

ENSURING DISPENSING ACCURACY
Some simple suggestions

1. **Lock up or sequester drugs with a high potential of causing errors**
 - This might be for your particular pharmacy or from reports in journals. For example, Warfarin, Lanoxin or Prednisone dispensed in the incorrect strength.
 - Hi-lite drug strengths for products with a wide range of available strengths.
 - Hi-lite high-potency medications.

2. **Careful drug storage**
 - Develop, follow and maintain a system of careful drug storage. For example, ensure all prescription stock bottles have their labels facing forward.
 - Avoid the use of external labels on bins, cabinets or drawers. Look-alike packages of different medications can easily be placed in the incorrect place and selected leading to an error.
 - Dispose of old or rarely used chemicals. If required, sequester it so special steps are necessary to retrieve it.

3. **Reduce distractions**
 - Distractions include:
 - people - limit idle chatter while filling prescriptions;
 - telephones - use fax machines, have a separate line for repeats using an answering machine;
 - radios and televisions - just add audio clutter to the workplace.
 - Reduce physical clutter by immediately reshelving the stock bottle. Reduce the clutter, put files away and keep the mail in your office.

4. **Design a safe dispensing environment...improve work flow**
 - Ensure adequate lighting
 - Regulate heat, humidity, and air quality

5. **Be aware of "Look-alike" or "Sound-alike" drug names**
 - While reviewing the patient profile, determine if the drug fits the patient's medical picture;
 - Interpretation of the prescription should include verifying the drug name, strength, dosage form, and dose. Flag the prescription in some fashion to verify that the drug or dosage was indeed verified.

6. **Look-alike Labels**
 - Often products may not only have similar names, but also have similar labels, which may lead to selecting the incorrect drug. If stored alphabetically according to brand name or company name, the two bottles may be shelved next to each other.
 - Manage this by moving the products so they are no longer side by side and attaching notes to the shelf indicating where each product may be found.

7. Poor abbreviations

- Physicians often use non-standard abbreviations. Ensure that you fully understand what the prescriber is writing;
- Use of confusing abbreviations (ie: AZT for Zidovudine or Azathiprine; PBZ for Pyribenzamine or PhenylButazone; ASA for Acetylsalicylic Acid & 5-ASA for 5-Aminosalicylic Acid [5xASA given!]; HCTZ for Hydrochlorthiazide or Hydrocortisone).

8. Develop thorough checking procedures:

- Always perform a final check on the prescription container contents;
- The triple-check method is important in maintaining an error-free environment for processing prescriptions. However, it is not an adequate system as all three checks are made against the same sets of information. Two additional checks are recommended.
 - Check the drug when it is pulled from the shelf;
 - Check the drug when it is labelled;
 - Check the drug when it is returned to the shelf;**PLUS**
 - Check the DIN on the stock bottle against the DIN in the computer;
 - The final check is a "show and tell" during patient counselling
 - Once the prescription container is filled and the label affixed, perform an additional check before the medication leaves the dispensing area;
- Best if done by a second pharmacist, if self-checking, set the work aside for a few minutes, then return to check;
- Compare the contents of the prescription container with the prescription label information.
 - Compare drug name on the prescription label to the name on the medication container;
 - Compare drug name on the prescription label to the container's contents;
 - Compare drug strengths on the prescription label and medication container
- The manufacturer's imprinted code on the tablet or capsule can be checked as an additional safety measure;
- Always perform a final check of the prescription label:
 - Is the patient's name the same on the label and the prescription?;
 - Does the drug name on the prescription label match that on the prescription order?;
 - Do the directions on the prescription order match that on the label?

9. Adequate Computer Systems

- It is important to utilize pharmacy computer systems which are able to detect overdoses, underdoses, duplicate therapy, or potential allergic reactions or drug interactions;
- Do not use software that force one or more zeros after a decimal point (1.0) or does not add zeros before a decimal number less than one (.1). For example, 1.0 mg can be easily misread as 10 mg; similarly, .1mg can be seen as 1 mg;
- Ensure label print size is large and clear enough to be easily read and understood.

10. Patient Counselling

- 83% of errors are discovered during counselling and corrected before the patient leaves the pharmacy;
- Increases patient compliance;
- Medication should not be delivered to the patient in a sealed bag. Be sure to open the prescription container and show the actual medication to the patient. This procedure will direct the patient's attention to the medication and to the pharmacist's instructions in its appropriate use;
- Should be done for refills as well as new prescription orders;
- Telephone follow-up calls for delivered prescriptions can prove to be a useful tool to discuss drug use and verify receipt of the correct medication.

PRESCRIPTION MEDICATION COUNSELLING TIPS

- Verify patient's name and prescriber's name?
- Why the patient is being prescribed the medication?
- How to take the medication?
- When to take and how long to take the medication?
- What to be done if a dose is missed?
- Foods, alcoholic beverages or NPMs that should be avoided?
- How will the patient know the medication is working?
- How to store the medication?
- Can the prescription be refilled, and if so, when?
- Show the patient what the medication looks like
- Does the patient have any questions of you?

11. Physician Handwriting

- Never guess if you encounter poor physician handwriting. Always call to confirm their intentions.

12. Stress and Unreasonable Workloads

- Pharmacists rank work overload as a significant factor contributing to dispensing errors. Sufficient staffing and appropriate work and meal breaks may reduce these risks.

13. Have A Comfortable Patient Waiting Area

- All pharmacists feel the pressure of impatient customers waiting during busy periods. The temptation to skip routine Quality Assurance Procedures becomes virtually irresistible. The manager/owner must develop ways to relieve the pressure and enable the pharmacists to take reasonable time to process each prescription;
- A comfortable waiting area with adequate seating may be all that is required to make a wait more enjoyable;
- Reorganize a portion of the pharmacy to allow greater shopping flow during waiting periods;
- Pharmacists may use waiting time to counsel patients while the pharmacy technician processes the prescription.