

CLOSE-UP ON COMPLAINTS

Several years ago, "Close-Up on Complaints" was a regularly featured article in *Pharmacy Connection*. It appeared in every issue and involved an analysis of a complaint that the College had investigated.

We've recently decided to bring back this regular feature as another learning resource for members.

Delivering pharmacy services is a complex, human process. Even with the assistance of technology, mistakes can still occur. "Close-Up on Complaints" will take a look at some of these errors, and use them as learning opportunities for all practitioners.

Ideally, pharmacists and pharmacy technicians will be able to identify areas of potential concern within their own practice, and plan and implement measures to help avoid similar incidents from occurring in the future.

Systematic Dispensing Error

An Error In Processing Batch Medications

SUMMARY OF THE INCIDENT

An elderly patient living in a retirement home was prescribed prednisone 20mg daily by her family physician in January 2014. The medication was to be administered once a day for seven days, for a chest infection. The prescription also included two refills, to be

used with discretion if the patient was still not feeling well. The retirement home sent the prescription to the pharmacy where the patient's medications were usually dispensed. The patient then received the prednisone 20mg daily, along with her other medications, in her weekly compliance strip.¹

Over the next few months, the patient experienced panic attacks, anxiety, aggression, insomnia, loss of appetite, and breathing problems. Four months after the original prescription was supplied — due to the patient's ongoing symptoms — the patient's daughter suspected that the patient was potentially suffering from another chest infection,

and requested that one of the prednisone refills be provided. It was then discovered that the patient was still on prednisone 20mg daily as the pharmacy had failed to stop the medication after the original prescribed duration of seven days, and had continued to dispense it with the other medications in the patient's weekly compliance strip.

This complaint was originally filed by the patient's daughter. After filing the initial complaint, the daughter informed the College that the patient had since suffered a broken hip. The daughter also stated that she was informed by the patient's physician that the prednisone may have been a contributing factor to the broken hip, as prednisone does affect a person's bones.

WHY DID THIS HAPPEN?

When the pharmacy first received the prescription for prednisone 20mg daily it was set to be dispensed in the weekly compliance strip with the rest of the patient's medications. No stop date was entered into the pharmacy's computer software and the prescription continued to be dispensed in the weekly batch for approximately four months. At the time of dispensing each week, the pharmacy did not consistently have a process in place to ensure that the batch was reviewed therapeutically prior to release.

Have a Complaint?

Anyone who is not satisfied with the care of services provided by a pharmacy, pharmacist, pharmacy technician, student or intern can [file a formal complaint with the College](#). Complaints must be received in writing and include as much detail as possible. The College investigates all written complaints.

COMPLAINT OUTCOME

The College's Inquiries, Complaints & Reports Committee (ICRC) oversees investigations of each complaint the College receives. The Committee considers a practitioner's conduct, competence and capacity by assessing the facts of each case, reviewing submissions from both the complainant and the practitioner, and evaluating the available records and documents related to the case.

The Committee found that this error was caused by a lack of appropriate processes and procedures in the pharmacy, and not by the behaviour of a single pharmacist or pharmacy technician. In all pharmacies, the Designated Manager (DM) is responsible for ensuring that the necessary and appropriate systems are in place to prevent errors. As such, the DM in this complaint was found to be responsible for not having the appropriate systems in place at the pharmacy at the time of the incident to prevent the error from occurring. The Committee ordered that the DM appear in person to receive a caution, and that he complete a specified continuing education or remediation program (SCERP) on medication system safety.

LEARNING FOR PRACTITIONERS

Taking time to review and reflect on this complaint provides a number of learning opportunities for practitioners. For example, it's clear that appropriate systems, procedures, processes and training are essential in avoiding medication incidents like this one.

The DM is responsible for ensuring that the medication processing systems are used correctly by the pharmacy staff to minimize errors, protect the public and enable practitioners to meet the Standards of Practice. DMs must ensure that all staff in the pharmacy understand and follow the procedures for processing

new prescriptions, refilling batched and non-batched prescriptions, and obtaining authorizations for prescription refills. In this case, the prednisone 20mg daily was not only entered incorrectly when it was first processed — it was missing the stop date — but there was also no consistent process in place to ensure that the patient's profile was reviewed prior to releasing the prescription.

This incident is a "red flag" situation; it is the professional responsibility of *all* practitioners to be diligent in identifying and responding to red flags that present in practice. This error went undiscovered for approximately four months, indicating that there was likely no formal documented process to check the prescriptions in the batch — a red flag. There should be a clear process for ensuring accuracy and appropriateness (both therapeutic and technical) for all batch prescriptions prior to dispensing. Ultimately, processes should be in place to ensure that ongoing refills are reviewed for therapeutic appropriateness — a measure which may have identified the error in question earlier.

This pharmacy, like many others, works with a high number of patients who are elderly, fragile and vulnerable. While these checks and processes should be in place in all pharmacies, those working with a high number of fragile patients must take extra caution and care. The same can be said for pharmacies with a high volume of prescriptions — extra care and attention should be given to the safeguards and structure of systems to avoid incidents. 

REFERENCE

1. Medications for patients in retirement or long-term care homes are often dispensed in weekly batches in multi-dose compliance "strips", similar to in a hospital setting.

CAUTIONS

A caution is issued as a remedial measure for serious matters where a referral to the Discipline Committee would not be appropriate. Cautions require the practitioner to meet with the ICRC in person for a face-to-face discussion about their practice and the changes they will make that will help avoid a similar incident from occurring in the future. It is not an opportunity for the practitioner to further argue their position, provide additional documentation, or attempt to change the ICRC's view with respect to their final decision. For all complaints filed after April 1, 2015, we post a summary of the caution and its date on the "Find a Pharmacy or Pharmacist" section of our website.

REMEDIAL TRAINING (SCERPS)

A SCERP is ordered when a serious care or conduct concern requiring a pharmacist or pharmacy technician to upgrade his or her skills has been identified. The ICRC orders SCERPs when they believe that remediation is necessary. For all complaints filed after April 1, 2015, we post a summary of the required program and its date on the "Find a Pharmacy or Pharmacist" section of our website.