EXEMPLAR

Entrustable professional activity (EPA) 1: Dispensing and error logs

Intern name	EPA-1B	**Ahpra registration**	PHA000XYZ123	**Date of dispensing**	XX/XX/XX
Intern training program	ABC ITP	**Stage of internship**	☐ 0-3 months ☐ 3-6 months ☒ 6-9 months ☐ 9-12 months	**Category of prescription**	Discharge Prescriptions

About this form

This form is to be used to provide information about the intern's ability to assess whether the prescription is appropriate for the patient, and then to dispense it accurately from a legal, ethical and technical perspective.

Refer to definitions of Critical Error and Near Miss Error.

Instructions for interns

Complete the Dispensing Log for ten consecutive prescriptions in one of your selected categories; use a separate form for each category. If a critical error or near miss is detected, complete the **Critical Error and Near Miss** log, using the numbers (1 to 10) to identify the prescription. After each prescription is dispensed, ask a supervisor to check the prescription and initial in the **Checked by** column. An additional page is provided if you wish to attach a duplicate dispensing label (optional – if you attach labels, please ensure the patient details are deidentified). You should also arrange with your supervisor to carry out Short Practice Observations (SPO) when you are dispensing some of these prescriptions.

Instructions for supervisors

After the intern has dispensed each of the 10 consecutive prescriptions in the selected category, review and check the dispensing for appropriateness and accuracy, and initial the Dispensing Log under Checked by. If a critical error occurs ask the intern to restart the count. Near misses do not require the restart of the count. These logs are part of sources of information to inform your entrustment decision for this EPA. Use the **Reflection, discussion and development** box to explore both the cognitive and technical/process elements of dispensing.

Dispensing log

No.	Date	Medication name, strength, quantity, directions	Check box in relevant column			Checked by
			No error	Critical error	Near miss	
1	TBC	Trelegy Ellipta (fluticasone furorate 100mcg; umeclidinium 62.5mcg; vilanterol 25mcg); Qty 1; 1 inhalation OD	☒	☐	☐	Supervisor
2	TBC	Sitagliptin 25mg tab; 1 tab OD; Qty 28	☒	☐	☐	Supervisor
3	TBC	Pravastatin 10mg; 1 tablet in the evening; Qty 30	☒	☐	☐	Supervisor
3	TBC	Insulin glargine 300 units/mL; Inject 20 units at night before dinner; Qty 1.5mL x 5 pen devices	☐	☐	☒	Supervisor
4	TBC	Levodopa 100mg; carbidopa 25mg; 1 tab TDS; Qty 30 tabs	☐	☐	☒	Supervisor
5	TBC	Ciprofloxacin 250mg; 1 tablet BD; Qty 14 tabs	☒	☐	☐	Supervisor
6	TBC	Esomeprazole 40mg; 1 tablet in the morning; 30 tabs	☒	☐	☐	Supervisor
7	TBC	Mirtazapine 45mg ODT; 1 tablet at night for 2 weeks; 30 tablets	☒	☐	☐	Supervisor
8	TBC	Glyceryl trinitrate 5mg/24 hours patch; 30 patches	☒	☐	☐	Supervisor
9	TBC	Dicloxacillin 500mg; 1 capsule QID for 6 days; 24 capsules	☒	☐	☐	Supervisor
10	TBC	Apixaban 2.5mg; 1 tab BD; Qty 30 tabs	☐	☐	☒	SPO performed with preceptor

Space for duplicate dispensing labels (Redact any patient identification details)

1		**6**	
2		**7**	
3		**8**	
4		**9**	
5		**10**	

Critical error and near miss log

A **CRITICAL ERROR** is an error which is not detected by the intern, but is detected when checked by a supervisor. A **NEAR MISS** is an error which is detected by the intern prior to subsequent checking by a supervisor.

