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MONASH
PHARMACY &
PHARMACEUTICAL
SCIENCES

Introduction

- Facilitating access to medicines, currently through dispensing, is a core component of the patient care process for pharmacists.
- Errors can occur anytime during dispensing and the consequences of these can result in poor patient outcomes.
- Common dispensing errors are wrong medicine, form, strength, quantity, or incorrect directions on labels.¹

Health care isn't as good as it can be

Girl, 2, 'could have died' after Boots pharmacist gave wrong medicine

Georgia Diebelius
Wednesday 28 Feb 2018 1:54 pm



*The label on the bottle reads "May be fatal if swallowed and enters airways" followed by "If swallowed, immediately call a poison centre or doctor". (Picture: Colchester Gazette/ SWNS)

Pharmacy error contributes to Melbourne woman's death

Family questioned medication but were told it was okay



Heather Saxena | 1st March 2018

1 Comment

A statin dispensing error by a Melbourne pharmacist contributed to an elderly woman's death, a Victoria coroner has found.

The pharmacist admitted to supplying 79-year-old Margaret Yeomans with rosuvastatin 40mg daily instead of simvastatin 40mg daily in June 2016, according to findings released this week.

Mrs Yeomans' husband later told police he picked up the medication from the pharmacy, and noticed the container and tablets looked different, and 'rosuvastatin' was written on the box.

However, another pharmacy staff member told him it was correct and it was probably just a different box.

7-month suspension for pharmacist whose dispensing error led to death



by James Waldron
06/10/2017 | 55 comments | News



Martin White (3062R) said propranolol was "side by side" with prednisolone on the dispensary shelf

