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Pharmacists Should Make Sure Prescription Bag Contents Are Checked at Point of Sale to Prevent Errors

Horsham, Pa—Giving a correctly dispensed prescription to the wrong patient is one of the most common mistakes reported to the Institute for Safe Medication Practices (ISMP)—the Institute believes that it is important for pharmacists to work directly with patients to catch errors. The July issue of the *ISMP Medication Safety Alert! Community/Ambulatory Edition* describes how mix-ups can happen and provides practical recommendations for reducing the risk.

The wrong patient receiving a dispensed prescription can happen for several reasons. In many instances, a patient's medication is accidentally placed in a bag intended for another patient. Most people pick up their medication and leave the pharmacy without ever opening the bag, missing a key opportunity to catch any mistakes. And many pharmacies do not require staff to open the bag prior to ringing up the sale, so they do not view the prescription with the patient to be sure the intended person is receiving it.

Another way a correctly filled prescription can be given to the wrong patient is when pharmacy staff selects the wrong patient's bag from the will call area. This error can occur if the pharmacist does not ask for a full name and date of birth from the individual picking up the prescription, and there are medications waiting for patients with a similar or the same last name. Using an address to identify patients is not ideal, as people with the same last name often live together and addresses may not be up-to-date in computer systems.

As one might expect, the consequences of receiving a prescription medication meant for someone else can be serious. Patients could accidentally take a drug contraindicated for their medical condition, misuse the medication received in error, or receive confidential health information about another individual.

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There are three relatively simple steps that community pharmacies and pharmacists can take to reduce the risk of a patient taking home another patient's medication by mistake:

- **Have patients review labels and contents of each prescription container to check that the medication is correct—even if this requires opening the bag**. This step alone can cut the risk in half of patients taking home a prescription intended for another patient. If someone else picks up the prescription, the patient should be notified via telephone to open the package at home and check the contents before taking any of the medication.

- **The pharmacist should always ask the patient to provide their full name and date of birth when picking up prescriptions**. This should happen even if the pharmacist is familiar with the patient, and the information should be compared to what is in the pharmacy's computer system or on the prescription receipt.

- **The pharmacist should talk to the patient about their medications**. The discussion should cover the medication's purpose, to ensure that the correct medication is being dispensed to the correct patient.

For a copy of the full article on point-of-sale pharmacy errors in the *ISMP Medication Safety Alert! Community/Ambulatory Edition*, which provides additional prevention strategies, visit the Institute's website at: http://www.ismp.org/newsletters/ambulatory/showarticle.aspx?id=21.

Also available from ISMP is a PDF document with tips for patients on how to read a pharmacy label to verify that they have received the correct medication and know how to take it. To receive a copy, contact Renee Brehio at rbrehio@ismp.org or 614-376-0212.

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