SAFETY AND QUALITY LEARNING LETTER

Subject	Safety Alert: Ensure patient and package cross-checks are in place when supplying Monitored Dosage Systems (MDS)
SPPG reference	**DOPC 27123**
Programme of care	**Directorate of Primary Care**
Assurances required	**None**

LEARNING SOURCE

A thematic review of adverse incidents involving monitored dosage systems and similar medicines adherence aids (collectively referred to as MDS in this letter)

SUMMARY

A thematic review of incidents involving MDS in community pharmacy identified a recurring pattern of patients receiving another patient's MDS. While the focus of this review was on MDS, the learning is transferable to other wrong-patient incidents.

Analysis found that these incidents occurred at **one of three distinct stages in the supply process:**

- **Bagging stage**: the MDS is placed into a bag which is labelled for another patient, or is subsequently labelled for another patient
- **Handout stage (collected in pharmacy):** although the collector's identity is known to staff, an MDS intended for another patient is inadvertently supplied
- **Delivery stage:** the MDS is delivered to the address of another MDS patient

MDS errors may not be recognised immediately, allowing patients to continue taking incorrect medicines for several days before the error is identified. This delay has resulted in missed doses of essential medicines, unintended exposure to other patients' medicines and serious clinical consequences, including hospital admission.

The risk is heightened because patients receiving MDS are often older, have multiple long-term conditions and are prescribed several medicines, which may include high-risk medicines. These patients rely on an MDS to adhere to their medicines and they may be less aware when the medicines provided are incorrect.

A major contributory factor noted in the review was that MDS patients and their carers are often well-known to staff. This is a risk factor in itself, as familiarity can lead to formal identity checks being overlooked during routine interactions.

TRANSFERABLE LEARNING

The key learning identified from this incident review is the need to cross-check the MDS/package in hand against the intended patient, regardless of how well known the recipient is or how familiar the process may seem.

Bagging Errors

- For bagging stage errors, the primary focus can be on the MDS accuracy check, as something that requires active concentration.
- Once MDS checking is complete, staff may transition to routine packaging and labelling tasks, where familiarity and repetition can increase the risk of slips and lapses.
- This can lead to a bag and label verification step being overlooked or omitted, particularly if there are interruptions, distractions, workload, and staffing pressures.

Handout and Delivery Errors

- Handout and delivery errors typically occur due to an error in storage (package placed in wrong place) or a selection error from that storage location.
- Similar-looking MDS packs, similar patient names and inadequate storage separation can contribute to selection errors.
- Limited segregation within delivery vans increases the risk of misplaced packages being selected as the driver often follows a routine route.
- Regular patients and well-known carers may be less likely to undergo a formal verification check due to familiarity and normal human interaction.
- Without a patient and package cross-check at handover, the initial selection or storage error can progress to supply.

Whilst this review focused on MDS, many of the same principles can be applied to all medicines supplied through community pharmacy.

ACTION REQUIRED

Community pharmacists are asked to share this learning with the pharmacy and delivery team and implement any improvements identified through local review; with particular attention to:

1. Reviewing handover processes both in pharmacy and on deliveries, ensuring there are systematic steps in place at the point of handover which:
    1) **Verify the intended patient with at least two identifiers, one of which is offered by the recipient**
    2) **Visually cross-check these details against the package in hand.**
2. Processes for bagging MDS
2. Storage arrangements within the pharmacy
3. Storage and sorting arrangements for deliveries

To aid this review case studies from have been included as an appendix to this letter. Pharmacies are recommended to consider these cases and their own error log, as well as putting in place ongoing regular review and audit.

Displaying the HSC Community Pharmacy Right Person Poster in dispensaries and collection areas will support staff understanding and improve public awareness of the risks.

Date issued	13 October 2026
Signed:	
Issued by	**Keith Thompson** **Head of Pharmacy and Medicines Management, SPPG**

Appendix: Case studies

The Bagging Error

If an MDS is bagged with the wrong outer label, patient and package cross-checks at the point of supply are unlikely to identify the error.

Case1: MDS bagging error

Two patients received the wrong MDS after the outer bag labels were attached to the wrong bags during the bagging process.

During handover, staff correctly verified the patient details on the outer bag label. However, as a result of the earlier bagging error, the MDS inside belonged to the other patient.

Contributory factors

- The MDS were assembled at the same time with unattached bag labels left with the MDS for final checks.
- Final accuracy check did not identify the mismatch between the MDS within the bag and the outer bag label.
- Staff shortages within a busy pharmacy.

Patient A noticed the error, did not take any medication, and informed the pharmacy.

Patient B did not recognise the error and had already started taking the incorrect medication. As a result, Patient B required medical assessment.

Strengthening final checking and bagging procedures

As part of the final accuracy check, confirm the medication, attached outer bag label and patient details on the prescription all match, before sealing the bag.

√ Some pharmacies use clear bags to store MDS to allow further checks at handout or delivery.

√ Some pharmacists initial the outer bag label when sealing the bag to confirm the correct patient label has been attached.

