**PROCESS**

**Error 1b)** Start date on new prescriptions

1. **Prescription Receipt** at Pharmacy

**2. Legal / Clinical Check:** PC70 pre-populated

**3.** Prescription Filed until Required

**Error 4** Incorrect details entered into database

**4.** Rx details entered into database for automatic pumps

**Error 5b)** Wrong volume measured

**5. Dose Preparation:**

Either manually or by automatic pump

**8. Dose Storage** in CD Cabinet

**12. Missed / refused doses**

**7.** In advance

**6.** Patient waiting

**10.** Dose reconciled to stock

**9.** Doses removed from CD Cabinet and organised for that days collection

**Error 12** Missed doses not communicated

**11. Dose Collection** by patient

**13. Records Completed:**

PC70 Completed at time of collection

**Error 11a)** Wrong patient, wrong dose

**14.** CD Register Completed

**15.** Prescription Ends

**16.** Prescription moved to completed file/box

Key points in the process where pharmacist check may occur.

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| **Process Point** | **ERRORS** | **IMPLICATIONS** | **RECOMMENDATIONS** |
| **1** | **Prescription Receipt** |
| 1. **Prescription for New Patient:**

No prior contact with prescriber / CAT team. | Patient may have:* Missed 3 or more consecutive doses at previous pharmacy.
* A valid prescription at another pharmacy.
* Changed dose.
 | Contact prescriber /CAT team, check if there is knowledge regarding recently missed doses, if applicable, confirm expected start date for the prescription, and the dose. |
| 1. **New Prescriptions:**

Confusion regarding the start date of the prescription. | Prescriptions may be started after the date expected by the prescriber, this can result in patients receiving a double dose at the end of the prescription, when a new prescription is issued. Doses refused when the start date falls on a public holiday but should be dispensed on the day prior to closure. | Prescriptions should run consecutively, check the finish date of previous Rx, and compare to the start date of the new Rx.Check previous dose compared to new dose, are they within expected range: max weekly increase Methadone 30mls, Reductions: methadone 5mg / 7-14 days, buprenorphine 2mg / 14 days.Rx’s due to start on the date of a holiday should be dispensed on a date prior to the closure, the same as for other instalment Rx’s. |
| **2** | **Legal / Clinical Check** |
| **PC70 is often fully completed:*** After each dispensing.
* When Rx finished
* Prior to dispensing.
 | Confusion regarding whether patients have attended, and days when doses are due.  | Populate PC70 with the dates on which doses are to be dispensed when the Rx first arrives in the pharmacy. Complete the PC70 with a signature at the time of dose collection. |
| **3** | **Prescription Filed**  |
| **Rx lost within pharmacy.** | Patients do not receive their dose.Impacts upon the patient, prescribers and pharmacy staff.Risk of double dosing if the Rx is re-issued and the original is then found. | Create a system for the safe storage of Rx’s. Avoid Rx’s sitting loose, becoming attached to other Rx’s or moving around the pharmacy.  |
| **4** | **Rx Details Entered into Database for Automatic Pumps** |
| **Typographical errors:**Incorrect:* Duration (14 days instead of 28).
* Dose.
* Start date ( and therefore finish date).
 | Doses may be doubled or halved, wrong start dates / finish dates entered, details entered into the wrong patients records. | Details entered into the system should be checked against the original Rx and then double checked by another qualified member of staff, avoid only one person looking at the data, and never assume the data is correct – check. |
| **5** | **Dose Preparation (General)** |
| 1. **Distracted during dispensing :**

Interrupted mid way during dispensing by telephone call / patient at the counter. | Potential for overdose. The wrong dose may be dispensed to the wrong patient. | Finish the dispensing process, the customer or telephone call has to wait until the dose for that patient is measured, bottled and labelled. |

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| **Process Point** | **ERRORS** | **IMPLICATIONS** | **RECOMMENDATIONS** |
| 1. **Wrong volume measured:**

The wrong volume is dispensed both when preparing doses in advance and at the time of collection. This may be due to confusion surrounding the required dose, or lack of attention when dispensing. | Potential for overdose. Patients have received more than double the intended dose.Patients have also received less than the dose prescribed. | Concentrate and pay attention during the dispensing process, if doubt exists as to the dose required – check, if there is doubt surrounding the volume measured – check. |
| 1. **Labelled with wrong patient details:**

Correct dose/ volume, but labelled with another patient’s label. | Potential for overdose, since the wrong patient is given the wrong dose. | Double check prescription and labels at the time of dispensing.Check the volume expected by the patient matches volume dispensed. |
| **6** | **Dose Preparation (Manual)** |
| **Wrong volume measured:**The wrong volume is dispensed both when preparing doses in advance and at the time of collection. This may be due to confusion surrounding the required dose, or lack of attention when dispensing. | Potential for overdose. Patients have received more than double the intended dose. | Concentrate and pay attention during the dispensing process, if in doubt as to the dose required - check. |
| **7** | **Dose Preparation (Automated Pump)** |
| **Automated system details not checked against Rx.**All details entered into the system are assumed to be correct. The doses, patient details etc are never double checked. | Patients receive the wrong dose.Potential for overdose. | The details on screen should be checked against the Rx at each dispensing. You would not dispense MST tablets without checking the Rx.Check the patient name, drug and dose. Ensure the Rx remains valid for the day the dose is being dispensed. |
| **8** | **Dose Storage** |
| **Lack of segregation of doses within the CD.**Doses awaiting collection, uncollected doses, and multiple doses stored together in the CD cabinet in a chaotic fashion. | Uncollected doses / doses awaiting reconciliation to stock may be issued in error.Confusion surrounding whether doses have been collected or not, resulting in multiple doses being issued on the same day.Patient receives someone else’s dose. | Clearly segregate doses either by date or patient. Ensure all doses are labelled appropriately indicating the date on which they are to be dispensed to the patient. Clearly segregate uncollected doses from doses awaiting collection. |
| **9** | **Doses Removed from CD Cabinet for Collection** |
| **Chaotic Dose storage:**Doses are placed out with the direct supervision of the pharmacist.Doses are not segregated from work areas where other doses or Rx’s are dispensed.  | Doses for collection may be:* Mixed in with other doses being prepared,
* Mislabelled,
* Given to the wrong patient.
* Packaged with Rx items for other patients.
* Handed out without the pharmacists knowledge or ability to intervene if they so desire.
 | Pharmacists should have the ability to double check patients’ identity, volumes being dispensed / handed out.Doses for collection should be appropriately stored in such to minimise the risk of the wrong dose being given to the wrong patient.  |