Item number	Details of error/near miss	How, when, and by whom detected	Consequences for patient	Why did this happen?*	How can this be avoided in the future?*	Actions or education needed by intern*	Supervisor comments
3	Selected expired product	Checking pharmacist identified error	Medication may be ineffective (putting the patient at risk of hyperglycemia) or cause harmful side effects.	Intern did not check expiry date on insulin pens or box of insulin. Intern's unfamiliarity of different storage requirements for certain medications. Intern's unfamiliarity of checking expiry dates on multiple devices.	Intern to familiarise themselves with expiries of different medication devices e.g how changing storage conditions of a particular medication may shorten its expiry.	Intern to target medication devices for checking. Intern to target 3 key medication devices that have shortened expiries once opened (e.g. eye drops, inhalers) or removed from the fridge (e.g., insulin/levothyroxine)	As per actions recommended.
5	Selected incorrect product. Levodopa 100 mg+benserazide	Error was self-identified post barcode scanning	Incorrect Parkinson's medication. Loss	Intern's unfamiliarity with multiple levodopa products available.	Intern to ensure that they check the entire medication	Intern to review the levodopa products available in the pharmacy	As per actions recommended. Discussed the potential

	25 mg (scored) tab qty: 100 was selected instead of levodopa 100 mg, carbidopa 25 mg (scored) tab qty:100		of symptom control for the patient.		name for medications that are a part of combination tablet formulations. Intern to continue to use barcode scanner to check dispensed medication matches selected product.	dispensary. Suggest intern to review the "Parkinson's" guideline on the eTG and the "Levodopa with Benserazide or Carbidopa" monograph in the AMH. Intern to target combination medication products for checking.	risks associated and impact on patient.

***Intern reflection**

Reflection, discussion, and development

Use this space to record intern reflections and/or discussions with supervisor either during or after the 10-item task. Consider the cognitive aspects of dispensing – including clinical reasoning and decision-making regarding the appropriateness of the prescribed medication – and technical/process aspects of dispensing a prescription. This is an appropriate place to record the thinking processes of both intern and supervisor, and any areas where the intern could develop additional expertise.

What?
I have completed a SPO with my preceptor involving the dispensing of apixaban for a 32-year-old woman with pulmonary embolism. I know apixaban is an anticoagulant and it is a high-risk medicine, so I was mainly concerned with the dose of anticoagulant and if it was right for this patient, because I know that the dose changes depending on the age of the patient, their body weight and their renal function, so these were the first parameters I checked in the medical records. I readily identified that the dose seemed too low for this patient and was happy with the way this was resolved with the prescribing doctor. In addition to this, I also identified that the patient's first preference for pain medicine at home is ibuprofen, which can cause bleeding with apixaban, and so I suggested paracetamol as an alternative if the need arises for pain management. However, in focusing on these key issues, I was not thinking about the more holistic aspects of a patient with PE, and it turns out that the PE was likely precipitated by use of COCP. I had not asked about recent medicine changes or prompted for medicines that may be problematic for patients with blood clots. Although the medical team had recommended ceasing the pill, I had the opportunity to determine if patient were on any medications that would exacerbate the underlying problem and reinforce the importance of stopping the pill. Furthermore, this patient smokes 10 cigarettes per day and would benefit from smoking cessation interventions, however I did not address this at the time of dispensing apixaban. When I dispensed the apixaban tablets, I double-checked the box and label to make sure I had the right medicine and right instructions.

So What?
I recognise now that when I review discharge medication orders, I need to think more holistically about the patients' medical condition. I have discussed with my preceptor the importance of including these investigations whenever I review a medication and that I should always check for drug-disease interactions, recent medication changes. In this case, the medical team had ceased the COCP but missing this in the future could lead to significant safety issues.

I should also be checking relevant lifestyle factors that may impact management of patient condition. In this case, being hospitalised with a life-threatening medical condition may move somebody to contemplate quitting smoking and I could have done a better job of assessing this and offering pharmacological or non-pharmacological strategies to assist.

Now what?
I have the following goals:

S: I am going to ensure to check for recent medication changes and for medicine-disease state interactions for every patient that I encounter. I am going to be especially mindful of including these questions in my review of the medication order when managing discharge prescriptions for patients with newly diagnosed medical conditions in hospital.
M: I will write up my next reflection on a discharge prescription where I encounter this problem; and ask my preceptor/supervisor to perform an ad hoc SPO on another discharge prescription to get feedback on how I'm going.
A: I will aim to do this before my board oral exam in 6 weeks
R: I am planning on staying in hospital pharmacy after I am registered and so getting better at reviewing of discharge prescriptions will give me more confidence with decisions I am making.
T: I will complete the reflection activity and ask my supervisor to complete a SPO within 6 weeks as practice for my exam.

Supervisor	**Name:**	Supervisor	**Intern**	**Name:**	Intern
	Date:	Date		**Date:**	Date
	Signature:	Supervisor		**Signature:**	Supervisor