MyDispense Asia 2019





4,340

Medications

1,900

Virtual patients

227

Virtual prescribers

77

Institutions using MyDispense

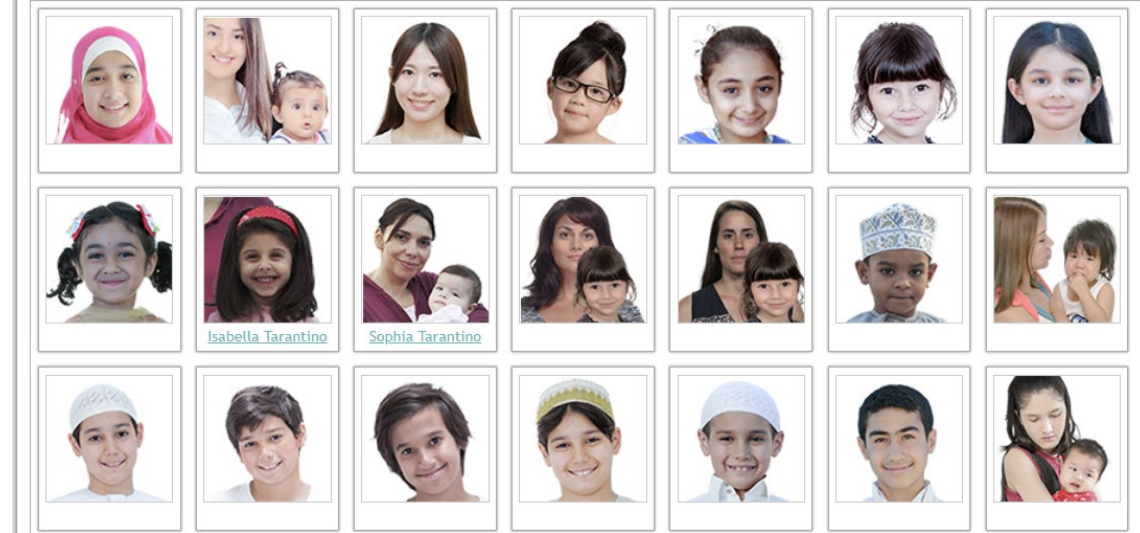
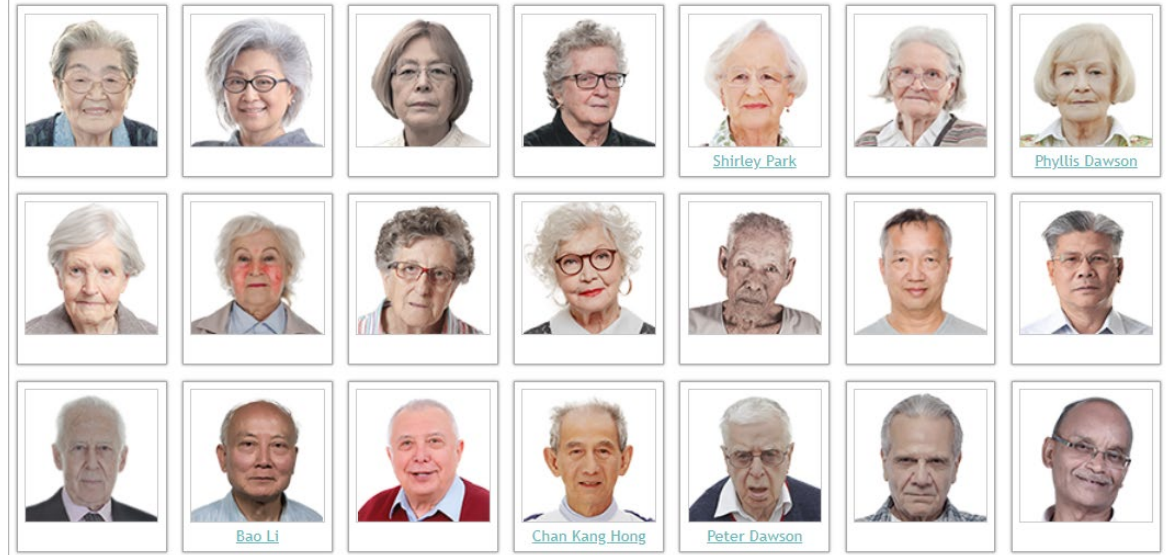
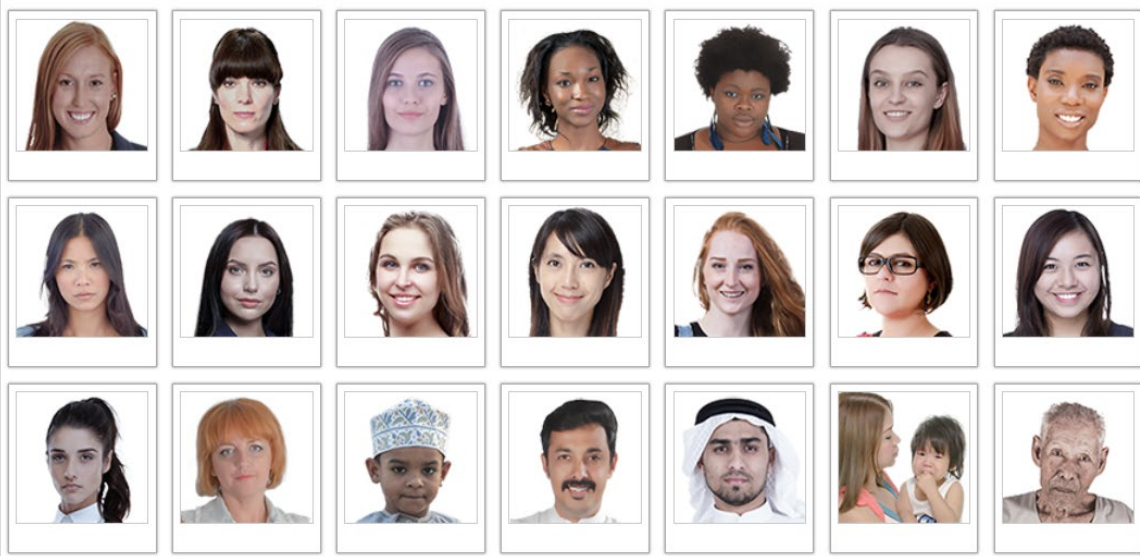
580,000

