# 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)

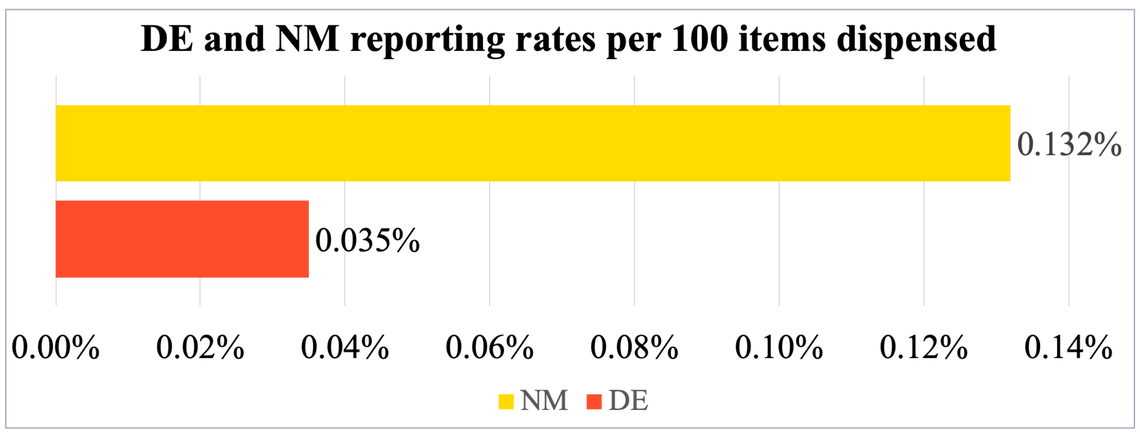
## AIMS / OBJECTIVES

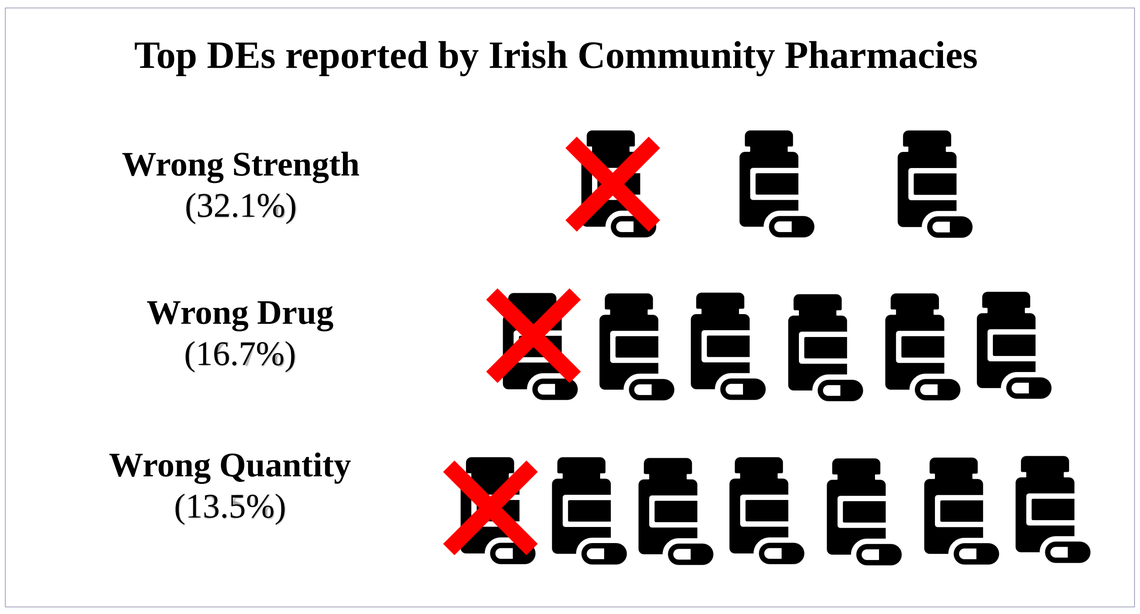
- Assess the reporting incidence of DEs and near misses (NMs) in a community pharmacy setting in the Republic of Ireland
- Identify the different types and causes of DEs, and their associated circumstances
- Evaluate the self-perceived compliance in recording DEs and NMs, and reasons for lack of compliance

