Safe delivery of medicine: monitored dosage systems

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The Patient Safety Group has developed guidance on the safe delivery of medication in a variety of situations. It is available here.

REPORT

- An incident has been raised in which a Monitored Dosage System (MDS) was dispensed by a community pharmacy, delivered to the home of a vulnerable patient and posted through their letterbox.
- The pharmacy had previously been advised that all medication should be handed directly to the patient's husband.
- The vulnerable patient subsequently took all the medication in the MDS and required treatment in A&E.

LEARN

- Although discussion amongst Medication Safety Officers shows many community pharmacy organisations have policies in place which do not allow deliveries to be posted through letterboxes, this incident shows this is not always the case or the instruction is not always followed. If it is allowed it should be documented in the SOP, consent must be sought, a risk assessment completed and organisations should check with their indemnity provider.
- This incident raises concerns about the safe delivery of medication, which are particularly pertinent as drivers adhere to social distancing guidance and "doorstep" deliveries.
- It also highlights the importance of effective communication between prescribers, pharmacists and patients/carers. Any risk should be taken into account when agreeing the suitability of providing an MDS and delivery arrangements. These should be documented.
- The Responsible Pharmacist (RP) must consider how this information is subsequently communicated with the delivery diver. The RP should be aware that any safety interventions which rely on human intervention (e.g. remembering to phone a patient representative) come with inherent risk.

SHARE

- Details were shared with Medication Safety Officers at the Community Pharmacy Patient Safety Group meeting. MSOs will disseminate learnings via their networks.
- Details were published on the Pharmacy Safety website, and shared with stakeholders.
- A resource was made available and shared back to the locality who raised the issue.

ACT

- Pharmacies should have robust processes and guidance in place for the home delivery of all medications, including for those in an MDS.
- Where a patient cannot take receipt of their medication, a solution should be determined between the community pharmacist, the GP and the patient representative.
- When coronavirus guidance changes, this may include the use of a key safe access system (with correct consent, SOPs and support for delivery drivers.)
- Pharmacy teams may wish to consider technical solutions to support delivery drivers, this may include:
  - Addition of instructions to bag label (this could be set up via the PMR), which are highlighted to the delivery driver when handed over for delivery.
  - Utilisation of technology (e.g. handheld terminals or software) which allow for personalisation of delivery details / text reminders to patient or patient representative.

REVIEW

- The Patient Safety Group will review whether there have been any similar incidents within their organisations.

Produced by the Community Pharmacy Patient Safety Group