In scanners we should trust

REGULARLY I receive reports surrounding dispensing errors and it stuns me that there is a consistent theme: most cases could have been averted if either a barcode scanner was used during the dispensing process or the patient had been effectively counselled.

Interestingly, before scanners were introduced to the dispensing process, selection errors accounted for about half of all cases heard by pharmacy boards and/or courts of law. Thankfully this number has come down due to their increasing use, but failure to use scanners still accounts for many dispensing errors.

Counselling is the cornerstone of effective and safe dispensing. From a risk-management perspective, it offers the pharmacist a final opportunity to detect any errors or anomalies in the dispensing or prescribing process. Unfortunately we've all experienced or heard anecdotal evidence of a lack of counselling in community pharmacy. In fact, I believe that this is one of the major issues community pharmacy has to confront in order to take the next step in its professional evolution and be recognised by our health professional colleagues as worthy of taking a place in disease state management and support.

In most cases when scanners are not used, or counselling is absent or inadequate, the defendant pharmacist usually blames a high workload, a lack of training or an impatient patient. Yet there is no justification for not using a scanner on every occasion that a medicine is dispensed, or counselling the patient on most occasions. The dispensing pharmacist is always held accountable under such circumstances, but so is the owner where it can be established that unnecessarily high workloads, or poor training on standard dispensary operating procedures or the use of the scanner, are implicated in any error.

Let's have a look at some real cases, for which I thank Steve Marty, Registrar of the Pharmacy Board of Victoria, for his help in compiling.

Similar drug names

Zanidip was supplied labelled as Zactin when fluoxetine (Zactin) had been prescribed. Although the pharmacist claimed to have counselled the patient, it appeared this only consisted of discussing the alcohol consumption and was, therefore, not extensive enough.

While a scanner (which should have allowed the error to be detected) was used, it appears that the pharmacist did not respond to the warning message displayed and just pressed 'enter' on the computer to continue dispensing. The pharmacy where the error occurred had a documented dispensing procedure that, if followed, should have allowed the error to be detected. The hearing panel considered that most of the steps in the dispensing procedure were omitted and determined that the pharmacist had engaged in unprofessional conduct and would be cautioned.

Lessons learnt:
Selection errors are the most common type of dispensing error. The correct use of a dispensary scanner on every occasion medication is dispensed is the best means of detecting this type of error. Had the displayed error message been noticed, the error most likely would have been detected.

Incorrect dose 1

On two separate occasions for the same patient at the same pharmacy, two different pharmacists supplied carbamazepine 100mg tablets labelled as carbamazepine 200mg, when carbamazepine 200mg had been prescribed. The patient took the incorrect medication until a seizure occurred when the error was detected.

It was established that the bar code for the particular brand of carbamazepine selected was missing from the drug profile on the computer software. As the pharmacists concerned did not know how to add the bar code manually, the error was not detected. Due to workload neither pharmacist appeared to have counselled the patient on either occasion.

Since then, the errors procedures at the pharmacy have changed, including the recruitment of more professional staff and the routine use of a dispensary scanner for all dispensed items. Both pharmacists were found to have engaged in unprofessional conduct and were cautioned.

Lessons learnt:
Some pharmacists are only prompted to routinely use a dispensary scanner after they have made a selection error. Had the pharmacist taken the time to enter the code manually when the first prescription was dispensed, the two errors probably would not have occurred. Staffing must be monitored to ensure that undue workload is not placed on any pharmacist at any time, not just after a serious error has occurred.

Incorrect dose 2

The incorrect strength of Diaformin was supplied, yet labelled with the strength prescribed. The product was not scanned because it had to be ordered in for the client. No counselling was provided, possibly due to an excessive workload.

Despite noting that procedures had changed since the incident, the panel determined that the pharmacist had engaged in unprofessional conduct and should be cautioned.

Lessons learnt:
Had the label been generated after the product had been received from the wholesaler, the scanner would have alerted the pharmacist to the selection error. The patient had been on the medication long term and it was determined that had any counselling been provided at the time of supply, the error would have been detected. ■