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

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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)

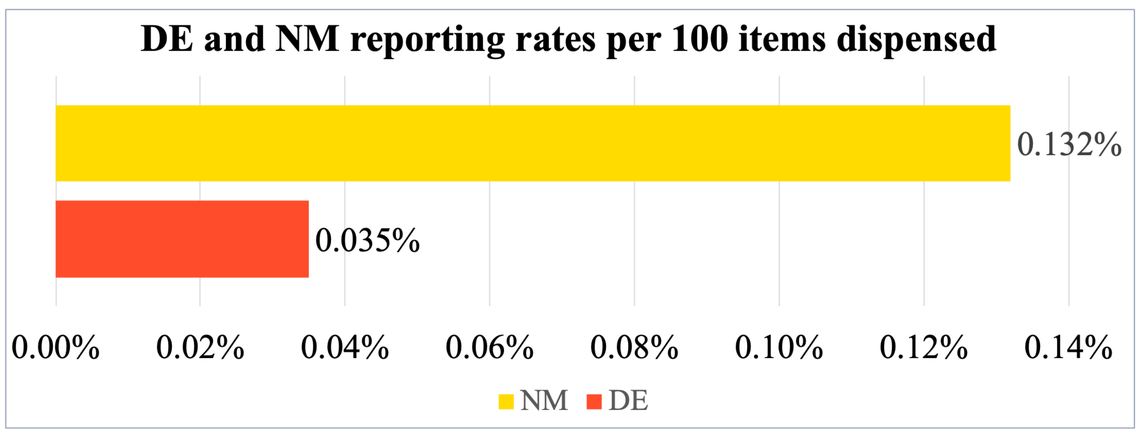
AIMS / OBJECTIVES

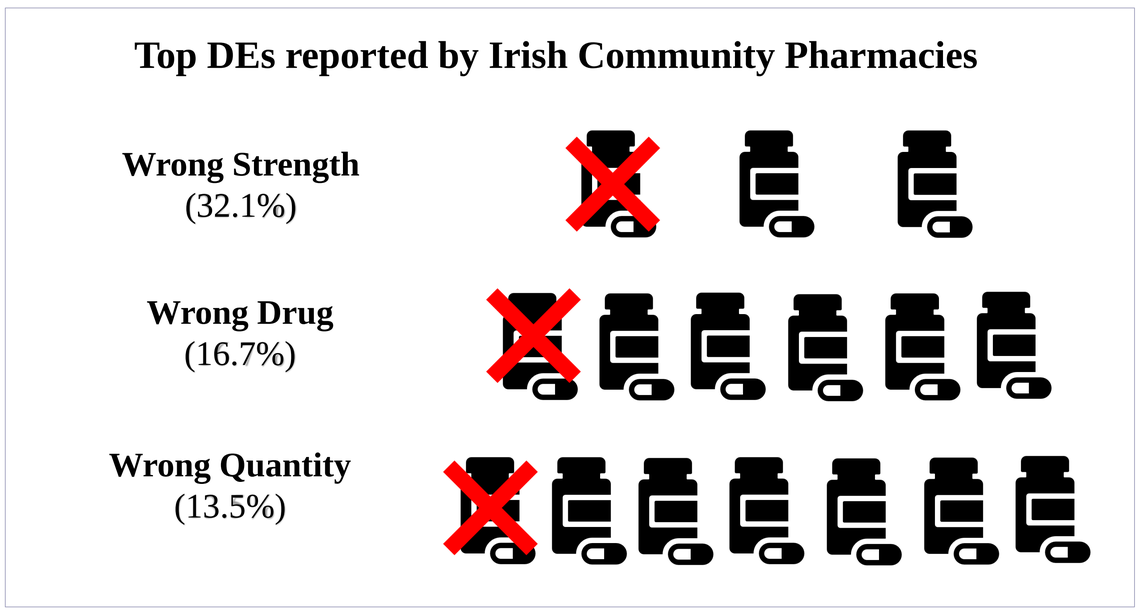
- Assess the reporting incidence of DEs and near misses (NMs) in a community pharmacy setting in the Republic of Ireland
- Identify the different types and causes of DEs, and their associated circumstances
- Evaluate the self-perceived compliance in recording DEs and NMs, and reasons for lack of compliance