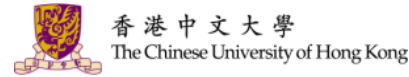
Exercises completed

Inventory



Patient avatar





MyDispense Asia 2019

Name: 陳嘉怡 XXX
Sex: F Age: 68 H.K.I.D.: A332542(5)
Address: 沙田銀城街5號沙田第一城, 47座13樓A室.
Order Date: 11 05 2018 MO: David Fang
Ward:

Doctor's Prescription

Drug Allergy:

Prescription

Abilify 1 mg/mL OS Thirty
Example directions

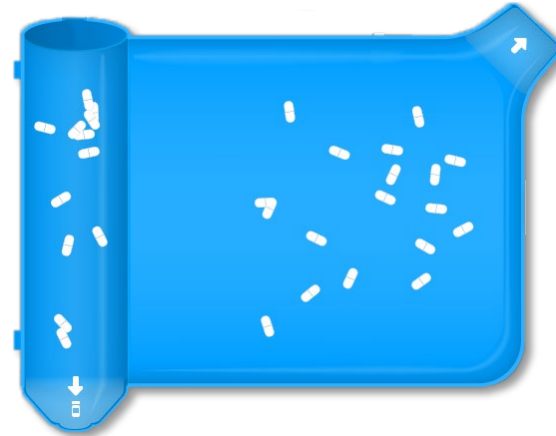
Generic substitution is allowed unless otherwise specified.

Doctor's Signature For Pharmacy Use Only (Ext. 5787)

Dr. code: IU08393

Filled by _____ Checked by _____ Issued by _____

請於領取藥單當天取藥, 此藥單有效期為四個工作天。
Please collect medications on the same day when the prescription is received.
The prescription is valid for 4 working days.



KEEP OUT OF REACH OF CHILDREN

PROXEN SR 750mg Tab Qty 28 Rpt 0
Naproxen 750mg Tab (MD)

Swallow whole ONE (1) tablet daily with or soon after food

Khun Phra Nuananong \$5.18
13/05/2016 Darshan Aman KS



Pharmville Community Pharmacy

48 High St, Pharmville 3052 Ph: 5877 2154 Prop. L. Wilkie

Maxamox
1000 mg Tablets
Amoxicillin Tablets
14 Tablets

Store below 25°C.
Protect from moisture.

Dosage: As directed by the physician.

Sandoz Pty Ltd
ABN 600 7544 9553
100 Harris Street,
Pymont NSW AUSTRALIA 2009
Tel: 1800 634 500



