FOCUS ON ERROR PREVENTION

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LOGGED PRESCRIPTIONS

When a patient requests a prescription refill, the need to retrieve the original prescription before the medication is dispensed is rarely required. However, pharmacists must be aware that when dispensing medications that have been logged and not previously dispensed, it is best practice to retrieve the original prescription to ensure accuracy and optimal patient outcomes.

CASE:

Rx

Ventolin Nebules 1mg/ml
Sig: 2ml bid
Mitte: 50ml

Pulmicort Nebuamp 0.25mg/2ml
Sig: 1 Ampule q4-6h prn
Mitte: 40ml

The above medications were prescribed for a one-year old child. The computer generated prescription was taken to at a local community pharmacy for processing by the child's father. The parent requested that only the Ventolin Nebules be dispensed.

The pharmacy assistant entered the Ventolin Nebules prescription into the computer and prepared the medication for checking by the pharmacist. The pharmacist checked and dispensed the Ventolin Nebules accurately.

After the father received the Ventolin Nebules, the pharmacy assistant entered and logged the Pulmicort Nebules into the computer. However in error, she selected Pulmicort Nebules 0.25mg/ml instead of 0.25mg/2ml as prescribed. The pharmacist continued to serve patients waiting for prescriptions and therefore did not immediately check the incorrectly logged prescription.

Shortly after leaving the pharmacy, the father drove to a second pharmacy and requested the Pulmicort Nebules. The pharmacist at the second pharmacy therefore called the original pharmacy and requested a transfer of the Pulmicort Nebules prescription. Unfortunately, this occurred before the pharmacist was able to check the logged prescription for accuracy.

Not knowing that the pharmacist had not yet checked the logged prescription, the pharmacy assistant selected the logged Pulmicort Nebules on the patient's file and transferred the prescription. Though the pharmacist was made aware of the transfer, he was not aware that the prescription being transferred was not yet checked for accuracy. The incorrect strength of Pulmicort Nebules was therefore transferred.

Approximately two hours later, after all waiting patients had been served, the pharmacist was able to check the logged prescription. The computer entry error was identified. The pharmacist therefore called the second pharmacy to advise them of the error, and transferred the corrected logged prescription. However, by that time, one dose of the incorrect strength was given to the child. The father of the child was understandably upset when advised of the error.

POSSIBLE CONTRIBUTING FACTORS:

- It was a busy period of time in the pharmacy. The staff therefore wanted to provide the needed medication (Ventolin) as soon as possible and enter the logged medication (Pulmicort) into the computer at a later time.
- The pharmacy staff was not aware that the parent had intended to go to another pharmacy for the Pulmicort Nebules.
- Both medications were not entered into the computer at the same time. Therefore, the pharmacist was not able to check both prescriptions at the same time.
- Pulmicort Nebules are listed in the pharmacy computer as 0.25mg/ml and 0.125mg/ml. However, the strength on the prescription was provided per

ampoule. That is, 0.25mg/2ml. The pharmacy assistant failed to notice the difference in concentration and selected the 0.25mg/ml strength in error.
- The pharmacist dispensing the Pulmicort Nebules did not have a copy of the original prescription to check for accuracy before the medication was dispensed. The pharmacist also failed to notice the relatively high dose of Pulmicort for a one-year old child.

RECOMMENDATIONS:

- When dispensing medication from a logged prescription, since the medication is being dispensed for the first time, it is best practice to retrieve the original prescription t o ensure accuracy. Therefore, if the logged prescription was transferred from another pharmacy, I recommend requesting a copy of the original prescription. A complaint which highlights this issue can be seen on the College's website, www.ocpinfo.com, by serching the term "logged prescriptions"
- Since it is unknown when a request for transfer of a prescription may occur, all logged prescriptions should be checked for accuracy as soon as possible.
- Before transferring a prescription to another pharmacy, check the date entered into the computer to ensure that the logged prescription had been checked for accuracy.
- Always double check pediatric doses for appropriateness. PC

Please continue to send reports of medication errors in confidence to:
Ian Stewart at: ian.stewart2@rogers.com
Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.

DISCIPLINE DECISIONS

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the sale of drugs by a corporation of which he was a director;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included:

- A reprimand;
- That the Registrar impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, that the Member complete successfully, at his own expense and within 12 months of the date of the Order, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, or an alternative program on ethics for healthcare professionals acceptable to the College;
- That the Registrar impose further specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, prohibiting the Member from acting in the capacity of a Designated Manager of any pharmacy for a period of 4 years from the date of the Order;
- A suspension of 15 months, with one month of the suspension to be remitted on condition that the Member complete the remedial training;
- Costs to the College in the amount of $30,000.

In its public reprimand to the Member, the Panel noted that the Member's conduct in this case was driven by greed and had tainted the profession. The Panel reflected that the Member had taken the first steps in rehabilitation by admitting and acknowledging his conduct, and underscored for the Member that this was the Member's last chance before the Discipline Committee. PC

The full text of these decisions is available at www.canlii.org
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