CORA Cork Open Research Archive
Cartlann Taighde Oscailte Chorcaí

Title	Dispensing error and near miss recording in Irish community pharmacies
Authors	Martin, S.;Murphy, Kevin D.
Publication date	2020-03-01
Original Citation	Martin, S. and Murphy, K. D. (2020) 'Dispensing error and near miss recording in Irish community pharmacies', Prescribing and Research in Medicines Management # PRIMM (UK & Ireland) 31st Annual Scientific Meeting, Manchester, UK, January 17th, in Pharmacoepidemiology & Drug Safety, Abstracts, 29: pp. 13. doi: 10.1002/pds.4977
Type of publication	Conference item
Link to publisher's version	https://onlinelibrary.wiley.com/doi/epdf/10.1002/pds.4977 - 10.1002/pds.4977
Rights	© 2020 John Wiley & Sons, Ltd.
Download date	2026-11-15 02:38:00
Item downloaded from	https://hdl.handle.net/10468/9790



UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Dispensing errors and near misses in a community pharmacy setting in the Republic of Ireland: Incidence, type, causes, and reporting compliance

Martin, S[1], Murphy, K[2]

St. James Late Night Pharmacy, Dublin[1]
School of Pharmacy, University College Cork[2]

University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

BACKGROUND

- Majority of complaints to the Pharmaceutical Society of Ireland (PSI) are related to dispensing errors (DEs)(1)
- Only 66% of pharmacies maintain accurate error logs(2)
- DE incidence has been found to range from 0.01% - 22% of total dispensed items(3), translating into 7,500 – 16.5 million DEs/year in Ireland(4)
- Wrong strength, wrong quantity, wrong drug, and labelling error have been found to be the main DE categories(3)
- Amongst the causes of DEs, misreading the prescription; sound-alike, look alike drugs (SALAD); and computer errors, have been found to be the most prevalent(3).
- Regarding circumstances associated with DEs, pharmacists have associated an increased workload with an increased perceived rate of DEs(5)