Maxamox
1000 mg Tablets
Amoxicillin Tablets

SANDOZ

PRESCRIPTION ONLY MEDICINE
KEEP OUT OF REACH OF CHILDREN

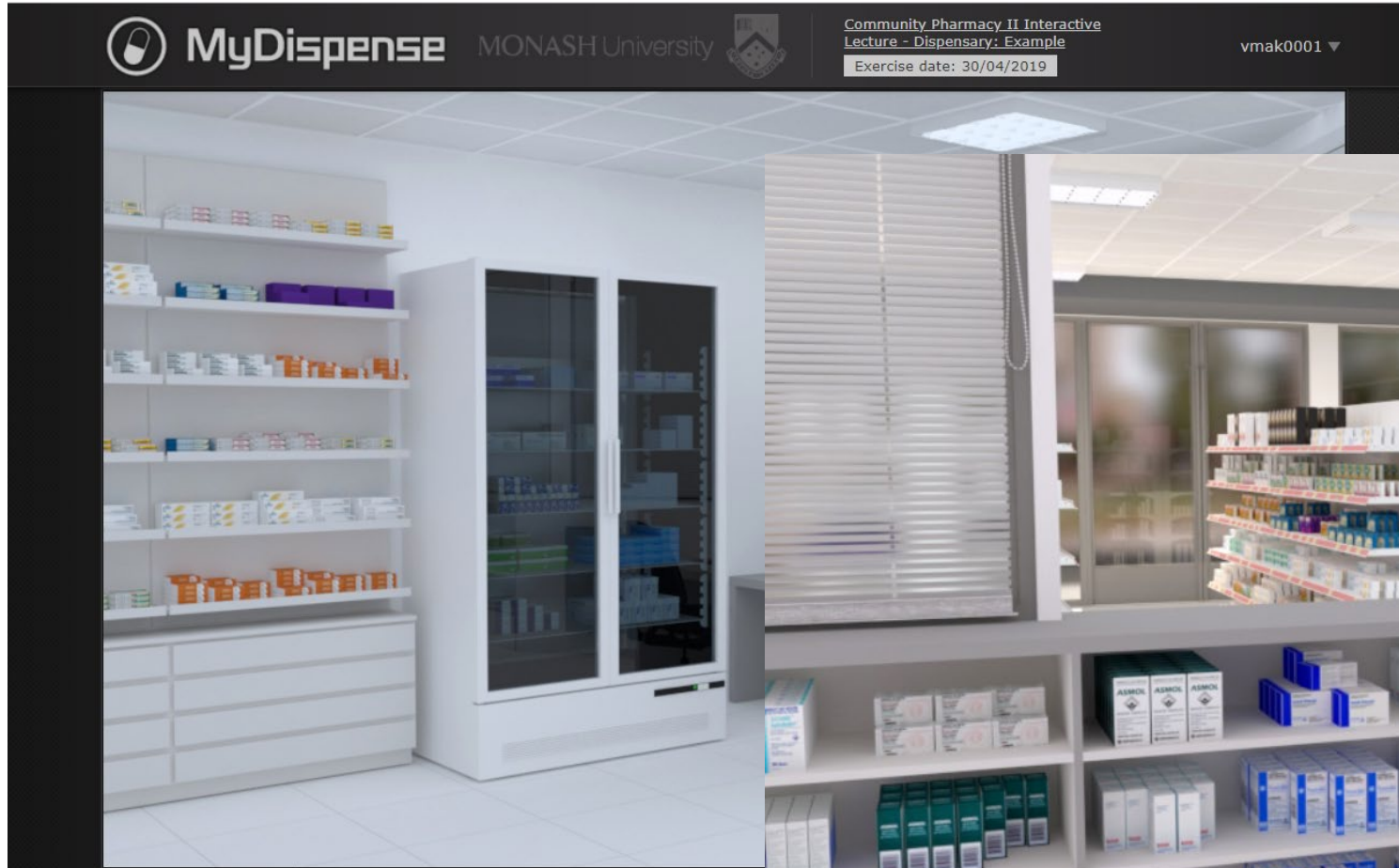
Maxamox
1000 mg Tablets

Amoxicillin Tablets
14 Tablets

Each tablet contains:
Amoxicillin 1000 mg (as amoxicillin trihydrate)
AUST R 76050

SANDOZ

Storage



HIV

Prescription

PBS-RPBS authority prescription **4480**
Not valid unless authorised by delegate

Dr. Laurence Carter **PF9265**
10 Gordon St, Granville,
QLD, 4650, Ph: 41233133

Patient's Medicare number: **2 9 7 6 8 6 5 4 6 A 1**

Patient's full name: **Layla Hassan**

Patient's address: **3 Newman St, Pharnville,**
Victoria Postcode **3052**

PBS entitlement number: **1 6 0 K 3 5 7 2 8 4 U L**

Safety Net entitlement card holder: Concessional or dependent, RPBS beneficiary or Safety Net concession card holder

Authorisation is requested for the following:
PBS prescription from State Manager, Medicare Australia
RPBS prescription from the authorised delegate of the Repatriation Commission

Brand substitution not permitted

Only one item per form

Genvoya 10mg-200mg-150mg-150mg Tab (...)

