"Close-Up on Complaints" presents errors that occur when providing patient care so that pharmacy professionals can use them as learning opportunities. 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.

CLOSE-UP ON COMPLAINTS: ENSURING THE APPROPRIATE THERAPY FOR THE APPROPRIATE PATIENT

SUMMARY OF THE INCIDENT

The incident occurred when a mother was picking up a prescription at the pharmacy for her two year old daughter. The pharmacist reviewed the prescription, asked her daughter's age and weight, confirmed that the medication was appropriate and instructed the mother on how to use the medication. The mother then provided her daughter the first dose and took her to daycare.

Later that day, the mother received a call from the daycare stating that the medication label indicated that it was actually for a different patient, not her daughter. The mother had been dispensed a prescription intended for a patient who was a higher weight than her daughter, but who was receiving the same medication. The mother returned to the pharmacy, where staff apologized and provided the correct medication. The mother was very concerned that she had overdosed her daughter that morning. The mother observed that the issue was only caught because the daycare had strict procedures on checking medication.

WHY DID THIS HAPPEN?

This incident was the result of the pharmacist missing a very basic step during counselling: checking that the correct patient received the correct medication.

In her response to the complaint, the pharmacist indicated that the pharmacy was very loud and busy at the time of dispensing, and that when she counselled the mother, she was slightly distracted and did not have the worksheet on which she had checked the prescription against the original with her. While the symptoms of the patient seemed to fit the medication, she neglected to both note the higher dosage and to perform a double check that the medication was for this specific patient.

COMPLAINT OUTCOME

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

ADVICE/RECOMMENDATION

Advice/recommendations allow an opportunity for pharmacy professionals to improve conduct or care.

Advice/recommendations are issued as a remedial measure for matters which are not serious in nature and are considered to pose low risk of harm to the public.

> "This incident was the result of the pharmacist missing a very basic step during counselling: checking that the correct patient received the correct medication."

While the panel noted that the pharmacist provided a good response to the incident once it was raised, they emphasized that a basic check had been skipped during patient counselling.

The panel emphasized that pharmacists should not be too busy to provide good patient care and are required to follow the Standards of Practice regardless of the volume of prescriptions or other conditions in the pharmacy. While this medication did not ultimately cause harm to the patient, it could have if she had received a full adult dose or the incorrect medication.

The Committee issued advice and recommendations to assist the pharmacist in how she may be more thoughtful in her practice when performing appropriate checks on prescriptions.

LEARNINGS FOR PHARMACY PROFESSIONALS

Patient Care

The Standards of Practice require that pharmacists apply their medication and medication use expertise to ensure patients receive the appropriate therapy. Prior to dispensing or counselling a patient, it is imperative to ensure that the right patient is receiving the correct medication. Pharmacists must also ensure that clear, legible and accurate records are kept for each patient and should have systems and checks in place to ensure that a patient's prescription is entered under the correct patient record.

Pharmacy professionals must never forget that patients, especially parents of young children, rely on pharmacy professionals to use their knowledge, skills and judgment to make decisions that positively enhance health outcomes and provide patient-focused care. This means ensuring that the medication their loved ones receive will not only not harm them, but will also treat their condition appropriately.

A child is a "red flag", or particularly vulnerable, patient and therefore more care and attention must be provided, given the potential seriousness of outcomes that could occur in this population. While the error that occurred was clinically minor, dosing with an incorrect dosage or administering an incorrect medication in a child has the potential to be much more severe.

Safety and Quality

Pharmacy professionals must accept responsibility for ensuring that the practice environment in which they have selected to work supports their provision of quality pharmacy care and services – they cannot forgo this requirement due to a busy environment or high volume of prescriptions.

The Standards of Practice require all pharmacists to support quality assurance and quality improvement and respond to safety risks when they appear. Pharmacy professionals must disclose medical errors and "near misses" and share information appropriately to manage risk of future occurrences. When an incident does occur, pharmacy professionals must act with honesty and transparency and assume responsibility for disclosing this harm to the patient and initiating steps to mitigate the harm. Pharmacies should have reliable emergency contact information for patients (or a patient's guardian) to enable early notification and reduce unnecessary stress in the event of a medication incident. Prompt notification should also be made to any other healthcare providers involved.

Designated Managers are responsible for reviewing errors and incidents to determine patterns and causal factors that contribute to patient risk, and developing and implementing policies and procedures that minimize errors, incidents and unsafe practices. This includes supporting staff in their obligation to report adverse events and close-calls.

Designated Managers must make sure that the pharmacy has the processes and procedures to ensure that a safe and effective system of medication supply is maintained at all times. They must also ensure the necessary equipment, system and staffing are in place to allow pharmacy professionals to meet the Standards of Practice of the profession and support the provision of appropriate pharmacy services.

If a pharmacy is too busy to complete basic checks and provide good patient care, then additional prescriptions should be directed elsewhere. Pharmacy professionals have an obligation to follow the Standards of Practice and provide safe and quality patient care at all times. PC