

Title	Dispensing error and near miss recording in Irish community pharmacies
Authors	Martin, S.;Murphy, Kevin D.
Publication date	2020-03
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	2023-09-29 03:51:27
Item downloaded from	https://hdl.handle.net/10468/9790



UCC

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)

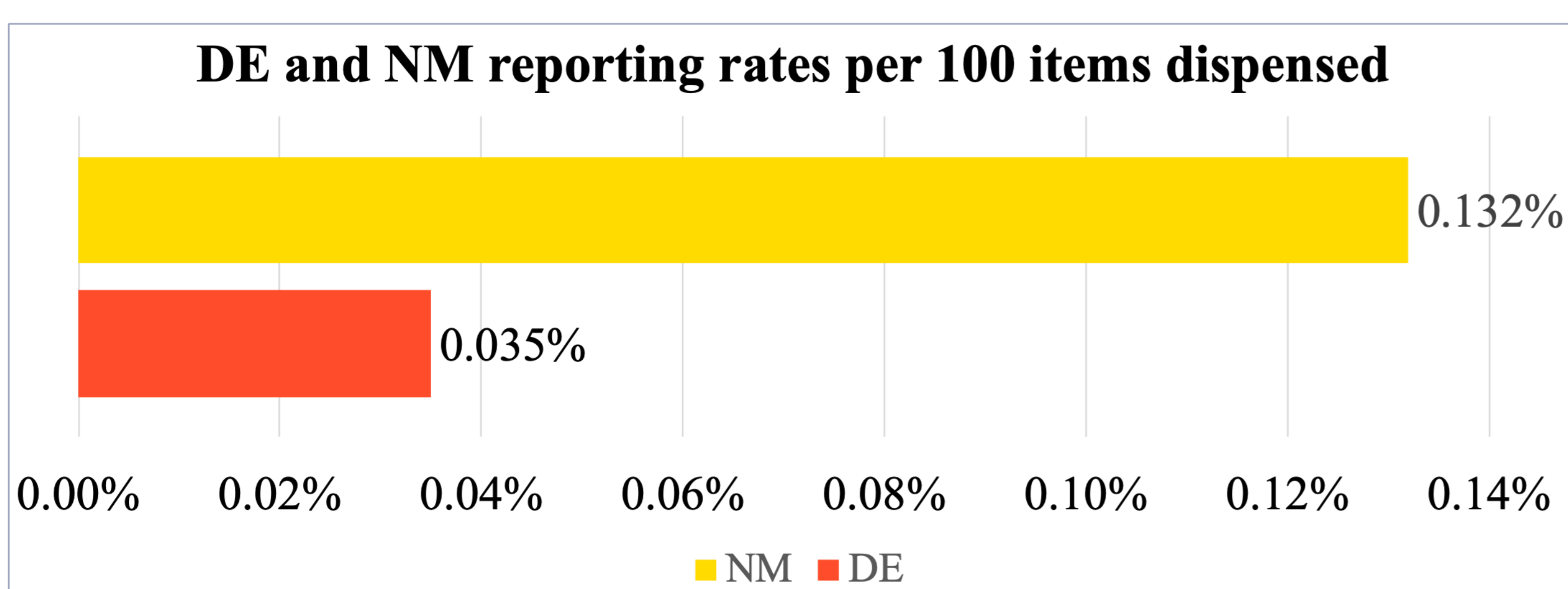
AIMS / OBJECTIVES

- 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



Top DEs reported by Irish Community Pharmacies

Wrong Strength
(32.1%)