Pharmacist/patient copy

Dosage directions: **1 daily**

Quantity: **30**

Number of repeats: **0**

Prescriber's Signature: *[Signature]* **21 03 2019**

Medicare Australia/OVA use: Quantity: Repeats: Photo/Delegate approval: **4522**

Hi, I'd like to get this script filled please.


Review of clinical documentation


The screenshot displays a video call interface. The main video feed shows a woman with short grey hair, wearing a grey patterned blazer, standing in a pharmacy. Behind her are shelves stocked with various medications and two posters on the wall: a green one that says "FREE BLOOD PRESSURE CHECK" and a red one that says "BEAT THE FLU". A small white box with a paperclip icon is overlaid on the video feed. Below the video is a control panel with several sections:

- Left Column:** A vertical menu with icons and text: a speech bubble icon, "Fact Finding", "Patient Questions", "Counselling", and "Attachments" (which is highlighted with a dark teal background).
- Middle Column:** Two items, each with a paperclip icon: "Pathology results" and "GP notes".
- Right Column:** A vertical menu with a hand icon, "Hand over", and "Do not dispense".

At the bottom of the interface is a dark navigation bar with several icons: a list icon with "x0", a camera icon with "x0", a checkmark icon, a monitor icon, a document icon, a person icon, a magnifying glass icon, a clipboard icon, a close icon (X), and left and right arrow icons.

Oral chemotherapy

MyDispense MONASH University  Topic 8: Oncology (Workshop- Part A) - Oral Chemotherapy Breast Cancer- Sophie Barker Part A vmak0001 ▾
Exercise date: 30/04/2019

Hi, I would like this prescription filled please 

Prescription

HOSPITAL PRESCRIPTION 4422

Patient's Medicare number: **6 9 3 8 8 4 7 9 Q B 5**

Pharmaceutical benefits entitlement or DVA number:

Safety Net entitlement card holder

Concessional or dependant, RPBS beneficiary or Safety Net concession card holder

Tick appropriate box (one scheme only per form)

PBS RPBS Chemo

UR number: **0** Ward: **Onc6S**

Name: **Sophie Barker**

Address: **29 Edgevale Rd, Pharmville, Victoria 3052** Age: **68**

Print patient's name: **Sophie Barker** Patient Weight:

Drug name and form	Strength	Dose, route and frequency	Quantity	Rpts	Supply Y/N	Approval number if required
Capecitabine 500mg Tab 500mg Tab (..)	500mg	4 tab bd, 14 days on, 7 days off each cycle.	112 Tablet	2	Y	000000
Height...						
Weight...						
BSA...						
CDX Capecitabine for meta breast cancer						

Drug hypersensitivities

DO NOT LEAVE BOX BLANK
If patient has no allergies enter N/A in box.











NKA

Prescriber's name: **DR Ian Kerr**

Prescriber number: **CK73396**

Signature: *Ian Kerr* Date: **30 04 2019**

Patient or pharmacist copy

x0 x0          

Antimicrobial stewardship

MyDispense MONASH University Topic 2: SSTI (Workshop 2B) - Activity 1 - Case 1: Paige Kaylee Baker vmak0001
Exercise date: 30/04/2019

Prescription

Dr. Amrita Aman 4451
18 Thanet St, Pharmville,
Victoria, 3052,
Ph: 78403332
Prescriber no. AX14938

Patient's Medicare no. 4731 9548 YB 5
Pharmaceutical benefits entitlement no.