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| **Process Point** | **ERRORS** | **IMPLICATIONS** | **RECOMMENDATIONS** |
| **10** | **Doses Reconciled to Stock** |
| **Delay in reconciling uncollected doses to stock:**Uncollected doses have not been reconciled promptly, and have been re-issued to patients after their Rx has finished. | Doses have been re-issued to patients after their Rx has finished, increasing the risk of double dosing, leading to confusion and missed appointments at the prescribers. | Record and reconcile uncollected doses promptly back into stock either at the end of the day or prior to opening the next day. |
| **11** | **Dose Collection** |
| 1. **Wrong patient / wrong dose:**
* Patient ID not confirmed.
* Multiple patients served at the same time.
* Doses left unsupervised both in the dispensary and the front counter.
* Bottle / cup not labelled.
 | Potential for overdose.Patient receives someone else’s dose, or the wrong dose volume. | Confirm the ID of the patient being served – name, address, date of birth, expected dose.Serve only one patient at one time.If using an automated system, only dispense one dose at one time.Ensure all bottles / cups are labelled, especially doses dispensed by automated systems.Double check the details on screen, on the bottle /cup match the patient prior to handing over the dose.Confirm the dose dispensed matches the dose on the Rx.Hand the dose directly to the patient. |
| 1. **Rx instructions ignored:**

Supervised doses dispensed as take home. | Patients who may be unstable or unable to cope with take home doses are put at risk of overdose, or dose may be diverted. | Adhere to the instructions on the Rx.You may be unaware of the reasons for the prescriber’s instructions.The risks and responsibility should you deviate from them are yours alone, and the consequences may be severe. |
| **12** | **Missed / Refused Doses** |
| **Missed / Refused Doses:**Missed / refused doses are not recorded.Doses remain in circulation with doses awaiting collection. | Confusion amongst staff:* If doses were missed / refused on specific days.
* How many doses have been missed / refused.
* Prescribers are not contacted regarding 2 / 3 consecutive missed doses.
* Potential overdose if prescribers issue new Rx’s.
 | Record missed / refused doses at the end of each day on the PC70.Identify patients who have missed 2 / 3 days and contact the prescriber, record that the prescriber has been contacted and the outcome.If future doses are to be withheld, ensure any pre-prepared doses are clearly segregated within the CD cabinet.Ensure any instructions from the prescriber are noted on the PMR system in the patient’s record, and instructions are communicated to other staff members e.g. note attached to the Rx, record made in the daily message book / diary. |

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| **Process Point** | **ERRORS** | **IMPLICATIONS** | **RECOMMENDATIONS** |
| **13** | **Record Completion** |
| **Paper work remains incomplete or not completed promptly.**PC70’s are not completed at the time of collection. | Confusion whether a patient has already attended or a dose supplied.Records remain incomplete with data missing.Running balance errors.Ultimately patients are in danger of receiving a double dose. | Different records may be completed at a variety of times; however they should all be completed promptly. **PC70** – pre-populate the dates when doses are due for collection and complete at the time a dose is collected. This allows other staff / locums to check if a patient has already attended or a dose has been supplied earlier in the day, or if doses have been missed.**CD Reg – see number 14** |
| **14** | **CD Register Completion** |
| **CD Register not completed promptly.** | Confusion as to whether a patient attended the pharmacy on a specific date, especially if all other records have left the pharmacy.This may also result in running balance errors. | The CD register is the only record guaranteed to remain within the pharmacy beyond the life of the Rx. It is a legal requirement to complete this document “*on the day of the transaction or on the following day.”*Complete this record promptly. |
| **15** | **Prescription Ends** |
| **Confusion surrounding the finish date.*** This is usually associated with confusion around the start date.
* Doses continue to be supplied out with the valid start and finish dates of the Rx.
 | Doses are supplied after the date on which the prescriber intended / expects the Rx to end.Potential for double dosing. | Clearly identify and note on the Rx the last date when doses are due.If PC70 has been pre-populated with dispensing dates, and is completed at the time doses are handed out, then completed Rx’s should be removed and transferred to the completed Rx file.  |
| **16** | **Prescription Filed on Completion** |
| **Rx Lost in Pharmacy.**Completed Rx’s filed incorrectly. | Rx’s cannot be found or checked when a new Rx is presented, or when a query arises, e.g. confirming start date / finishing date, previous dose. | Introduce a system for storage of completed addiction Rx’s, e.g. filed alphabetically by patient and date.Move completed Rx’s to the designated file as soon as it is finished. |