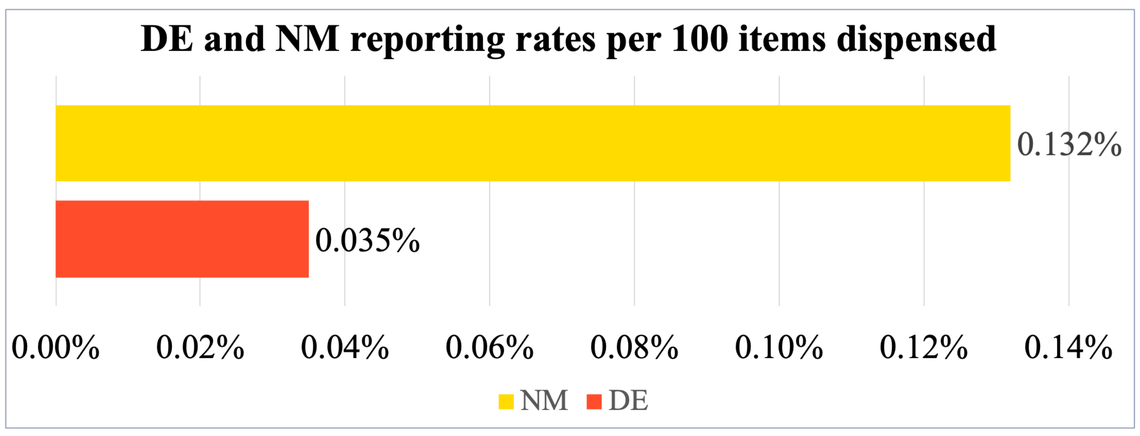
AIMS / OBJECTIVES

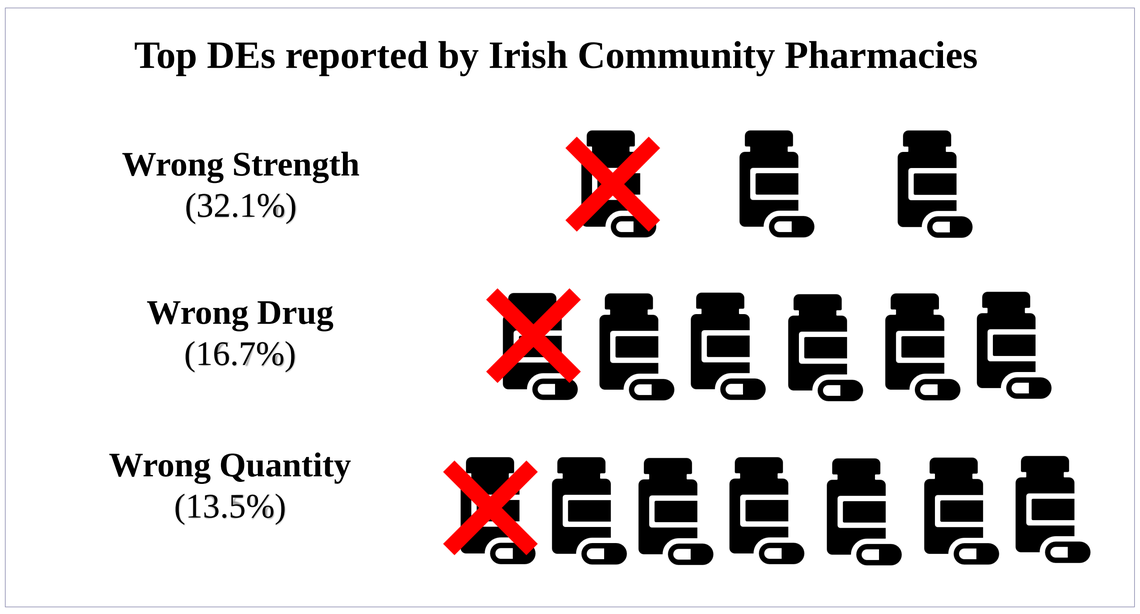
- Assess the reporting incidence of DEs and near misses (NMs) in a community pharmacy setting in the Republic of Ireland
- Identify the different types and causes of DEs, and their associated circumstances
- Evaluate the self-perceived compliance in recording DEs and NMs, and reasons for lack of compliance

