication safety initiatives
- Improving patient safety on a day-to-day basis
- Submitting medication error reports to the National Reporting and Learning Systems (NRLS)
- Improving reporting and learning from medication incidents
- Responding to requests from the Patient Safety Domain in NHS England and Medicines Healthcare product Regulatory Agency (MHRA) for further information about medication error incidents.

Contact the Pharmacy Services Team on 01727 891800 / 0330 1231035 or by emailing them for more information.
Patient Safety Incident Report Form

- Easy and quick to use, with tick boxes and drop down menus
- Can print off copy for pharmacy use – useful for GPhC inspection
- Patient information is not seen by NPA – pharmacy adds this by hand after printing

- NPA forwards information (anonymously) to NHS England – no need for pharmacy to submit separate report to NRLS
- Feedback has been good
- More members are using the form
- Guidance notes on completing the form are on the website
At what stage during the medication process did an actual or potential error occur?

- Prescribing
- Preparation of medicines in all locations/dispensing in a pharmacy
- Administration/supply of a medicine from a clinical area
- Other (please specify)

Description of medication incident:

Were there other important factors?

- Poor transfer/transcription of information between paper and/or electronic forms
- Poor communication between care providers (verbal or written)
- Use of abbreviation(s) of drug name/strength/dose/directions(e.g. MTX,1 mg)
- Handwritten prescription/chart difficult to read
- Omitted signature of healthcare practitioner
- Patient/carer failure to follow instructions
- Failure of compliance aid/monitored dosage system (MDS)
- Failure of adequate medicines security (e.g. missing CD)

- Medicines with similar looking or sounding name
- Poor labelling and packaging from a commercial manufacturer
- Healthcare practitioner undertaking supplementary prescribing
- Variance to guidelines for sound clinical reasons
- Involving a medicine supplied under a Patient Group Direction (PGD)
- Involving an OTC medicine
- Failure in monitoring/assessing medicines therapy
- Failure of clinical assessment equipment
Common errors being reported

• Types of error:
  o wrong drug/medicine – 33% of reported errors
  o wrong dose or strength - 24% of reported errors

• Examples of wrong drug/medicine:
  o Seretide instead of Serevent
  o Novomix instead of Novorapid
  o Chlorpromazine instead of chlorphenamine

• Important factors – for those reports which ticked any:
  o 71% ticked “medicines with similar looking or sounding name”
  o 14% ticked “poor labelling and packaging”
Contributing factors

• For reports that identified contributing factors, 56% selected “Work and environment factors”
• This category includes poor/excess administration, physical environment, work load, hours of work and time pressures
  o Examples reported:
    o “self dispensing and checking, workload and not enough staff”
    o “busy time of the day”
    o “busy, main dispenser off”
Dispensing errors

Glyn Walduck, FCILEx
Head of Claims
NPA Insurance – what is on offer?

Insurance across the spectrum for members, pharmacists, families and those working in pharmacy practice

e.g. PI, PL, legal defence to GI for shops, homes and personal lines
What we insure you for...

1. Breach of your professional duty – all amounts you are legally liable to pay as compensation and costs for claims made against you for breach of professional duty caused by negligence or omission and costs

2. Public liability – damages and costs in the event of accidental injury or death of any person and/or accidental damage to another persons property caused by your negligence or omission and costs

3. Product liability – damages and costs for injury or death or accidental damage to another persons property caused by the retail sale or supply of products and costs
What we insure you for...

4. Legal expenses:

• Against prosecution for an offence arising from the conduct of the retail pharmacy business

• Legal expenses resulting from the representation by legal or other expert at Coroner’s Inquests and other Fatal Accident Inquiries

• Legal expenses incurred in responding to a GPhC investigation and representation by a legal or other expert at Fitness to Practise hearings (Disciplinary/Health) up to a maximum of £5,000 plus VAT
Who is covered?

- Members
- Employees
- Self-employed persons who are engaged by members e.g. locum
What’s it all about?

- NPA Insurance Professional Indemnity Cover
- NPA Member Support

Holistic approach and added value
What happens when it all goes wrong?

- Complaints
- Claims
Responding to complaints

The Letter:

- How to write it *(Tip: Who ‘s overlooking my shoulder)*
- Apology
- Investigation
- Communicate findings
- Risk management/steps taken to prevent repetition – revisiting SOPs and amending if need be
- Parliamentary and Health Service Ombudsman
- Final paragraph

Beware of Standard Template Letters
Claims

• Service issues
  - Goodwill gestures
• Claims
• Quadruple jeopardy
  - Police CPS
  - Police Service NI
  - Procurator Fiscal
  - Coroner
  - GPhC
  - NHS
Your NPA and NPAI Working Together To support, protect & represent

- Managing the press
- Liaising with Pharmacy Services on ethical and competency issues
- Feeding into consultations with policy e.g. Medicines Rebalancing Legislation and Sanctions guidance
- Managing Risk with Professional Development - Delivery Driver Course
When it all goes wrong

- Indemnity
- Defence
- Advice
- Assistance

- NPA Insurance Ltd
- NPA Members PI Insurer
Upcoming NPA Events

www.npa.co.uk/events