Open Book
Learning from close calls and adverse events

Dispensing errors: Learning from the national primary care patient experience survey

This report alerts providers to key medication-related findings from the national primary care patient experience survey, and includes some recommendations for improvement.

It is relevant to pharmacy staff involved in the dispensing and supply of medicines to patients. Please consider this report, and whether the suggested changes are relevant to your own systems.

Introduction

In 2016 the Ministry of Health and the Health Quality & Safety Commission introduced the national primary care patient experience survey. The survey helps to find out what people's experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff.[1] The information gathered is used to improve the quality of service delivery and patient safety.

The survey looks at a patient's experience of the whole health care system using primary care as a window. It focuses on the coordination and integration of care, rather than just the last visit to a general practice.

The survey is modular (Figure 1). Patients answer questions relevant to their experiences. For example, questions on medication and chronic conditions are answered only by patients for whom these are relevant. The survey is conducted nationally every three months. Patient feedback is voluntary and anonymous.

Figure 1: The modules of the national primary care patient experience survey

Medication-related survey findings

The survey asks a question about 'wrong medication':

> *In the last 12 months have you been given the wrong medication or wrong dose by a doctor, nurse or pharmacist (outside of hospital)?*

Possible responses are a single selection: No, Yes or Don't know.

A subsequent question invites written comments:

Is there anything else you'd like to tell us about being given the wrong medication or dose?

Four quarterly surveys were undertaken throughout 2017/18, with 54,866 total responses (Figure 2). The 'wrong medication' question was answered by 40,919 people; 2,363 (6 percent) indicated they had been given the wrong medication or the wrong dose of a medication in the past 12 months. Written comments were provided by 1,494 respondents (63 percent). Of these, 70 percent were female. The majority (72 percent) identified as European and five percent as Māori.

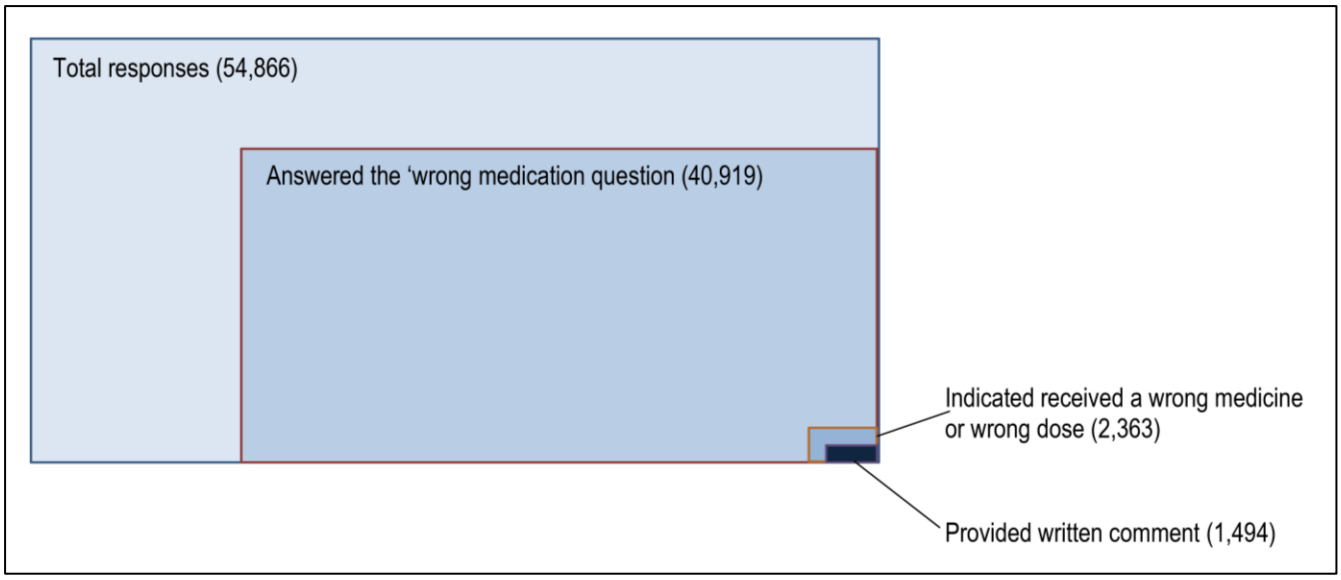

Figure 2: Responses to the 2017/18 financial year national primary care patient experience survey