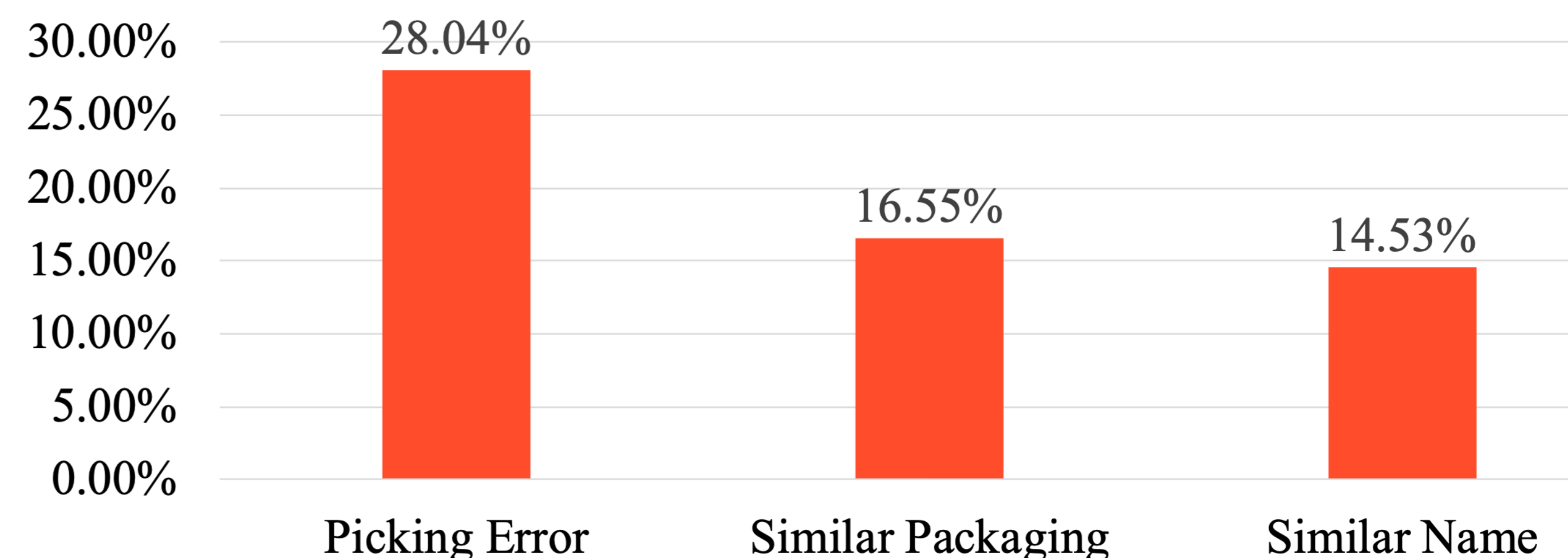
Wrong Drug
(16.7%)



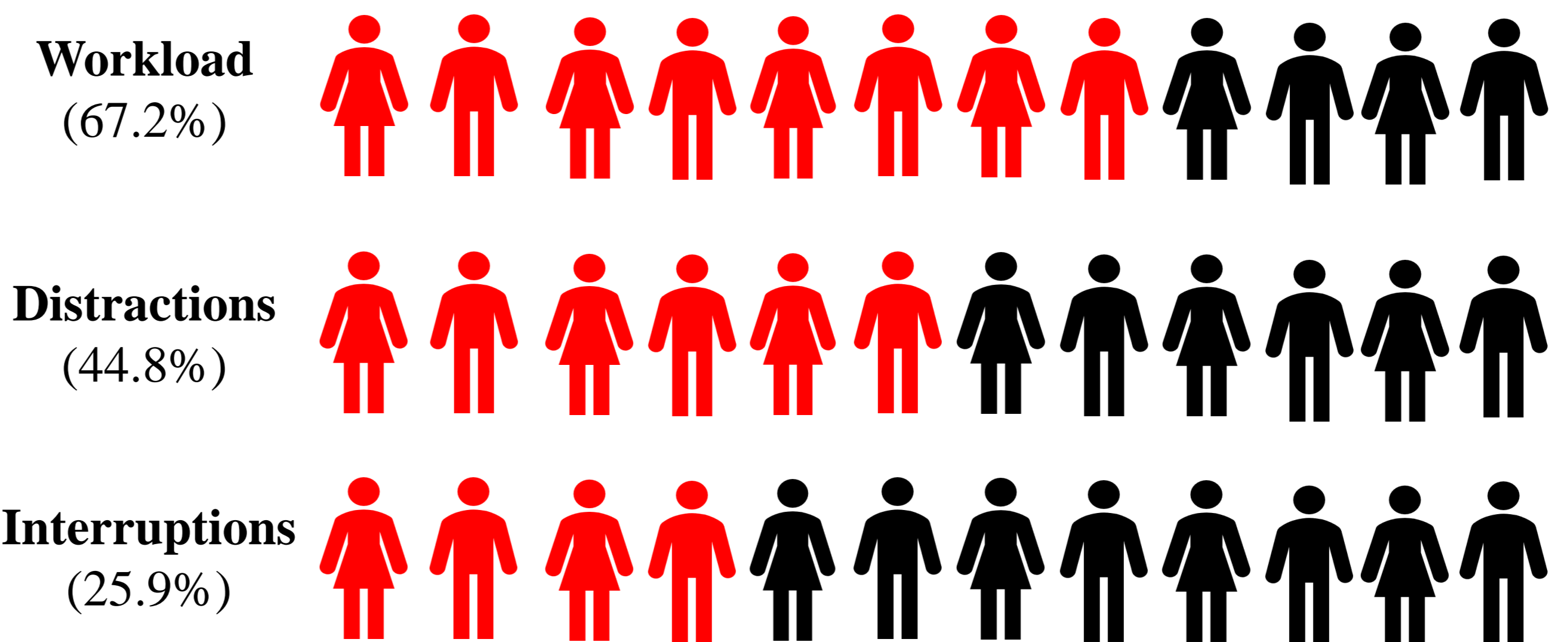
Wrong Quantity
(13.5%)



