

Threshold criteria for single one-off dispensing errors

Cases are **likely** to be referred to the Investigating Committee if one or more of the following statements are true;

- There is potential for, or evidence that moderate or severe harm or death was caused as a result of the incident (the definitions of these are from the NPSA definitions for grading patient safety incidents).
- There is evidence that there was a deliberate attempt to cause harm to patients or the public.
- There is evidence of ill health or substance abuse by the pharmacist.
- There is evidence that the individual departed from agreed safe protocols or standards operating procedures and in doing so took an unacceptable risk.
- There are no systems to record dispensing errors in the pharmacy (this should result in the Superintendent/Pharmacy owner being referred).
- There has been a failure to make a dispensing error log (if aware of the error).
- There are no systems to learn from incident in the pharmacy (this may result in the Superintendent/Pharmacy owner being referred).
- No attempt has been made to learn from the incident.
- The Society has previously given advice that would have prevented the incident if it had been implemented.
- There has been an attempt to cover up.
- There has been a failure to co-operate with an investigation carried out by the Society's Inspector or other investigatory body.
- There is evidence of other misconduct that would form the basis of a complaint.
- There is a failure to apologise/provide an explanation to the patient/representative (where appropriate)