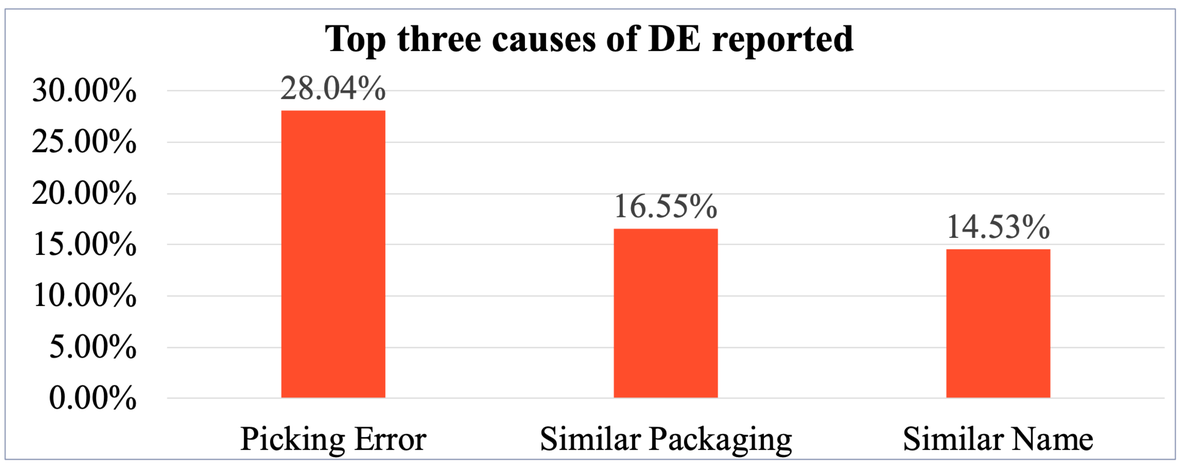
METHODS

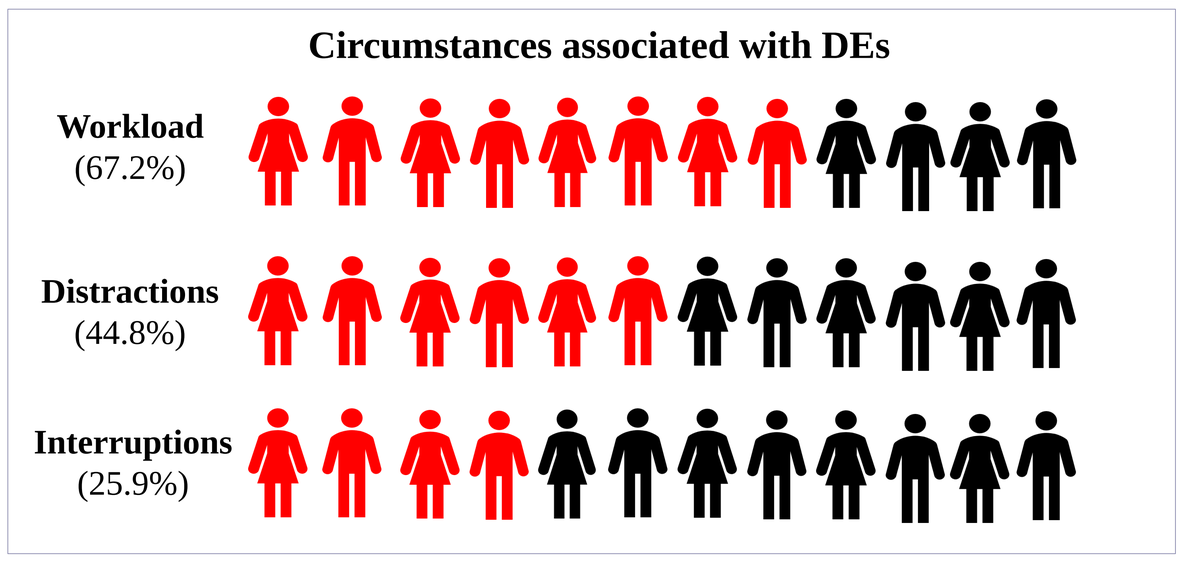
- All community pharmacies in the Republic of Ireland (n=1688) were invited to complete online survey. Participants were questioned regarding general pharmacy information; DEs and NMs reported between 1/1/2019 – 30/6/2019; types and causes of DEs; perceived circumstances associated with DEs; perceived 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

