Delivering pharmacy services is a complex, human process. Although technology is a helpful tool to assist in identifying red flag situations, mistakes can still occur. "Close-Up on Complaints" presents some of these errors so that practitioners 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.

Dealing with Dispensing Errors: How Effective Communication Can Help

SUMMARY OF THE INCIDENT

The incident occurred when a mother visited her local pharmacy to pick up a prescription for her infant son. The infant had been prescribed an oral suspension of clavulin at a dose of 30mg/kg/day, twice per day for 14 days.

A pharmacy assistant dispensed the prescription to the child's mother without asking if she had questions or offering to have the pharmacist counsel her on how to properly give her son the medication. The mother left the pharmacy and went home to care for her sick child.

Once she returned home, the mother thought of some questions about the medication, and phoned over to the pharmacy. She asked the pharmacist if there would be enough of the solution to last for the full 14-day prescribed course. The pharmacist assured her that there would be more than enough solution — a 14-day course would only require 49mL of the 70mL bottle.

After hanging up the phone, the mother read the manufacturer's label on the bottle, which stated that the medication would only be stable for seven days —half the treatment period prescribed for her son.

She once again phoned the pharmacist to inquire, but the pharmacist refused to acknowledge his mistake. He instructed her to return to the pharmacy in seven days and he would give her another bottle of the medication to finish the second half of the treatment period.

When the mother arrived at the pharmacy seven days later, she was presented with the second bottle. The label directed that this bottle was also to be taken for 14-days — labeling that she felt was confusing and misleading. No further instructions clarifying these directions were provided by the pharmacist. The pharmacist also charged her for the cost of the second bottle — making her very upset since she thought she had already paid for the whole prescription. The pharmacist curtly told her that she would need to pay if she wanted the remainder of the medication. In her complaint to

Have a Complaint?

Anyone who is not satisfied with the care of services provided by a pharmacy, pharmacist, pharmacy technician, student or intern can file a formal complaint with the College. Complaints must be received in writing and include as much detail as possible. The College investigates all written complaints.

the College, the patient's mother stated that the pharmacist also refused to provide his full name when asked. She said that he would only wave to his name tag, which apparently only showed a short-form of his first name.

WHY DID THIS HAPPEN?

The pharmacist in this complaint made several mistakes.

Initially, he did not counsel the patient's mother on how to administer the medication when she first visited the pharmacy and did not appropriately explain the directions when dispensing the second bottle of medication. He also made a dispensing error by not checking the medication's expiry date and drug stability. As well, he failed to catch this mistake on more than one occasion, and provided the patient with false information about the medication by stating it would last the full 14 days. He also acted rudely and unprofessionally, and failed to communicate effectively with the patient by not explaining to her that she would have to pay for the second bottle.

The situation was likely worsened by his unprofessional and insensitive behaviour.

COMPLAINT OUTCOME

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

The Committee found that the pharmacist in this case acted unprofessionally, failed to counsel the patient, provided false information to the patient, failed to observe expiry/stability dates, demonstrated lack of care in labelling, refused to provide his name upon request and did not communicate effectively with the patient's caregiver.

The Committee ordered that the pharmacist appear in person to receive an oral caution, and that he complete remedial training — a specified continuing education or remediation program (SCERP) — on *Confronting Medication Incidents.*

LEARNING FOR PRACTITIONERS

This complaint is multi-faceted, and as such, there are several lessons for practitioners. Like many complaints the College receives, this incident could have been avoided (or at least de-escalated) if the pharmacist had been more diligent and used more effective communication techniques.

The first issue occurred when the pharmacist allowed the pharmacy assistant to release the medication without him first counseling the patient's mother on her child's prescription. Pharmacists must assess and educate patients on their prescriptions. If the pharmacist had properly assessed this patient, he would have noticed that he was dealing with an infant — a red flag population of vulnerable patients who require extra care and attention. For these patients, even small errors can cause significant problems.