The Handout Error

Familiarity with patients or their representatives can lead to patient and package cross-checks being omitted.

Case 2: Incorrect MDS handed out in the pharmacy.

A patient was supplied with an MDS intended for another patient. Staff recognised the patient's daughter when she attended to collect the medication. However, an incorrect pack was selected from the shelf. As the patient's daughter was well known, conversation during handover took place. The check to confirm that the package details matched the intended patient was not completed.

Contributory factors:

- Similar patient names meant that both MDS packs were stored together.
- Familiarity with the collector contributed to the patient and package verification step not being completed.

The patient took medication, including clopidogrel and propranolol, from the incorrect MDS for at least four days before collapsing. Their prescribed prednisolone and levothyroxine were omitted during this period. The patient required hospital admission and subsequent transfer to intensive care for ongoing management.

Safer hand-out at the pharmacy counter and on delivery

Strengthen patient and package cross-checks at every handout and delivery by using at least two patient identifiers (e.g. name, address and/or date of birth) and ensuring the details on the MDS supplied match the intended patient.

√ Familiarity with patients or their representatives should never replace completion of formal patient and package cross-checks.

√ Where medicines for multiple patients are collected or delivered together, a separate patient and package cross-check must be completed for each patient.

√ Patient and package cross-checks must be performed consistently by all staff, including delivery drivers.

√ Compliance with SOPs should be routinely monitored through supervision and audit, and any identified deviations addressed promptly.

√ Use a process which requires the recipient to provide a confirmatory piece of information e.g. "What's your address?"

The Delivery Error

Errors will go undetected unless all staff consistently perform patient and package cross-checks for every patient, every time, regardless of familiarity.

Case 3: MDS delivery error

Two patients received each other's MDS due to a delivery error. Dispensed prescriptions for a particular locality are placed together in tote boxes in the delivery van. The two items that were mixed up were the last two items to be delivered that day. The driver saw Patient A outside their home and while chatting to them, selected and handed over the wrong MDS. The remaining MDS was then delivered to Patient B. The patients did not have similar names and the medication and outer bags were labelled correctly. A delivery sheet normally completed to cross-check the bag labels for each delivery was not used.

Contributory factors

- Failure to follow SOPs, including use of the delivery sheet.
- These were the final two deliveries and there may have been reduced vigilance at the end of the shift.
- Familiarity with the patient led to omission of the patient and package verification check.

Patient A took multiple medicines, including Madopar, Metformin, Gliclazide, Sitagliptin, Ramipril, Atorvastatin, Quetiapine and Pramipexole, intended for Patient B. Medical assessment and additional monitoring were required. Patient B identified the error the following morning, did not take any medication and alerted the pharmacy.

Reducing selection errors

Have clear segregation and storage arrangements within the pharmacy and during deliveries.

√ Take particular care with patients who have the same or similar names or the same care provider.

√ Use alerts, highlighting systems and separate storage locations, where appropriate.

√ Consider ways in which storage risks may be reduced, e.g. regular clear out with appropriate follow up in line with SOPs

√ Some pharmacies separate MDS by day of collection/delivery and ensure patients with same/similar names are on different days.

The Alphabetical Error

Patients with the same or similar names often have their MDS stored together, creating a risk of selection error, that will go undetected if patient and package cross-checks are not completed.

Case 4: Selection error within the pharmacy leads to a delivery error

A patient received an incorrect MDS after the wrong pack was selected and delivered.

Two patients with the same name and surname, but different addresses, received their medicines in MDS. All MDS in the pharmacy are arranged for collection/delivery on a weekly basis and stored in alphabetical order.

Patient B's MDS was mistakenly selected within the pharmacy and delivered to Patient A. The error was not identified during delivery, when medicines for multiple patients in the same household were handed over.

Contributory factors:

- MDS for patients with the same name and surname were stored together.
- The outer bag label may have been obscured by other medication being delivered to the same household
- Failure to verify that patient details matched the package details for **each** patient receiving a delivery within the same household.

Patient A took Patient B's medication for two days before becoming unwell. The patient received medication including azithromycin and montelukast in error, while prescribed medications, including aspirin and nicorandil were omitted. As a result, the patient developed high blood pressure and sweating and required assessment by out-of-hours services

Training

Ensure all staff involved in the medicines supply process, including dispensary staff, counter assistants and delivery drivers, have completed SOP training and been assessed as competent in patient and package cross-checks.

Support patients and carers to be active participants in medicines safety by encouraging them to understand their medicines, recognise unexpected changes and to *Know, Check, Ask* if they think something is not right with their medication.

Reporting Incidents

Report and review all near misses as well as incidents to identify patterns. Use learning from incidents and near misses to refine standard operating procedures and staff training.

Community Pharmacists are encouraged to report incidents, including near misses, via the Online Anonymous Incident Reporting System so that learning and good practice advice can be shared.

Where an incident has caused harm, you can discuss reporting with a Pharmacy Adviser at your local SPPG office. Note: Incidents involving controlled drugs (CD) must be reported via the CD incident reporting website