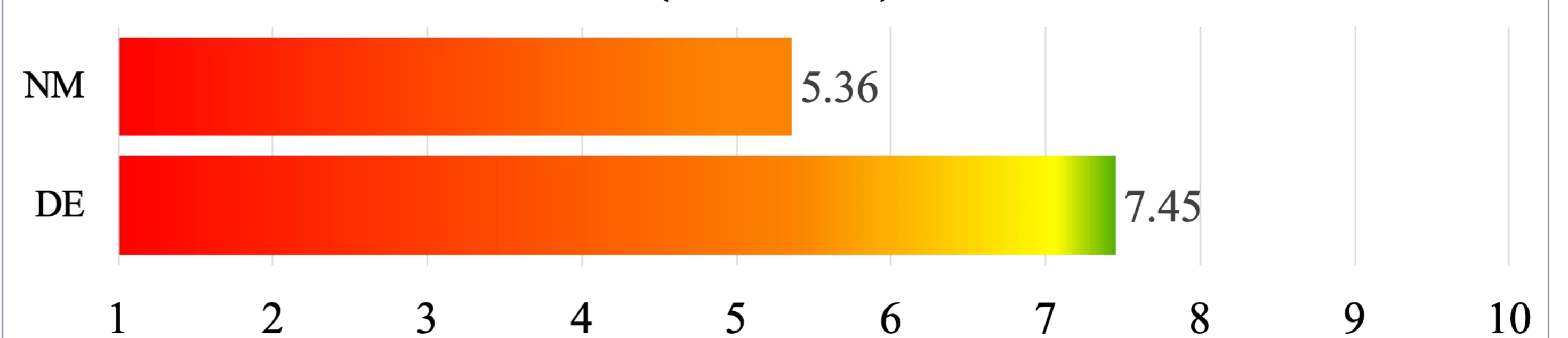
Top three causes of DE reported



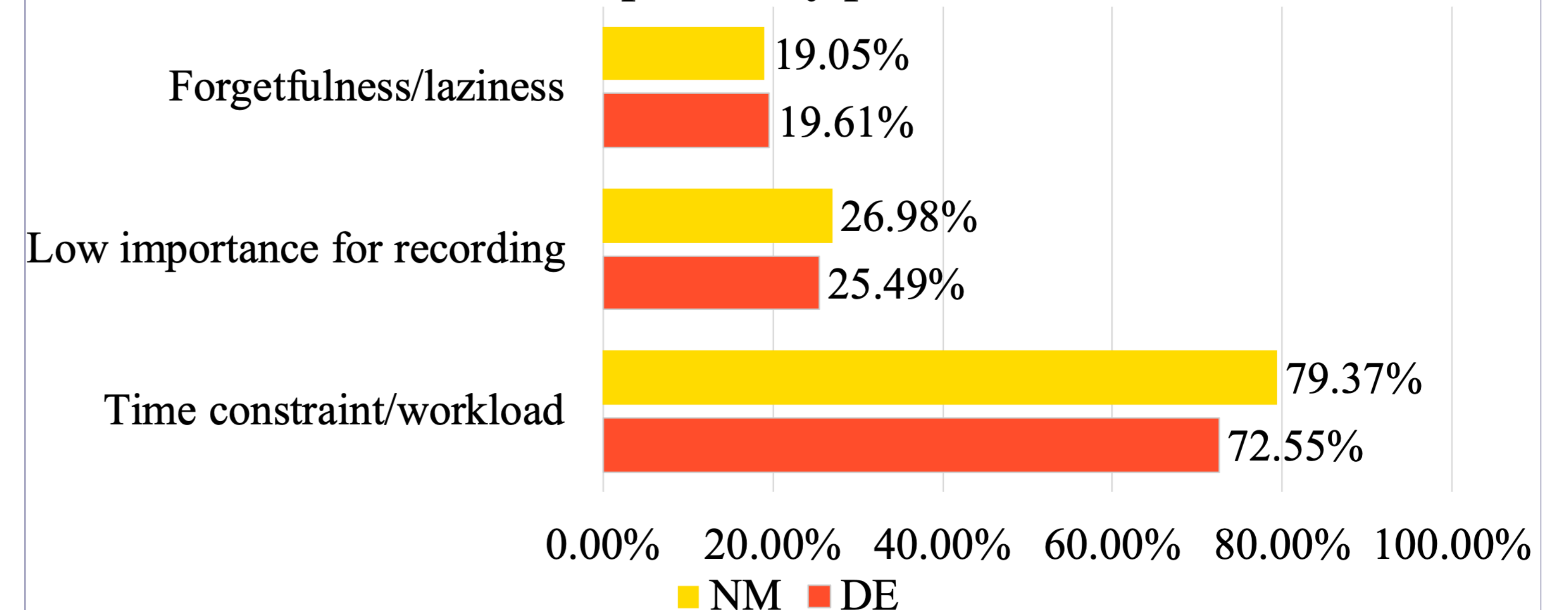
Circumstances associated with DEs



Self-reported compliance in recording DE and NM (1-10 scale)



Main reasons for not recording DEs and NMs as reported by pharmacies



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