Health and Social Care Board

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To: Community Pharmacists

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Dear Colleague

URGENT: Further Dispensing Errors involving Beta Blockers

The Quality and Safety Learning Letter "Dispensing Beta Blockers- Selection Errors" was issued in April 2014 to all Community Pharmacies and HSC Trusts (Appendix 1.) The purpose of the letter was to share the learning from a number of adverse incidents where beta blockers were involved in selection errors at the point of dispensing, some of which had serious consequences for the patients involved.

Unfortunately since this letter was issued, there have been a further four dispensing incidents reported to the HSCB which involved beta blockers. Again, serious harm resulted in some of these cases. The incidents are summarised in the table below:

Beta Blocker Dispensing Errors

Drug Prescribed	Drug Dispensed
Atenolol 100mg	Allopurinol 100mg
Allopurinol 100mg	Atenolol 100mg
Metoclopramide 10mg	Metoprolol 50mg
Pravastatin 40mg	Propranolol 40mg

Upon receipt of this Learning Letter, community pharmacists were asked to confirm that they had:

- Shared the Learning Letter with all staff involved in dispensing medicines to patients

- Reviewed and if necessary, updated their SOPs and arrangements for managing beta blockers, taking account of the suggestions in the Transferable Learning section of the letter

Even though this confirmation was provided by the majority of pharmacies, it is concerning to note that adverse incidents involving beta blockers still continue to occur. One pharmacist involved in one of these incidents advised:

"Don't think the advice in the Learning Letter doesn't apply to you. We didn't make any changes when the letter came out because at the time we couldn't see the risks. After this incident, we moved our beta-blockers straight away to beside the liquids. We also added alerts to our computer and make sure there is a second check of all prescriptions - by the pharmacist if necessary!"

Action for All Community Pharmacies

1. Revisit the 'Quality and Safety Learning Letter' (Appendix 1) with all members of the pharmacy team. Consider again each of the practical steps recommended to reduce the risks of incidents involving beta blockers.

2. Ensure there are two members of staff involved in the dispensing process where possible. Where this is not possible, the pharmacist should carry out a second check on the dispensed product.

If you have any queries regarding this letter, please contact your local Medicines Governance Adviser or Medicines Management Adviser.

Yours Sincerely

Mr Joe Brogan
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Head of Pharmacy and Medicines Management