Pharmacy Regional Newsletter

June 2026

Safety Risk: Repeat Printing of Labels

A recent adverse incident reported to SPPG highlighted a medication error in a community pharmacy involving a **missed dose reduction** on an instalment prescription, which was not identified during the final accuracy check. This led to inaccurate directions on the label which resulted in the patient inappropriately continuing on the previously prescribed dose. This error occurred because:

- The label had been generated using directions from a previous entry on the PMR, without verification against the current prescription.
- The prescription involved a complex tapering regimen, which further increased the risk of an error.

This incident highlights the risks of relying on PMRs, and reinforces the importance of **robust checking processes** at all stages of dispensing.

In order to maximise safety, **community pharmacists should ensure that:**

- Reprinted labels are accuracy checked, including a comparison of the label against the prescription
- Complex regimens are highlighted to dispensing staff
- All processes are reviewed to ensure they are robust

In this issue

Free PrescQIPP resources for Community Pharmacists

Community pharmacists can access evidence-based, quality assured, free resources on PrescQIPP*, using the DoH NI subscription, including clinical guidance and tools, such as:

Bulletins and webkits on a huge variety of clinical topics, such as pain, respiratory, anticoagulation, antimicrobial stewardship, polypharmacy and more

Masterclasses across a variety of key therapeutic areas and delivered by national experts in their field

Clinical and skills webinars to upskill with leading experts

Virtual Professional Groups that meet monthly/quarterly to network and share good practice, including:

- Antimicrobial stewardship
- Care homes
- Medication safety
- Nutrition
- Pharmacy technicians
- Polypharmacy and deprescribing
- 'Talking meds' Podcasts - Fortnightly engaging conversations about medicines related dilemmas

PrescQIPP Funded by the NHS for the NHS

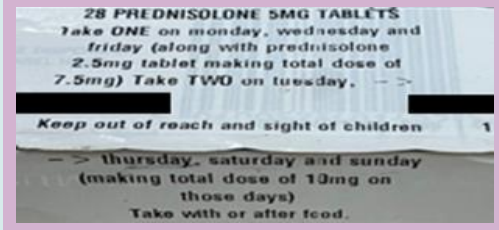
Community pharmacists should:

- Use their health service email address to register, with NHS area "National" and "DoH NI" as the employer/work type
- Register for a 'welcome webinar' to help get the most out of the website

**For information: PrescQIPP is a Community Interest Company, operating on a not-for-profit basis for the benefit of health service patients, commissioners and primary care clinicians. It is funded by the NHS for the NHS and receives no funding from the Pharmaceutical Industry for any of its resources.*

Does the label make sense?

Would you know how to take these medicines correctly based on the labels attached?

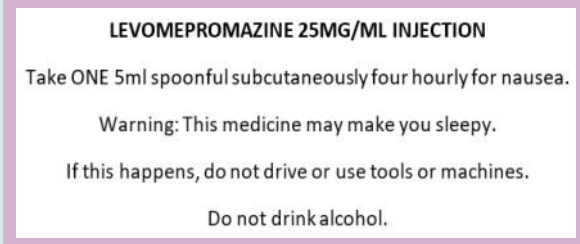


Example 1: Prednisolone 5mg tablets were prescribed for a transplant patient. The directions on the labels are complete but the patient missed the instructions on the second label so took 10mg on Tuesdays only.

A proportion of colleagues surveyed also missed the second label on the pack.

Example 2: Lansoprazole 15mg orodispersible tablets
The label was produced from the prescription barcode. The clinical check didn't detect that the label had no frequency.

These directions combined with the BNF warning led to the parents administering a dose prior to every feed, 8-10 times daily. The intended dose was *'One quarter of a tablet once daily'*. It's not possible to dissolve a whole tablet in 10ml of water and then use a portion because the tablets do not dissolve completely – see NI Formulary for instructions.



Example 3: Levomepromazine 25mg/ml Injection, inaccurate directions which occurred due to entry of an incorrect pharmacy software shortcut code during labelling and were not picked up on final accuracy check. This was noted on receipt at the nursing home and the patient did not receive any of the incorrectly labelled medication.