The written comments were extracted and analysed according to where the 'wrong medicine' event related to (eg, community pharmacy, general practice, hospital or 'other' provider). Comments do have limitations in that there is often little detail and context to understand what exactly happened.

Some comments for the 2017/18 survey lacked detail, or were of a general nature, so could not be attributed.

What does the survey tell us?

A number of themes have emerged from the survey.

One positive theme is that patients recognise that pharmacists prevent errors. Some examples follow:

> *Being on warfarin, one has to be careful with antibiotics and my chemist always checks a script before he processes it. If not right, he won't give it to me.*
>
> *I was very impressed at the lengths the chemist went to find me, fix this, as I was away from home when the mistake was made.*
>
> *My pharmacist caught the error each time.*
>
> *The pharmacist dealt with it, and instead of the doctor explaining everything, the pharmacist always gives me the information and seems to help me understand more what I am taking and how.*

Some negative themes included the following:

1. Patients reported receiving a medicine for which they have a known allergy.
2. Common dispensing errors included:
    - wrong quantity (under- and over-supply)
    - wrong medicine
    - wrong dose strength
    - wrong patient
    - compliance pack errors (omissions, double-ups)
    - being dispensed a medicine that has previously been discontinued.
3. Patients are not aware of the empiric nature of antibiotic treatment; often they view a change of antibiotic once sensitivity results are available as an error or failure.
4. Patients commented on delays in reaching a diagnosis and incorrect diagnosis.
5. Patients have a poor understanding of when events are predictable/unpredictable or preventable/unpreventable.
6. For some patients, cost is a barrier to using medicines, particularly if there is an error and they need to make an extra visit to the GP and/or need another prescription.

How can providers make improvements?

No one thing will reduce all medication-related errors. However, some simple steps can help reduce the risks.

- Pharmacists should go through a patient's dispensed prescription at the time of collection. This can detect errors before the patient formally receives their medicines.
- Several of the patients' comments in the survey noted that the patient captured the error. This illustrates that the engaged patient can detect errors and prevent harm, acting as the final check in the system. Cohen et al[2] showed a 56 percent reduction in the wrong medicine reaching patients by simply opening the bag at the point of handover. By going through the medicines with the patient, errors were identified. Is this what the patient is expecting? Does anything look different?
- Pharmacists can increase patient medicines counselling (medicines education). Cohen et al[2] showed that this can reduce errors by 27–68 percent. When patients take an active and informed role in their medicines many errors can be intercepted and prevented.
- Always check for allergies before dispensing a medicine.
- Undertake medicine reconciliation to maintain an accurate medicines list that reflects how the patient takes their medicines.
- Maintain an accurate patient held list of their medicines (eg, 'yellow card', medication app or electronic reminder).
- Health care professionals should provide context to their patients about what medication-related events are predictable/unpredictable or preventable/unpreventable, and explain things clearly.
- Where a medication-related error has occurred, the health care professional concerned should consider meeting any additional costs incurred by the patient (eg, an extra visit to the GP or another prescription).

1. Health Quality & Safety Commission. Adult inpatient experience survey. Updated 30/07/2018. URL: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/primary-care-patient-experience (accessed 27 September 2018).
2. Cohen MR, Smetzer JL, Westphal JE, et al. 2012. Risk models to improve safety of dispensing high-alert medications in community pharmacies. *J Am Pharm Assoc* 52: 584–602.