Patient counselling is emphasized as providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications. The study sought to establish that as healthcare providers, pharmacists can play a significant role in mitigating medication errors and ensuring patient safety. The project involved analyzing and categorizing medication incidents to identify patterns and develop strategies for improving patient care. The study also aimed to develop a framework for patient education and training, emphasizing the importance of verbal communication and patient involvement in the medication management process.

**Potential Medication Incidents:**

- **Incorrect Patient:** The patient brought in five prescriptions for four patients. Three were for her and two for her husband. When counseling the patient, she questioned the two medications that were for her husband and then realized that the medications were incorrectly prescribed.

- **Unfamiliar Therapy:** A prescription for amoxicillin was filled on its usual strength of 500 mg instead of 250 mg on the prescription. The pharmacist was prompted to double check with the nurse who realized that the doctor wanted him to be on 500 mg. Amoxicillin was continued to be prescribed.

- **Unnecessary Therapy:** The pharmacist had missed prescribing a concurrent prescription as a reminder for regimens. The error was caught when reviewing the product to the patient post-

**Result(s):**

- **Pharmacist-led Identification of medication errors at patient counselling & pick up:**
  - **Prescription Reconciliation**
    - Example: During counselling, the pharmacist realized that she had filled regular childbirths, which should be "one tablet every 4 hours" but the directions entered were "two tablets once daily".
    - Comment: Providing written instructions to the patient and ensuring they are read is emphasized as “providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications.”

- **Demonstration of Product**
  - Example: Presenting the prescription in concern with the pharmacist and the patient, this is verified that the right medication is dispensed, not only by a medication expert (the pharmacist), but also the person who will be consuming the medication (the patient).

- **Questionable Therapy**
  - Example: The pharmacist had prescribed clonazepam 5 mg tabs, at which the product used. She asked the patient if they had any questions before the patient leaves the pharmacy.
  - Comment: Dispensing the medication in terms of the label to the patient as an independent double check by two stakeholders—the pharmacist and the patient. This verifies that the right medication is dispensed, not only by a medication expert (the pharmacist), but also the person who will be consuming the medication (the patient).

**Patient-led Identification of medication errors at patient counselling & pick up:**

- **Incorrect Patient:** The patient brought in five prescriptions on four patients. There were for her and two for her husband. When counseling the patient, she questioned the two medications that were for her husband and then realized that the medications were incorrectly prescribed.
  - Comment: Simplifying and standardizing the packaging and labeling of the medications for different patients into different bags or, at least, if they are in the same family (main source of error).

- **Unfamiliar Therapy:** A prescription for amoxicillin was filled on its usual strength of 500 mg instead of 250 mg on the prescription. The pharmacist was prompted to double check with the nurse who realized that the doctor wanted him to be on 500 mg. Amoxicillin was continued to be prescribed.
  - Comment: Using written prescriptions (e.g., decreased, the same, increased, changed, etc) but set at a behavioral point that the patient is catching potential error or unintended therapy changes.

- **Improper Storage:** The medication was continually stored in the refrigerator while waiting for pick up. The patient was asked about changes in pick up and the error was realized. The medication was replaced and dispensed.
  - Comment: Using reminders (e.g. auxiliary labels, different coloured bottles) can help identify prescriptions with special storage requirements.

**Conclusion(s):**

- Errors identified at counselling and pick up are often “near misses”, and solutions for identifying such errors are typically behavioural in nature.

- Pharmacists can provide patients with the knowledge to identify and intercept medication incidents through counselling and education.

- Incorporating and tailoring a list of prime questions, as well as a visual demonstration of the dispensed products to patients can mitigate errors in the final stage before the medication leaves the pharmacy.

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**Contact Information:**

For more information contact us below:

- **Website:** www.ismp-canada.org
- **Telephone:** 416-733-1331 (Toll Free)
- **Fax:** 416-733-1416
- **Address:** 4711 Yonge Street, Suite 501
- **Email:** info@ismp-canada.org

**References:**

2. CPhIR Community Pharmacy Incident Reporting (CPhIR), Edmonton. [www.cphir.ca](http://www.cphir.ca)

**Images:**

- Drawing by Nathaniel Bean from Freepik.com

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