It is reported that 1 in 5 adults in Northern Ireland have low health literacy and very poor literacy skills, and the average adult reading age in the UK is 9 years old[1]. These recent examples highlight the importance of clear labelling of medicines and consideration of the ability of the patient to understand the instructions, which form part of Pharmacy Professional Standards[2].

Advice for Community Pharmacy

- **Are prescription directions complete?**
  A clinical assessment of every prescription should be undertaken by a pharmacist, determining suitability of the medication, appropriateness of the quantity and its dose frequency for the patient[2]
- **Use barcode scanning** (where available) to label the prescription.
- **Apply robust labelling checking practices**
  Labelling of dispensed products should be clear and legible, computer-generated and include any cautionary and advisory labelling recommended by the current BNF[3]. If directions appear over multiple labels, apply these so that the patient receives an uninterrupted set of instructions
- Ensure that directions are complete and that someone reading this for the first time would clearly understand how to take the medicine
- **Counsel patients**
  The patient should receive sufficient information and advice to enable safe and effective use of the medicine[2]:
  - ⇒ Ensure appropriate counselling takes place particularly if the directions are complicated
  - ⇒ Don't make assumptions about a patient's ability to understand the information provided. Check that the patient has understood the information. Information for patients should be clear and logical and tailored to the needs of the individual patient[2]
  - ⇒ Direct to additional resources (if available) to assist the patient or carer to take their medicines e.g. Guidance on the NI Formulary for **administration of lansoprazole orodispersible**.

MDS dispensing incidents via an automated packing system

A number of similar incidents have been reported to SPPG relating to Monitored Dosage System (MDS) dispensing via an automated packing system—see examples in table.

Incident	Prescribed Drug	Dispensed drug
1	Quetiapine 100mg four times daily	Quetiapine 25mg four times daily
2	Nebivolol 2.5mg daily	Nebivolol 5mg daily
3	Famotidine 40mg daily	Furosemide 40mg daily
4	Ticagrelor 90mg BD dispensed, although previously discontinued	

Background and contributory factors

Each patient has an individual profile within the system software that contains all medication details and facilitates automated packing of MDS. New patients or new medicines must be manually added. This patient profile is distinct from and independent of the Patient Medication Record (PMR). Prescriptions are scanned separately onto the clinical system and the dispensing labels generated.

Incidents 1-3: An incorrect entry of the medication onto the patient profile resulted in dispensed pouches describing and containing incorrect medication, despite dispensing labels being correct. Two of these patients were care home residents who were new to the pharmacy - kardexes had been used to set up the patient profiles rather than prescriptions. In all three incidents, there was **no double check** of the entry onto the patient profile, against the prescription.

Incident 4: An old patient profile was inadvertently used and a previously discontinued medication was dispensed. The staff member was unfamiliar with the software and old versions of patient profiles were stored on the system making it possible to select an out-of-date version for the patient.

In all cases, subsequent accuracy checks after dispensing failed to spot the errors.

Learning

Automated MDS packing systems can improve accuracy and efficiency. However, it is important to consider any potential for error. New patients, new medication for existing patients, mid-cycle changes, inpatient stay and new staff can introduce additional risk. Robust processes and safeguards are required to mitigate any risk and ensure patient safety.

- **Document key information:** While the PMR does not link to the automated packing system, it can be used to document key information, such as dates and details of medication changes, which may help prevent errors.
- **Double Check:** An independent second check of manual entries onto a patient profile linked to an automated dispensing system, **against the prescription**, will reduce the risk of error. This step should be included within the relevant Standard Operating Procedures (SOPs).
- **Final Accuracy Check:** This check should confirm that the prescription, dispensing label and medication within the MDS, all match.
- **Training:** Pharmacists are responsible for ensuring that all relevant pharmacy staff are trained on and are following up-to-date SOPs. Training should be relevant to the type of MDS used and appropriate to the level of involvement in the preparation and supply of MDS. Training should cover known risks such as using old patient profiles and manual entry errors, as well as locally encountered issues. Training provided should be on-going and documented.