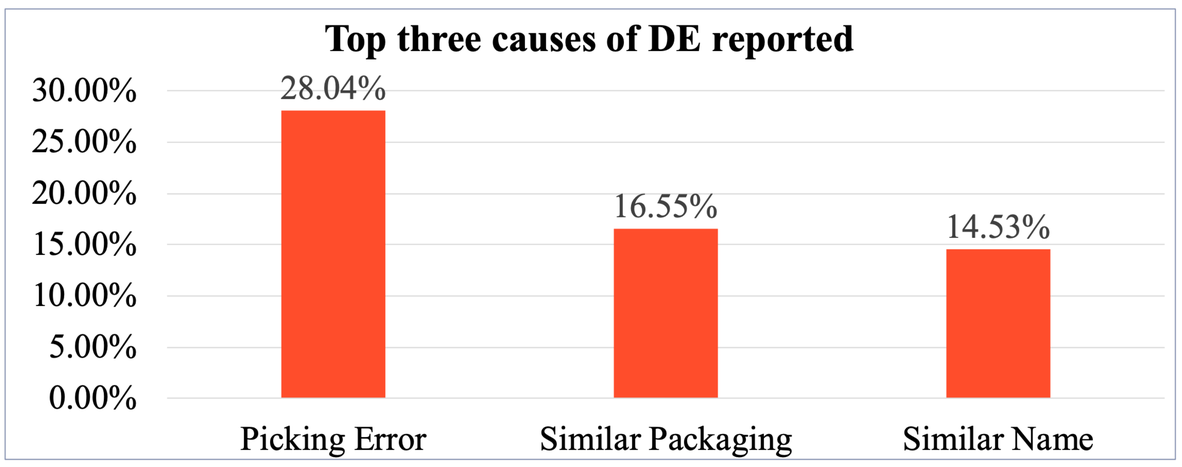
## METHODS

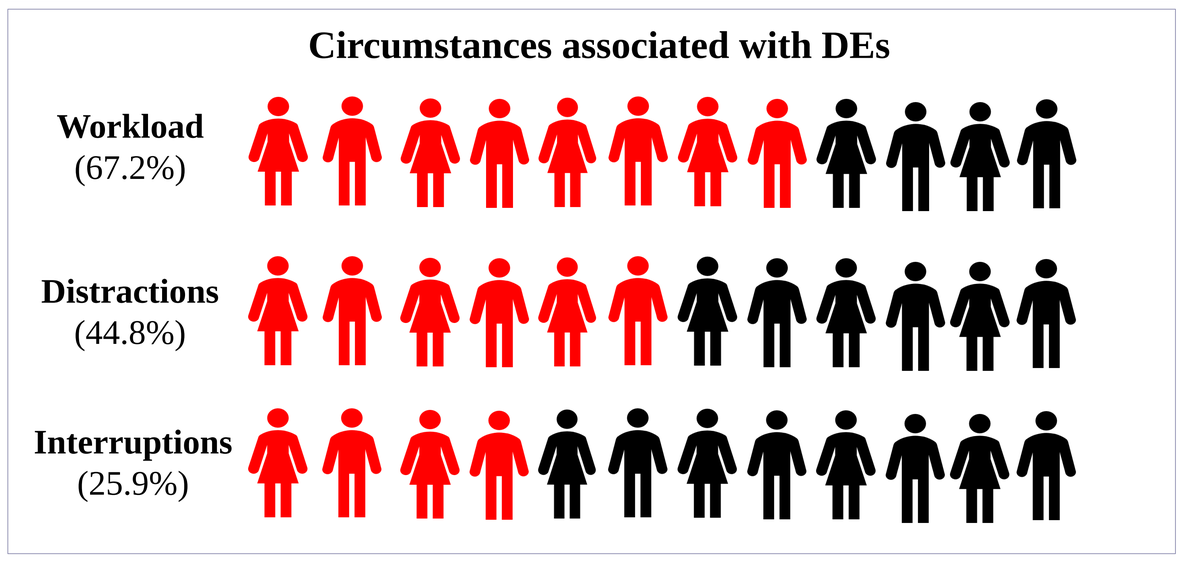
- All community pharmacies in the Republic of Ireland (n=1688) were invited to complete online survey. Participants were questioned regarding general pharmacy information; DEs and NMs reported between 1/1/2019 – 30/6/2019; types and causes of DEs; perceived circumstances associated with DEs; perceived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

