EXEMPLAR

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

Intern name	EPA-1A	**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**	Paediatric Prescription

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	Amoxicillin 50mg/mL mixture, Qty 100ml; Give 6 mL by measure every 8 hours for 5 days	☒	☐	☐	Supervisor
2	TBC	Betamethasone dipropionate 0.05% cream, 5 x tubes; Apply to the affected area twice daily	☒	☐	☐	Supervisor
3	TBC	Chloramphenicol 0.05%, 10mL; 1 drop q2h for 2/7 then 1 drop QID mdu	☒	☐	☐	Supervisor
3	TBC	Fluticasone propionate 50mcg dMDI, Qty x 1; Shake well and Inhale ONE puff twice daily *Rinse Mouth Out After Each Dose*	☒	☐	☐	Supervisor
4	TBC	Ibuprofen 20mg/mL, 100mL; Give 5mL every 8 hours for 3 days	☐	☐	☐	Locum pharmacist
5	TBC	Prednisolone 5mg/mL, 30ml; Give 3.6mL daily with food for 3 days and then stop	☒	☐	☐	Supervisor
6	TBC	Metoprolol 50mg tab, 28 tablets; Take ¼ (one quarter = 12.5mg) tablet BD	☐	☐	☒	Supervisor
7	TBC	Montelukast 5mg, 30 tablets; Take 1 tablet in the evening	☒	☐	☐	Supervisor
8	TBC	Roxithromycin 50mg, 10 dispersible tablets; 1 tablet BD	☒	☐	☐	Supervisor
9	TBC	Meningococcal B vaccine (Bexsero), 1 injection 0.5mL; For doctor's use. **Give paracetamol prior to administration of vaccine**	☒	☐	☐	Supervisor
10	TBC	Cefalexin 250mg/5mL mixture, 1 bottle, Give 4.5mL by measure every 6 hours for 5 days and then stop.	☐	☐	☒	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
6	Inappropriate issue of 5 repeat supplies on medication, not issued by prescriber. Prescription had nil repeats	Preceptor during final prescription check	Potential that patient would not receive appropriate follow-up during long-term therapy, review of new medicine, dose titration etc.	Potential complacency when dispensing medicine; did not realise this was a new medicine for a 10-year old child			
10	Ancillary labels not included – Label 6, expiry date and “Shake Well Before Use” Incorrect prescription date recorded	Preceptor during SPO	Potential inappropriate storage of medication, potential to use expired stock and potential for uneven dosing if mixture not shaken prior to use				[Intern] had forgotten the importance of adding explanatory ancillary labels to dispensed mixture of cefalexin. We have discussed the impact of this error and the importance of visual labels to complement patient education.

							[Intern] made a minor documentation error (wrong prescription date). We have discussed implementation of a systematic checking process.

***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 cephalexin mixture for 5-year-old boy with cellulitis. I performed a routine safety check of the medication order including, weight, allergies and indication for the antibiotic. However, I forgot to investigate whether the patient has other comorbidities or is taking other medications. Furthermore, I suggested that the order be changed to flucloxacillin as this is considered first-line in the treatment of cellulitis as per the therapeutic guidelines. I did not realise that the therapeutic guidelines also mention the cephalexin mixture is preferred in children due to taste.

When I dispensed the cephalexin mixture, I ensured that the right product and instructions were typed. I also measured the volume of water required to reconstitute the mixture using an appropriate measuring cylinder. My preceptor noticed that I did not calculate if the volume of mixture supplied would cover the 5-day antibiotic course duration. Also, I forgot to add ancillary instructions such as shake the bottle, refrigerate and an expiry date for the reconstituted mixture. I also typed the wrong date on the dispensing label as I assumed the prescription was written for today.

So What?

I recognise now that when I review paediatric medication orders, I tend to assume that the patient do not have any comorbidities or are taking other medications. I have discussed with my preceptor the importance of including these investigations whenever I review a medication and that I should not assume the patient does not have other medical conditions. In this case, none of the patient's medical conditions significantly impacted the appropriateness of the order but missing this in the future could lead to significant safety issues.

I routinely check the therapeutic guidelines to ensure that the antibiotic ordered is first-line for that indication as I want to do my best to support antimicrobial stewardship. However, I need to recognise that to help support patient-centred care it sometimes means choosing agents that are not first-line but are better tolerated by the patient. In this case, the taste of the mixture was a significant factor in choosing to prescribe cephalexin. I need to consider patient specific factors that can influence the decision to prescribe certain medications.

Early today, I was completing dispensed items for paediatric prescriptions without making error but during the SPO I forgot to add important ancillary labels. I realise now that whilst I know that the need to refrigerate and shake a mixture is important, the patient/carer may not know this information. It is important to add extra instructions on the label as the carer may forget these important points which may then compromise how the medication is used. I need to start putting myself in the mindset of the patient and ensure that my instructions are clear for people who may have never used this medication before.

Now what?

I have the following goals:

Goal 1:

S: I am going to ensure to check for comorbidities and other medications 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 paediatric prescriptions.

M: I am going to create a template of routine questions that I will ask patients/investigate when I review a prescription. I will also reflect on my next encounter with a paediatric prescription and ask my preceptor/supervisor to perform an ad hoc SPO on another paediatric prescription.

A: This should be able to be completed by the end of this month

R: Perfecting my review process will help me establish my style as a pharmacist and prepare me for Part A and C of the oral examination

T: I will complete the template by the end of this week and ask my supervisor to complete a SPO by the end of this month.

Goal 2:

S: I want to develop a more systematic process of checking the final dispensed product before release to the patient. This includes ensuring that ancillary labels are included.

M: I will develop a written check list of things to check for the final dispensed product. I will use this to review the next dispensed items I am completing and then will try to perform the same check without the list.

A: This should be able to be completed within the next couple of weeks. I will also seek comments and feedback from my preceptor about the checklist I have developed

R: Establishing my own systematic checking process for dispensed medications is an important skill for my future as a pharmacist. I recognise that at some stage it will be me responsible for the final check of dispensed items

T: I will create the checklist in the next two weeks and trial for two weeks.

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