DISPENSING ERRORS

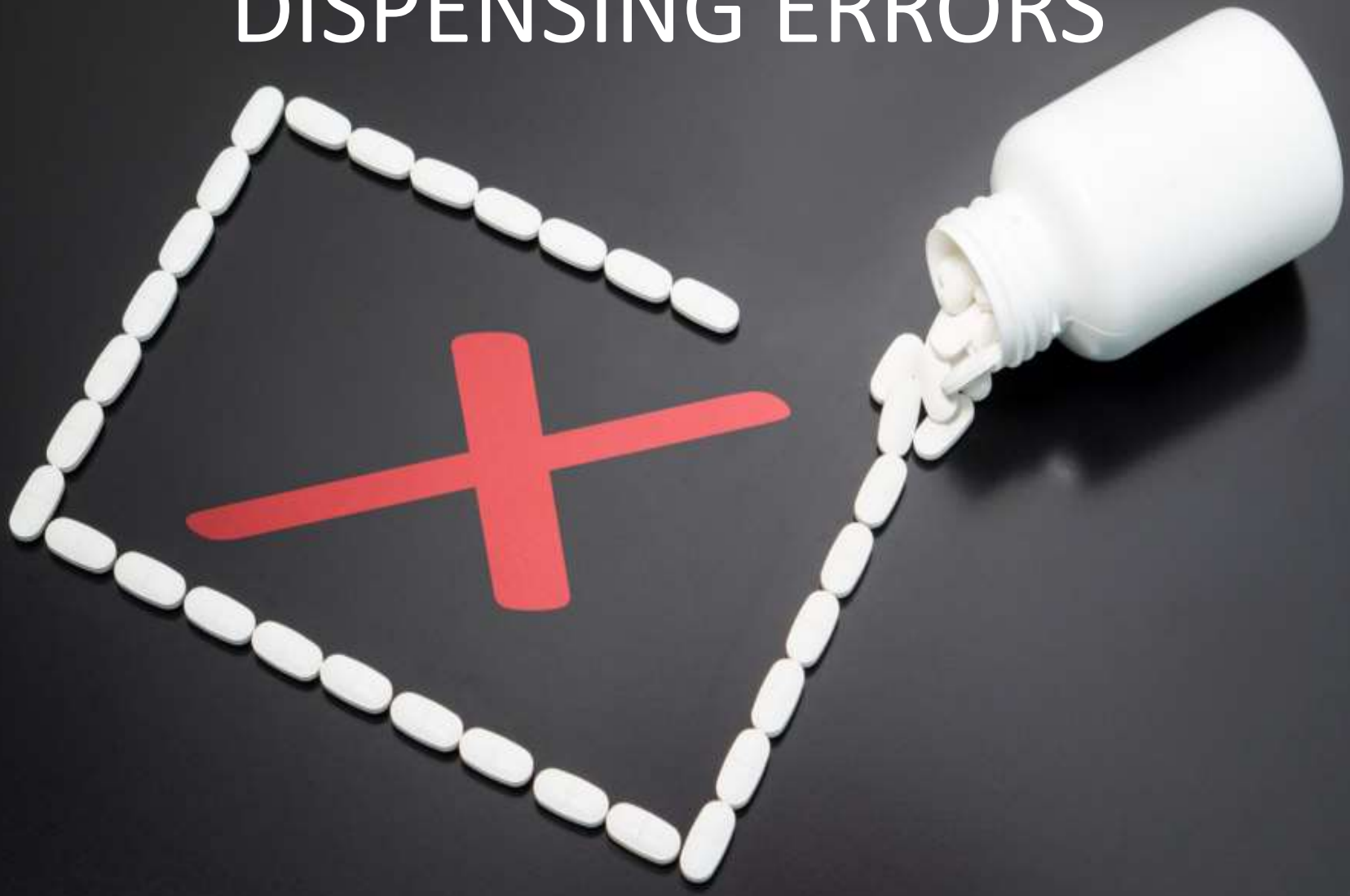

Table 3.1: Some examples of common dispensing errors

Prescriber's Intention	Misinterpretation
AD (right ear), AS (left ear), AU (each ear)	OD (right ear, OS (left ear), OU (each ear)
q.o.d. (every other day)	q.d. (daily) or q.i.d. (4 times a day)
b.t. Bedtime	Mistaken as "b.i.d." (twice daily)
U or u (units)	Zero, causing a 10 or 100-fold increase in dose Example: 2U to become 20U or 200U
Trailing Zero	5.0 mg mistaken as 50 mg
Naked decimal point	.5 mg mistaken as 5 mg
Numerical dose and unit of measure run together	10 mg. The m is mistaken as a 0 or 00, risking a 10 to 100-fold overdose
Drug name and dose run together	Inderal 40 mistaken as Inderal 140 and, Tegretol 300 mg mistaken as Tegretol 1300 mg
Large doses with wrongly placed commas	100000 units mistaken as 10,000 units
Look-alike and sound-alike drug names	Celebrex mistaken as Celexa or Cerebyx and, Zidovudine mistaken as azathioprine or aztreonam
Drug name abbreviations	CPZ for Compazine (prochlorperazine) mistaken as chlorpromazine; HCT for hydrocortisone mistaken as hydrochlorothiazide
Stemmed drug names	Norfloxacin mistaken as Norflex and, intravenous Vancomycin as Invanz
Symbols	'3' the symbol of drachm is mistaken as 3. x3d symbol for 'three days' is mistaken as '3 doses'

- Causes of Errors: Common causes of such errors include:

(1) Wrong prescription evaluation.
(2) Dispensing the wrong medicine.
(3) Poor handwriting of the prescriber and poor communication amongst healthcare professionals.
(4) Ambiguities in product names, directions for use, medical abbreviations or writing.
(5) Poor dispensing procedures or techniques.
(6) Inadequate knowledge regarding drug usage and treatment.
(7) Poor understanding of the directions for use of the medicine.

(8) Inadequate knowledge regarding the adverse effect(s) of the drug.

(9) Unsafe working environment, lack of communication and a non-co-operative staff.

10) Incorrect abbreviation use.

(11) Incorrect dosage and dosage form.

(12) Similar packaging and labeling.

(13) Wrong labeling.

(14) Providing a patient with the wrong quantity or strength of a medication.

(15) Dispensing medicine for the wrong patient.