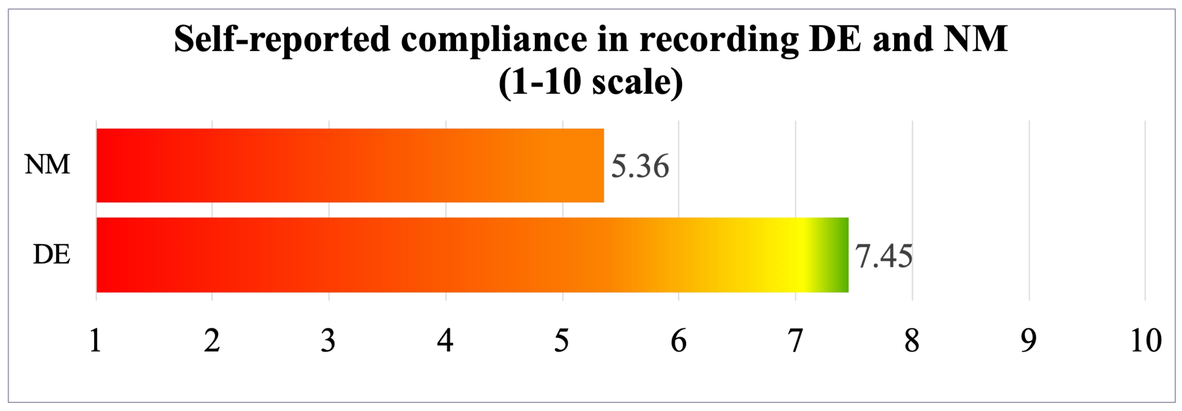
RESULTS

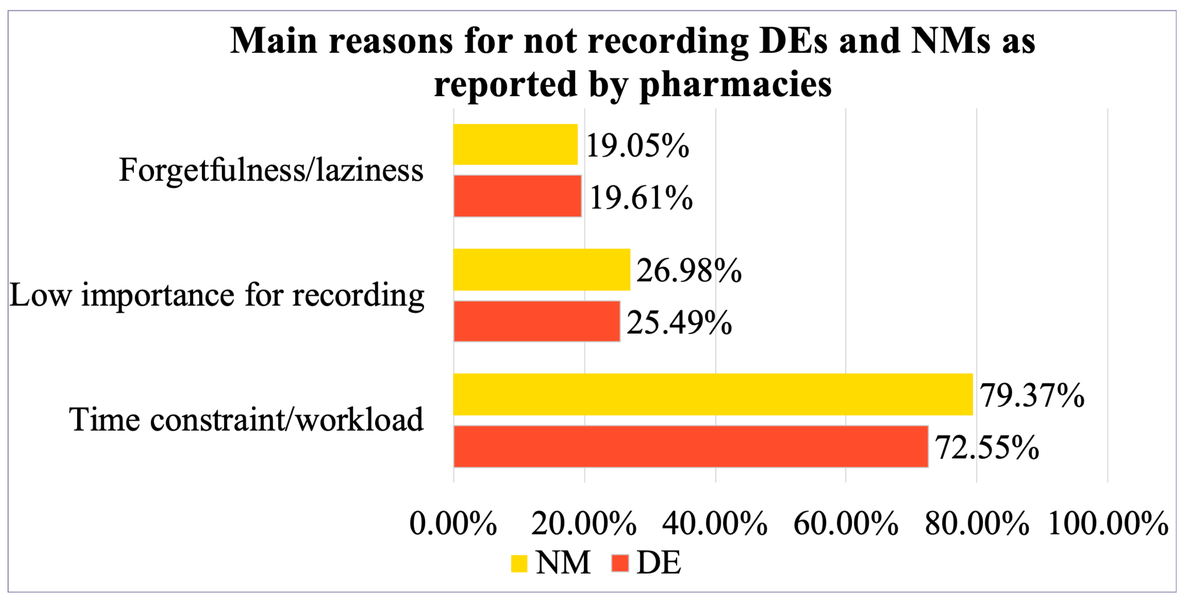












CONCLUSION

•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.

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