Supplement to *Guide to Good Dispensing:*

Final Check & Supply of Medicine

Wrong Patient medication errors form a subset of dispensing incidents that occur when medication intended for one patient is inadvertently dispensed, supplied or administered to another.

This incident type can cause serious harm to patient outcomes and trust – but is almost entirely avoidable. This new section of the *Guide to Good Dispensing* aims to highlight common areas where these errors are most likely to occur and provide guidance to help reduce their likelihood.

Outlined below are some key routine checks designed to support and guide your practice.

1. Ask OPEN-ENDED questions to confirm a person's identity

This encourages them to provide more information, reducing the risk of a simple 'yes' or 'no' answer that may not confirm their understanding. For example, ask "Can you tell me your name please?" rather than, "Are you Mrs Smith?"

- Always use **3 points of identification**, e.g. first name, last name, last 3 numbers of mobile number, year of birth, driver's licence, current address, or Medicare card number.

2. Take extra care if a language barrier exists, or cognitive impairment is evident

These people may be more likely to accept supply of another person's medicine when closed questions are used.

- Use open-ended questions.
- Use other forms of identification to help verify personal information, e.g. driver's licence, Medicare card.
- Include a note on patient's profile to flag communication barriers.
- Download a simple and free translation app. Be mindful these are not always 100% accurate. Utilise staff members, or the person's family or friends to translate if available.
- Contact Services Australia for multilingual interpreter and translation services. The website also includes downloadable written information about common health topics.

3. Cross-check patient details against prescription

Misidentifying patients with similar names and selecting the wrong patient profile in dispensing software—especially among family members—are frequently reported as contributing factors.

- If there is an existing patient with the same or similar name in the dispensing software, double check details (such as date of birth or Medicare number) align, consider the medicines previously dispensed and if they are likely to be prescribed for the current patient.
- Be aware of hyphens in names, or maiden names. Sometimes they appear differently in software depending on user input.
- Add a pop-up warning in dispensing software for patients with same/similar names.
- Pay attention to dispensing software warnings such as "*This medicine is new for the patient*" to cross check the correct patient has been selected in the software. Counselling is another opportunity for verification.
- Using more letters of a patient's last name will help to narrow the search for a patient.

4. Implement a system for managing prescriptions for multiple patients, such as family groups

- Separate scripts for related patients within a basket.
- Add a laminate or note to indicate multiple patients.
- Organise individual scripts in smaller baskets within a larger one for the entire group.

5. Establish multiple checkpoints within the Dose Administration Aid (DAA) process

Pharmacists and pharmacy staff need to be cautious when dispensing DAAs, as errors can occur at various stages and may be easily overlooked. All staff should be trained to recognise the risks associated with this service. Common errors include providing a DAA to the wrong patient, particularly those with similar names or appearances. Mistakes can also arise when a completed DAA is sealed in a paper bag before a final check or when medications are entered into the wrong patient's profile.

- Ensure DAA supply procedures include a final check of the DAA unit and not relying on the label attached to a paper bag.
- Use three points of identification to confirm the patient's identity when entering medicines to a patient profile and when supplying a DAA.
- Ensure address details match the DAA details before proceeding with delivery.
- Flag in your dispensing and DAA software systems and with all staff when DAA patients have similar names.

6. Don't rush the pre-screening stage when administering medicines by injection

Vaccine related incidents have occurred due to misunderstandings about the intended vaccine for the patient. This can happen when family members are present together or when there is confusion about vaccine eligibility based on factors such as age, pregnancy status or other criteria.

- Ensure you have comprehensive pre-screening procedures in place, including checking the Australian Immunisation Register **before** vaccinating, confirming patient identity and the expected medication/vaccine, and establishing eligibility before vaccination. (See PDL Guide to Medicines by Injection for further detail)
- Keep different vaccines separated and avoid placing multiple vaccines in the same tray unless they are for the same person, such as when multiple family members are in the consultation room together.
- Ask open-ended questions to ensure booking or consent forms are cross-checked to confirm patient identity and expected vaccine before administering. For example, "Which vaccine are you expecting today?"

7. Allocate time for patient consultations, especially for Staged Supply clients and Opioid Replacement Therapy patients

A common error is when clients with the same or similar first name is supplied with another client's dose, or similarly, with the supply of takeaway doses. Be mindful of locums who may not be familiar with your patients or processes.

- Similar preventive strategies, as discussed earlier, can be applied for patients with similar names.
- Use IT systems to identify clients, and when preparing and confirming doses.
- Verify the client's identity by cross-checking their photo ID and/or date of birth in the client profile.
- Confirm dose with the patient before every supply.

8. Never make assumptions at the collection point

Sometimes, baskets of medicines for collection contain the same/similar medications. Other times, a staff member may retrieve the 'right' medication, already labelled up, in the refrigerator or S8 safe, but it is for a different patient. This has occurred with S8s, insulins, thyroxine, vaccines and other injectable medicines.

- Always verify the patient's identity and never assume the correct medicine or basket has been selected.
- When receiving special orders after the initial dispensing, keep a copy of the prescription with the dispense labels to allow any pharmacist to conduct a final check.
- Organise the refrigerator and S8 safe systematically, ensuring there is enough space to properly store dispensed medications.

9. Stay attentive when filing Scripts-on-File

Prescription handling errors, such as filing a prescription under the wrong person's name or returning repeat prescriptions to the wrong individual, are simple mistakes that can be easily prevented.

- Check each prescription carefully before returning to a person.
- If prescriptions are kept at the pharmacy, implement a system to separate them from other patients' files and ensure patient details are clearly marked for easy identification.
- Maintain separate files for each individual. Avoid assuming family relationships, as sometimes privacy considerations may be involved.
- For patients with similar or identical names, include a warning message to highlight the similarity, and the need to double-check patient details.

10. Confirm patient details in person when delivering medications

Staff visiting a residence take on additional responsibilities and risks. Delivery errors can occur if the delivery label doesn't match the patient's details or address.

- When arranging delivery, ask the recipient to confirm the address with an open-ended question, rather than stating an assumed one, to avoid errors.
- Confirm with the patient if a third party is authorised to receive the delivery and note their details.
- Ensure delivery staff or contractors record the identity of the person receiving the delivery, particularly if it's a third party.
- Avoid leaving deliveries unattended if the patient or an authorised third party is unavailable.

11. Set clear expectations for wait times

Managing workload to minimise errors is key to patient safety. Communicating reasonable wait times to patients helps clarify expectations and reduces pressure on staff.

12. Don't skip the counselling

Providing counselling on the supplied medication, including confirming its purpose, is a key opportunity to verify the patient's identity. PDL reports show that lack of counselling is a contributing factor to *Wrong Patient* medication errors.

13. Review your efficiencies and workflow

To enhance daily productivity and reduce risk of errors, implement measures that streamline daily processes:

- Manage interruptions so you can focus on core tasks – e.g. delegate or train pharmacy staff to support in non-clinical tasks (e.g. taking phone calls, taking a message for non-urgent cases).
- Spend some time each morning to prioritise daily tasks and manage workload.
- Ensure adequate staffing ratios to meet the fluctuating demands of the day to help reduce stress and fatigue.
- Identify and address physical and resource bottlenecks and barriers that hinder smooth workflow.
- Create standard operating procedures to eliminate ambiguity during busy times.
- Don't skip breaks. They are essential to maintain focus, sustain performance, and mental and physical wellbeing.

Call PDL on 1300 854 838 if you need incident support or advice.