STANDARD OPERATING PROCEDURE

Dispensing Error Reporting SOP

Document no.	SOP-PHA-008
Revision	1.0
Owner	Pharmacist in Charge
Effective date	September 15, 2026
Review cycle	Every 12 months

1. Purpose

To respond to dispensing errors and near misses in a way that protects the patient first, corrects the record, and uses a non-punitive review to prevent repeat errors.

2. Scope

Applies to any dispensing error or near miss discovered by staff, the patient or the prescriber, whether the medication has already been picked up or is caught before release.

Definitions

Near miss	An error caught and corrected before the medication reached the patient.
Dispensing error	A discrepancy between what was prescribed and what was actually filled, labeled or handed to the patient.
Root cause analysis	A structured review to identify the underlying process or system factors that allowed an error to occur.

3. Responsibilities

Pharmacist	Assesses patient safety risk, corrects the record and leads the root cause review.
Pharmacy Technician	Reports errors or near misses observed and assists with correction under pharmacist direction.
Pharmacist in Charge	Reviews significant errors, decides on required external reporting and tracks corrective actions.
Patient	Reports suspected errors and provides information needed to assess and correct the issue.

RACI matrix

Activity	Pharmacist	Pharmacy Technician	Pharmacist in Charge	Patient
Assess immediate patient safety risk	R/A	I	I	C
Contact patient about a dispensed error	R/A	I	I	C
Document the error or near miss	R	R	A	-

Activity	Pharmacist	Pharmacy Technician	Pharmacist in Charge	Patient
Conduct root cause analysis	R	C	A	-
Report to prescriber or external body if required	R	I	A	I

R = Responsible, A = Accountable, C = Consulted, I = Informed

4. Materials and PPE

Materials, tools and systems

- Incident and near-miss report form
- Patient contact log
- Root cause analysis worksheet
- Corrective action tracker
- Pharmacy dispensing system audit trail

5. Procedure

Step	Task	Owner	Done
5.1	**Recognize and stop the process** As soon as an error or suspected error is identified, pause the related workflow so no further steps compound the issue while it is assessed.	Pharmacy Technician	☐
5.2	**Assess immediate patient safety risk** Determine whether the medication has been taken, and evaluate the potential clinical impact of the error before deciding next steps. **Checkpoint:** Patient safety risk is assessed and documented before any other corrective step begins.	Pharmacist	☐
5.3	**Notify the pharmacist in charge for significant errors** Notify the pharmacist in charge immediately for any error with clinical significance or that has already reached the patient.	Pharmacist	☐
5.4	**Contact the patient if medication was dispensed** Call the patient promptly to explain the error, advise on any needed action, and arrange correction or medical follow-up as appropriate. **Warning:** Do not delay patient contact while internal paperwork is completed; patient safety comes first.	Pharmacist	☐
5.5	**Correct the prescription record** Correct the electronic record and any physical label or product still in the pharmacy's possession to reflect the accurate prescription.	Pharmacist	☐
5.6	**Document the error or near miss** Complete the incident report form describing what happened, how it was caught, and the immediate action taken, regardless of whether the patient was affected.	Pharmacy Technician	☐
5.7	**Classify the error type and severity** Categorize the error, such as wrong drug, wrong strength, wrong patient or labeling error, and rate its severity using the pharmacy's classification scale.	Pharmacist	☐

Step	Task	Owner	Done
5.8	**Conduct root cause analysis** Review the workflow steps involved to identify the underlying cause, such as a look-alike product, a workflow gap or a distraction, rather than stopping at individual blame.	Pharmacist	☐
5.9	**Notify the prescriber if applicable** Contact the prescriber's office when the error could affect the patient's therapy plan or requires their awareness for follow-up care.	Pharmacist	☐
5.10	**Report externally if required** Report the error to the state board or another required body if it meets the threshold set by local law or pharmacy policy.	Pharmacist in Charge	☐
5.11	**Review with staff in a non-punitive huddle** Share the root cause and any process change with the team in a blame-free huddle so everyone understands how to help prevent a repeat.	Pharmacist in Charge	☐
5.12	**Track corrective actions to closure** Log any process, training or system change identified in the corrective action tracker and confirm it is implemented and effective.	Pharmacist in Charge	☐

6. Quality checks

- Every error and near miss is documented, regardless of severity.
- Patient safety risk is assessed and, where dispensed, the patient is contacted the same day.
- Root cause analysis looks at process factors, not just individual blame.
- Corrective actions are tracked until confirmed complete.

7. Records

- Incident and near-miss reports
- Patient contact log
- Root cause analysis worksheets
- Corrective action tracker

8. KPIs

- Number of near misses reported per month (higher can mean better reporting culture)
- Number of errors reaching the patient per month
- Average time from discovery to patient contact
- Percentage of corrective actions closed within the target timeframe

9. Common mistakes

- Correcting the record without documenting the error at all.
- Delaying patient contact until an internal report is finished.
- Treating root cause analysis as a way to assign blame rather than fix the process.
- Not tracking whether a corrective action was actually implemented.

10. Revision history

Revision	Date	Description	Reviewed by
1.0	September 15, 2026	Initial release	Ilia Pirozhenko

Approval

Prepared by	Approved by	Date

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