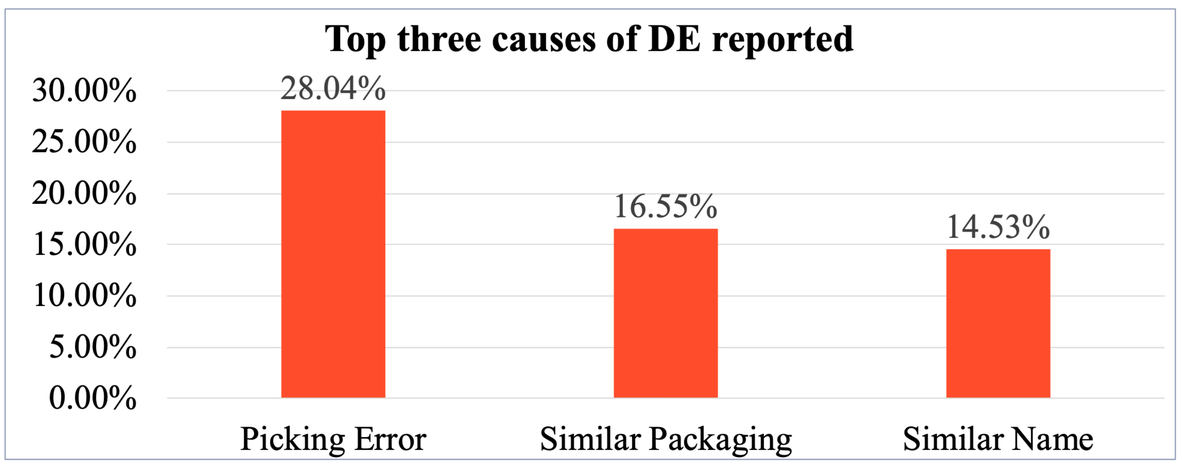
METHODS

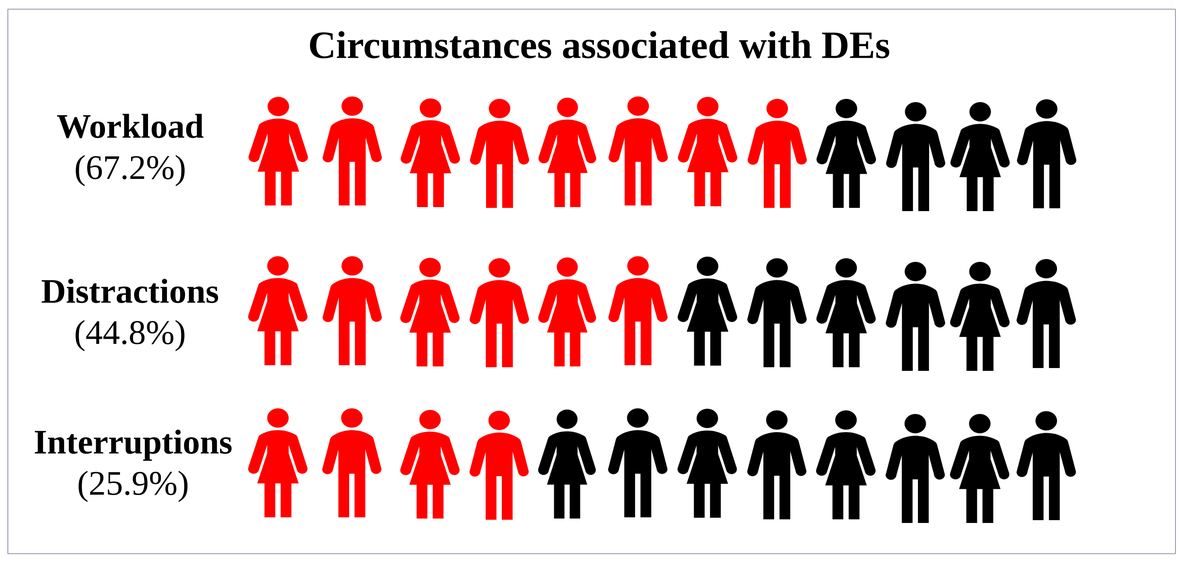
- All community pharmacies in the Republic of Ireland (n=1688) were invited to complete online survey. Participants were questioned regarding general pharmacy information; DEs and NMs reported between 1/1/2019 – 30/6/2019; types and causes of DEs; perceived circumstances associated with DEs; perceived reasons for not reporting DEs and NMs; and for their self-perceived compliance in recording DEs and NMs
- A DE was defined as any error detected after the medication had been given to the patient or their representative
- A NM was defined as any error that was detected before the patient or patient's representative was handed the dispensed prescription