(16) Putting incorrect information on the label.

(17) Dispensing of expired medicines.

- Some of the common dispensing errors are:

(1) Look-alike and sound-alike (LASA) drug names can lead to the unintended interchange of medicines that can result in patient injury or death.

(2) Incorrect selection of a drug name that may appear close when entering orders into electronic order entry systems my lead to incorrect dispensing.

- Some steps of the dispensing process that could be used as good strategy to reduce the risk of error.

(1) Confirm contents of prescription: It is important to call and verify with the prescriber to clarify any uncertainties or doubts regarding the prescription, if any.

(2) Beware of LASA medicines: A new, unfamiliar drug may be read as an older, more familiar one. Some of these errors can be fatal.

(3) Be cautious while interpretation: Inappropriate abbreviations, misplaced zeros,decimal points, and faulty units are common causes of medication errors due to misinterpretation.

(4) Organize workplace: Proper lighting, adequate counter space, and comfortable temperature and humidity in Pharmacy can help facilitate a smooth flow from one task to the next, thus reducing the chances of dispensing errors.

(5) Reduce distraction when possible: Avoid multitasking and distractions by improving the Pharmacy's internal work environment.

(6) Reducing stress and balance workloads: Give regular breaks and freedom from certain secondary responsibilities.

(7) Store medicines properly: Store look-a-like drugs away from each other. Lock-up drugs with a high potential of error.

(8) Thoroughly check all prescriptions: Repeated checks and counterchecks is an important strategy to minimize dispensing errors. It is advisable to have the rechecks done by another person, typically a pharmacist. If not possible, delay self-checking rather than continuous self-checks

(9) Always provide thorough patient counselling/guidance: Counselling should involve providing information and instructions on how to take the medication by appropriate route of administration..

(10) Educating patients: Educate patients about safe and effective use of their medicines to promote patient involvement in their healthcare to reduce medicine errors.