Safety Net entitlement cardholder (cross relevant box) Concessional or dependant RPBS beneficiary or Safety Net concession cardholder

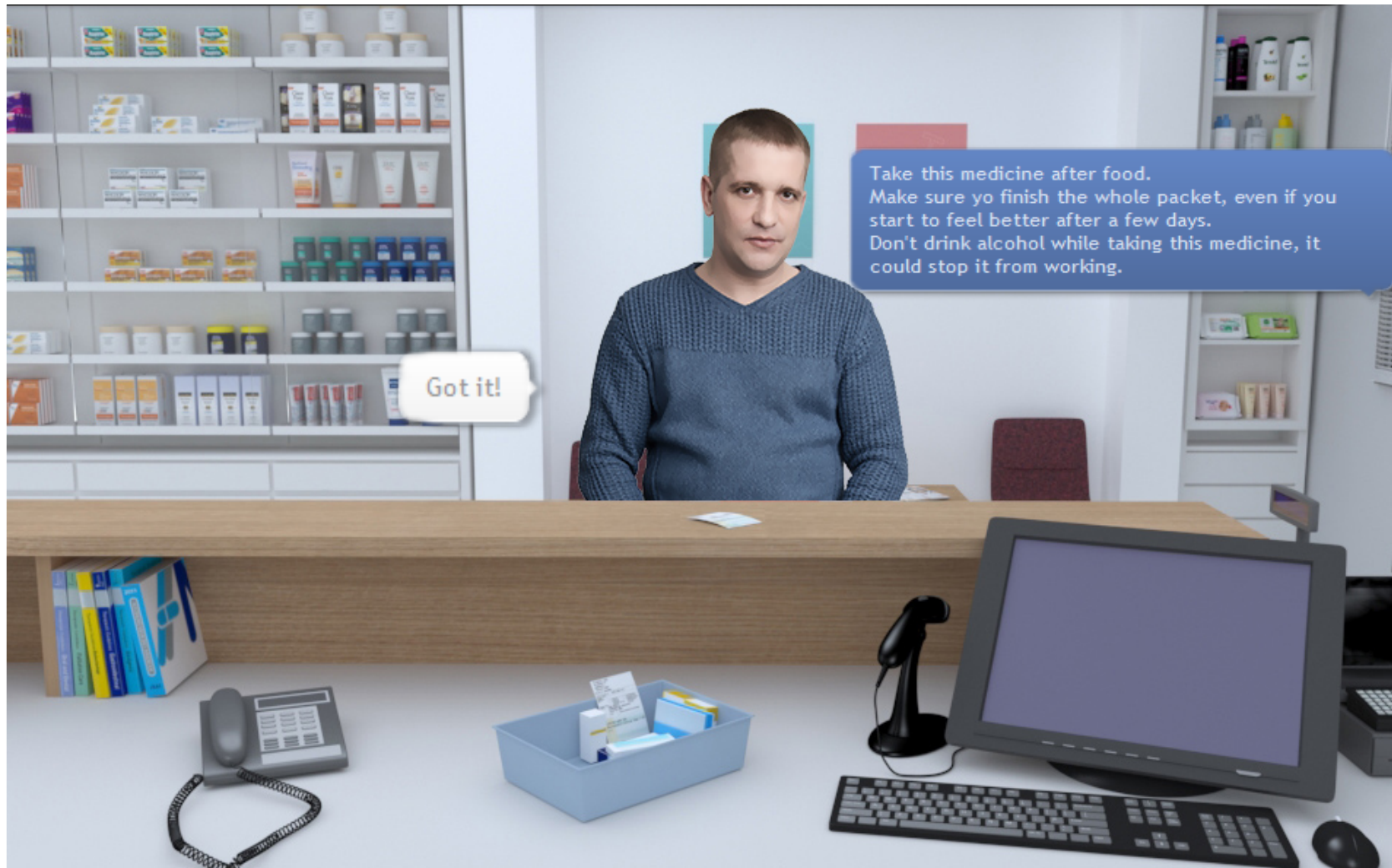
Patient's name **Paige Kaylee Baker**
Address **2/9 Edgevale Rd, Pharmville, Victoria 3052**
Date **30 04 2019**
PBS X RPBS Brand substitution not permitted

