# Dosage errors in dispensed medications (05HDC03953, 26 April 2006)

*Pharmacy ~ Pharmacist ~ Trainee pharmacy technician ~ Recormon ~ Tacrolimus ~ Dispensing errors ~ Dosage ~ Standard of care ~ Systems ~ Documentation ~ Standard operating procedures ~ Professional standards ~ Supervisory responsibility ~ Right 4(2)*

A man complained about two separate dispensing errors in relation to medication prescribed to his 10-year-old daughter. The girl was on regular medication (tacrolimus) to stop her body from rejecting a transplanted kidney, and Recormon to treat anaemia.

At her local pharmacy, the girl was dispensed the incorrect strength of Recormon, and the incorrect strength of tacrolimus three months later. Both errors raise the issue of failing to check the medications before they were given to the family. In addition, in both cases staff failed to accurately record who was responsible for those checks, and therefore it was not possible to establish the identity of the responsible pharmacists.

In the case of the Recormon, it appears that an informal practice of sharing responsibility for checking prescriptions had developed amongst the pharmacists when it was busy, and for partial dispensings. This practice was not in the standard operating procedures, and was open to misinterpretation. It was held that the pharmacy breached Right 4(2) by failing to have a system to cover the informal practice of sharing the responsibility for prescriptions.

The tacrolimus dispensing error occurred because of a failure to check the medication before it was given to the customer. Because the documentation was not completed, the responsible pharmacist could not be identified. It was held that the charge pharmacist at the time of the error was responsible for ensuring that his staff followed standard operating procedures. In failing to do so, he breached Right 4(2).

In both cases the medication was dispensed by a trainee technician. It is the role of the charge/supervising pharmacist to check the prescription prepared by the technician, particularly when the technician is in training.

The charge pharmacist implemented a number of changes to systems at the pharmacy, including pharmacists and technicians signing the third part labels so that it is clear who has prepared and checked each item.