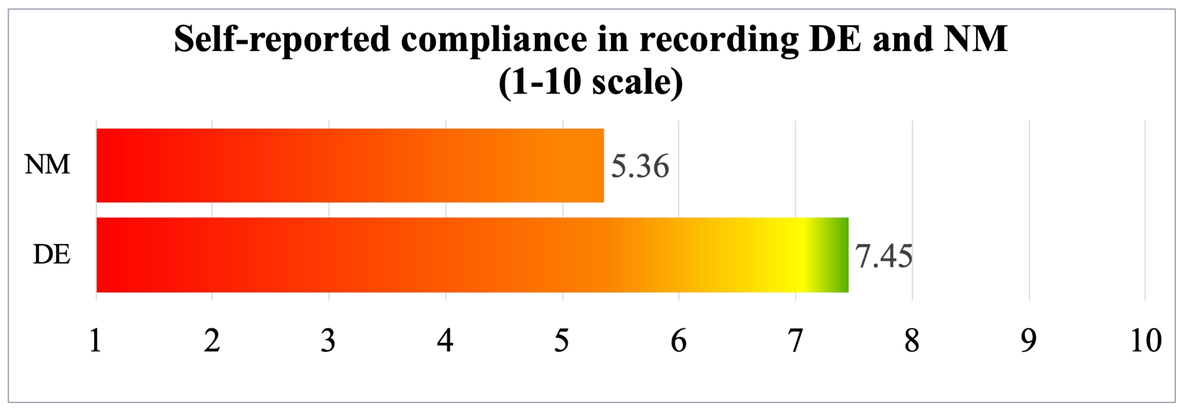
RESULTS

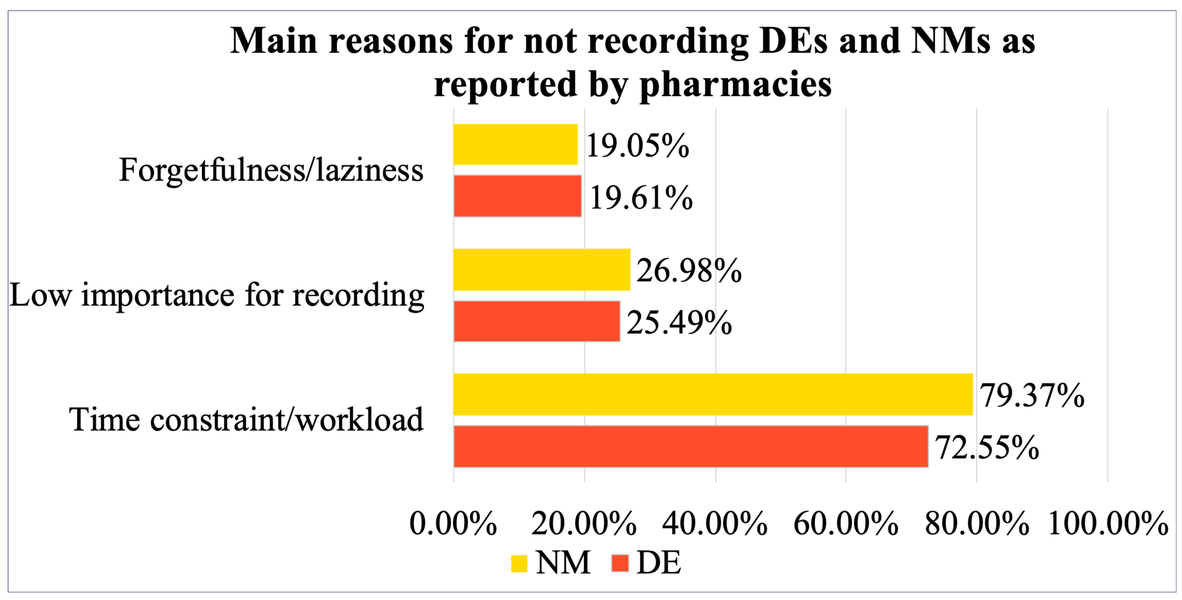












CONCLUSION

•In Ireland, similarly to other countries, DEs happen at much lower rate than NMs
•Pharmacists are aware of under-reporting of DEs and NMs
•Pharmacists and pharmacy staff can learn from well documented DEs and NMs, and a better reporting strategy is needed
•More studies are necessary to identify strategies to prevent DEs in a community pharmacy setting

References available on request.

Acknowledgments:
We would like to thank all community pharmacists that completed the survey, as without their help, this project would not have been possible

CONTACT: For more information on the content of this poster, please contact Sergio Martin, St. James Late Night Pharmacy; sergio.martin.moran@gmail.com