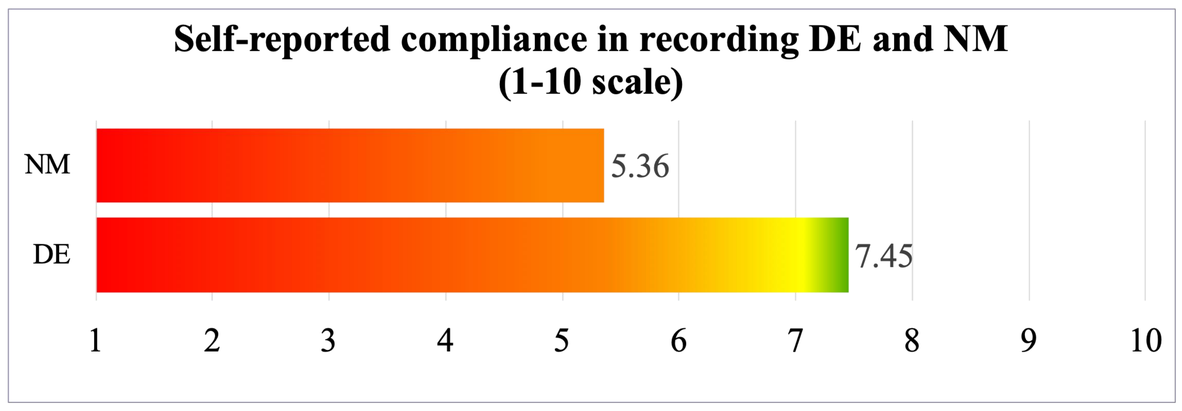
## RESULTS

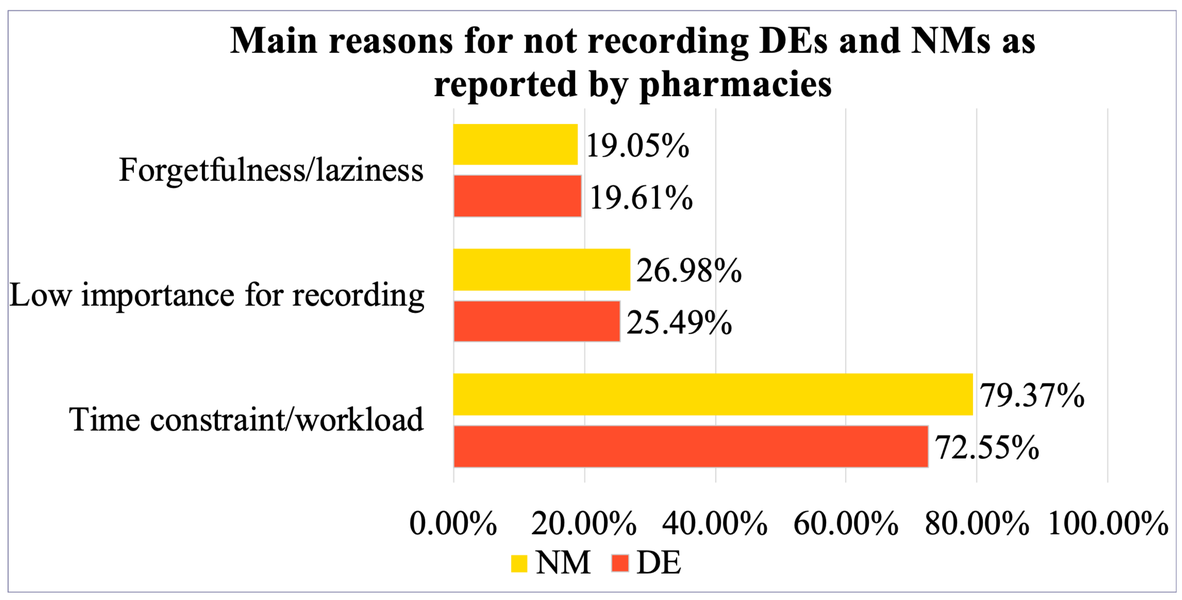



## CONCLUSION

**•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.**

**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