Category: Medication

Preventing: Dispensing errors

Key words: Sando-K, Phosphate Sandoz, wrong medicine, dispensing, look-alike sound-alike medicines

Sharing Learning Points

LOCALLY

July 2022

ARI Hospital Dispensary would like to share learning from an adverse event involving Look Alike Sound Alike (LASA) Medicines

What happened?

Sando-K was prescribed for a patient but Phosphate Sandoz was dispensed in error.

- Hospital dispensary received a prescription for Sando-K, an effervescent tablet containing potassium.
- Due to a misbalance for Sando-K in the dispensing robot, labels for Sando-K were issued but the medicine was not, despite there being stock in the robot.
- A member of staff manually output the medicine by choosing the medicine to be issued from a drop down list. At this point Phosphate Sandoz, an effervescent tablet containing phosphate, was chosen instead of Sando-K.
- The dispensing label for Sando-K was then placed on the Phosphate Sandoz.
- The mismatch between the prescription & label and the medicine itself was not picked up during the dispensing checking stage and Phosphate Sandoz labelled as Sando-K was issued to the ward for the patient.
- Nursing staff identified the discrepancy prior to administering to the patient, dispensary was notified and the correct medicine was issued.
- The adverse event was reported in Datix.

Risk to the patient had they been administered the incorrect medication include hypocalcaemia, hyperphosphataemia, and untreated hypokalaemia.

The products have similar sounding names and similar looking packaging.

If you have any comments about this or any similar adverse event please send them to lindsay.cameron2@nhs.scot NHS Grampian Medication Safety Advisor

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What went well?

- Nursing staff picked up the discrepancy prior to administering to the patient.
- The adverse event was reported in Datix for review.
- The dispensary team have discussed the adverse event at their weekly brief.

What, if anything, could we improve?

- The process for expediting misbalances in the dispensing robot.
- Adding a check name flag in the dispensing robot drop down list for LASA medicines.
- Raise awareness of LASA medicines.

What have we learnt?

Medicines with similar names and similar containers/packaging increase the risk of selecting the wrong product.

It is easy to choose the wrong medicine from a drop down menu.

Actioning the dispensing robot misbalance sooner may have prevented the incorrect medicine being issued.

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