KEFLEX 250mg/5mL Susp (AS)
3 mL oral TDS for 5/7. QTY: 1 RPT: 0
Allergic to penicillin

Doctor to sign original and duplicate Turn over for privacy note
A. Aman





Can you dispense this antibiotic? It's for my daughter Paige's leg infection. Do you know if the syrup tastes OK? Paige is quite fussy.

Counselling



Key Feature



Your Label		Correct Label	
<p>KEEP OUT OF REACH OF CHILDREN</p> <p>KEFLEX 500mg Cap Qty 20 Rpt 0 Cephalexin 500mg Cap (AS) Take ONE capsule orally four times a day</p> <p>Emma-Lin Park 30/04/2019 Petrou Kakarikos \$7.62 VM</p> <p> Pharmville Community Pharmacy 48 High St, Pharmville 3052 Ph: 5877 2154 Prop. L. Wikie</p>		<p>KEEP OUT OF REACH OF CHILDREN</p> <p>KEFLEX 500mg Cap Qty 20 Rpt 0 Cephalexin 500mg Cap (AS) Take ONE capsule FOUR times a day.</p> <p>Emma-Lin Park 30/04/2019 Petrou Kakarikos \$7.62 VM</p> <p> Pharmville Community Pharmacy 48 High St, Pharmville 3052 Ph: 5877 2154 Prop. L. Wikie</p>	
Your Selections		Feedback	
Patient name	Miss Emma-Lin Park	Miss Emma-Lin Park	
Script date	30/04/2019	30/04/2019	
Script type	Doctor (PBS)	Doctor (PBS)	
Prescriber	Dr. Petrou Kakarikos	Dr. Petrou Kakarikos	
Directions	Take ONE capsule orally four times a day	Take ONE capsule FOUR times a day.	
Repeats	0	0	
Quantity	20	20	
Initials	VM	VM	
Drug on label	KEFLEX 500mg Cap Cephalexin 500mg Cap (AS)	KEFLEX 500mg Cap Cephalexin 500mg Cap (AS)	
Product selected	 KEFLEX 250mg Cap Cephalexin 250mg Cap (AS)	 KEFLEX 500mg Cap Cephalexin 500mg Cap (AS)	
Product scanned	KEFLEX 250mg Cap Cephalexin 250mg Cap (AS)	KEFLEX 500mg Cap Cephalexin 500mg Cap (AS)	
Ancillary Labels	No ancillaries attached		

- MyDispense allowed students to practise dispensing medicines in an environment where it is safe to make mistakes and learn from these.
- Students utilise the opportunity and engaged voluntarily with the supportive learning environment.
- Students used the opportunity to practise by repeating the exercises.

References

1. James, K. L., Barlow, D., McArtney, R., Hiom, S., Roberts, D. and Whittlesea, C. (2009), Incidence, type and causes of dispensing errors: A review of the literature. *International Journal of Pharmacy Practice*, 17: 9–30.
2. Diebelius, F. (2008, Feb 28). Girl, 2, 'could have died' after Boots pharmacist gave wrong medicine. Retrieved from <https://metro.co.uk/2018/02/28/girl-2-died-boots-pharmacist-gave-wrong-medicine-7349325/>
3. Saxena, H. (2008, March 1). Pharmacy error contributes to Melbourne woman's death. Retrieved from <https://www.pharmacynews.com.au/news/pharmacy-error-contributes-melbourne-womans-death>
4. Waldron, J. (2017, Oct 6). 7-month suspension for pharmacist whose dispensing error led to death. Retrieved from <https://www.bbc.com/news/uk-england-nottinghamshire-42735588>