ANALYSIS OF PHARMACISTS' ERRORS AND MAIN WAYS TO PREVENT THEM

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Problems related to medications are common in all countries of the world including Ukraine, and they are responsible for significant morbidity, mortality, side effects and cost. True incidences are unknown and difficult to obtain for many reasons, ranging from poor reporting, differences in definitions of what constitutes a medication error, lack of awareness of reporting techniques, lack of time, fear of litigation, inability to determine causality, reluctance to admit error, cost etc. For example, even in advanced countries (e.g. United States) estimates for all types of medication errors (including such variants as missed dose, wrong dosage, wrong medication, wrong time, wrong route, etc.) range from 1.5 to 35%.

The purpose of this study was to record prospectively the frequency of medication order errors in Ukrainian pharmacies with the objective of assessing the impact of pharmacist intervention in preventing potential harm.

Errors due to look-alike or sound-alike medication names are most common in pharmacies and hospitals, and are responsible for thousands of drug diseases or even deaths. Up to 25% of all medication errors are attributed to name confusion, and 33% to packaging and/or labeling confusion. Thousands of medication name pairs have been confused based on similar appearances or sounds when written or spoken, or have been identified as having the potential for confusion. Systems and recommendations have been developed that may reduce the occurrence of such errors.

It has been proposed that INNs should be used to reduce errors due to sound-alike, look-alike proprietary names as well as to avoid duplicate prescriptions due to multiple proprietary names for the same active drug. There are multiple case reports in the literature of patients being admitted to the hospital for side effects resulting from overdoses caused by taking two or more prescriptions with the same active ingredient but different brand names. However, the opposite has also been proposed – that trade names be used due to similar-sounding generic names, particularly in certain drug classes. For example, the majority of the cephalosporin antibiotics have generic names that look and sound very similar, but often have very different proprietary names.

This study estimates the reasons for medication errors. However, proper graphic design of drug packages and marking is the best way to prevent them.