As a regulated healthcare professional, pharmacists have an ethical responsibility to both help and not harm their patients. In this case, since he was apparently unfamiliar with the medication, the pharmacist should have ensured that this medication was both therapeutically appropriate and would not harm the infant. This requires taking extra time to review appropriate resources. If he had done this review, the pharmacist would have noticed the problem with the stability of the reconstituted medication.

The pharmacist had an additional opportunity to catch his mistake and properly counsel the patient's mother when she phoned with questions about her son's therapy. This time, the pharmacist provided incorrect information about the duration the initial bottle of medication could be used for. When the patient's mother identified the issue with the medication's stability, the pharmacist said he did not have another bottle of the medication in stock to reference. However, he should have consulted an alternate resource to confirm the required information and ensure the infant received the intended benefit of the medication.

When the patient's mother came to pick-up the second bottle of medication for the remaining seven days, it was labelled for a 14-day course. The pharmacist had processed this bottle of medication as a repeat — and in many pharmacies the label can not be altered on repeats. However, he could have provided handwritten instructions on the label or clearly explained to the patient why it was labelled for 14 days when the remaining duration of therapy was seven days. He should have also explained that the second bottle was

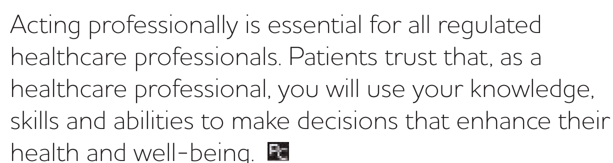
not included in the initial charge and the second charge was only for the cost of the medication.

If a problem is identified, it is always best to de-escalate the situation by apologizing to the patient, empathizing with how they are feeling, and explaining options that could help fix the problem. Using this approach would have helped the pharmacist when discussing the error in stability, the issue with labelling and additional cost of the second bottle of medication. Once a dispensing error was discovered, the pharmacist also should have reviewed the pharmacy's dispensing error protocol, discussed the issue with the designated manager, and made a plan to avoid similar incidents in the future.

Ensuring you provide proper counselling is important. But ensuring that the patient understands it and feels informed is even more important. Some good techniques for communicating with patients include:

- Watching the patient's non-verbal cues to ensure they understand
- Providing rationale and explanations for your decisions or business processes
- Asking the patient to repeat the information you've just provided
- Using open-ended questions and listen to the patient's responses
- Following-up with a phone call if you're not sure the patient understood everything

Acting professionally is essential for all regulated healthcare professionals. Patients trust that, as a healthcare professional, you will use your knowledge, skills and abilities to make decisions that enhance their health and well-being.



ORAL CAUTIONS

An oral caution is issued as a remedial measure for serious matters where a referral to the Discipline Committee would not be appropriate. Oral cautions require the practitioner to meet with the ICRC in person for a face-to-face discussion about their practice and the changes they will make that will help avoid a similar incident from occurring in the future. It is not an opportunity for the practitioner to further argue their position, provide additional documentation, or attempt to change the ICRC's view with respect to their final decision. For all complaints filed after April 1, 2015, we post a summary of the oral caution and its date on the "Find a Pharmacy or Pharmacist" section of our website.

REMEDIAL TRAINING (SCERPS)

A SCERP is ordered when a serious care or conduct concern requiring a pharmacist or pharmacy technician to upgrade his or her skills has been identified. The ICRC orders SCERPs when they believe that remediation is necessary. For all complaints filed after April 1, 2015, we post a summary of the required program and its date on the "Find a Pharmacy or Pharmacy Professional" section of our website.

PRACTICE TIP!

As a members of a self-regulated profession, pharmacists must be able to rationalize the clinical decisions that they make, to their peers and to any person or organization which may be affected by their actions, including individual patients, the public, their employers, and other healthcare professionals.
http://www.ocpinfo.com/library/practice-related/download/Professional%20Judgment.pdf

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