Guide to Good Dispensing

Dispensing requires a systematic approach, risk assessment and clear documentation to minimise errors in the process. This guide is designed to minimise dispensing and clinical errors via a stepwise approach to assessing and completing the dispensing process. PDL recommends following this protocol whenever dispensing occurs.

1. Prescription intake

Provide the customer with an identifying docket or number, if available. Clearly identify items requested. Separate prescriptions for individual patients to prevent errors.

Patient details – check:

- Name
- Address
- Date of birth
- Contact phone number
- Other details e.g. email address
- Concessional entitlements
- Medicare number
- Allergies
- Generic substitution preference
- Consent to access patient's Active Script List (ASL)

2. Clinical review & medication reconciliation

Compare the current prescriptions with prior medication history, identifying and resolving discrepancies, and documenting medication changes. Review intervals between previous supplies to ensure dispensing is safe and in line with the prescriber's intentions and therapeutic standards.

3. Confirm validity of prescription

Prescription details – check:

- Date of prescribing
- Doctor's signature
- S4 requirements
- S8 requirements
- PBS Authority approval
- Date of last supply (PBS 4–day and 20–day rule)

4. Computer input

Input prescription details using either electronic identifier, e.g. token or barcode, selection from ASL or using the pharmacist's original copy of the prescription.

Check:

- Prescription data matches patient and prescription details
- Medication profile for consistency of treatment and compliance, duplication of therapy, changes since previous supply, evidence of misuse
- Medicine, dose and quantity are therapeutically appropriate for patient and condition
- Real Time Prescription Monitoring system for past supply and review of supply intervals where relevant and/or legislated
- Prescriber's intentions if any questions or concerns.
- My Health Record where relevant
- Interactions
- Computer software is used to select and record any brand change
- The prescriber's specific directions are printed on the label
- The generated labels (one for each pack if multiple packs), and any repeat form
- Prescription details are translated accurately from the electronic form, including prescriber annotations

5. Item selection

Collect the item either manually or robotically and **check** against the original prescription or electronic record for:

- Drug- active ingredient and brand name
- Strength
- Dosage form
- Quantity

6. Labelling

Label each item checking:

- Expiry date
- Directions on the original prescription document
- Drug, strength, dosage form and quantity against the pharmacist's original copy of the prescription
- Appropriate cautionary and advisory labels
- Reference to generic substitution, e.g. "This replaces..."
- The label does not obscure important information on the manufacturer's packaging, wherever possible (especially name, strength, expiry date and batch number)
- **Ensure identification of dispenser/checking pharmacist is recorded, e.g. record initials on the label and/or prescription, or electronically. This is important if more than one pharmacist is involved in the dispensing and counselling process**

7. Confirmation of item selection

- Where possible, attach or partially attach the label to the product, scan the barcode on the label (if double scanning available), then scan the product
- Ensure the dispensing software has confirmed the label and product are matched before proceeding.
- When dispensing multiple quantities of the same item, scan and label each item
- **PDL strongly recommends the use of scanners in dispensing**

8. Assembling prescription

- **Assemble dispensed medicines** with all documentation, counselling aids and messages for pharmacists or assistants
- Check all items belonging to the prescription Identify and/or set aside any items requiring intervention with patient or agent
- Place in a container which leaves all items visible to staff. Return S8s to safe and cold items to fridge if not supplied immediately to consumer. Include a laminate or message regarding the medicines stored elsewhere
- Store items awaiting collection out of the reach of the public and in a manner to protect consumer confidentiality and privacy

9. Final check & collection of prescription

Check:

- The drug (active ingredient and brand name), strength, dosage form and quantity against the pharmacist's original copy of the prescription or electronic record
- If provision of other professional services is appropriate
- Staff can be informed (e.g. via laminate, tag or note) of issues requiring specific advice such as generic substitution, clinical intervention, special storage requirements
- If provision of CMI is appropriate
- The correct person is collecting the prescription by use of open questions or against a docket or numbering system. Do not rely on Yes/No answers. Identifying questions may include "Please state your DOB", or "Please state your full name and address"
- Consideration to privacy and confidentiality is offered
- The pharmacist responsible for releasing the prescription is identifiable

10. Documentation

The following should be documented in the patient's notes, including clear explanation for any actions or decisions:

- Discussions with other healthcare professionals and any agreed action or plan
- Concerns or issues with the prescription and actions taken or plans agreed with prescriber or consumer
- Deferral or declinature to supply including reasons for this action
- Relevant information provided by the consumer
- Reasons for supply outside therapeutic standards
- Provision of risk management advice or therapy e.g. offer of staged supply, offer of HMR, supply of Take-Home Naloxone

Call 1300 854 838 or log in at pdl.org.au if you need advice or support in relation to an incident.