

## Discussion Question

### Week 5 DQ 1

Due Week 5 Day 2 (Tuesday, October 18)

Recall the seven rights of drug administration. Consider the reasons for errors regarding these seven rights. Refer to page 64 (Examples 1 through 6) for the most frequent causes of medication errors. What **two strategies** for properly administering medication do you suggest?

Remember to structure your response into paragraphs using correct spelling/grammar and meeting the 150-word minimum.

The first strategy I would suggest for properly administering medication would be double checking for accuracy before it leaves the pharmacy. After reading the scenarios, I noticed that most of the mistakes were simple mistakes that could have been captured if they had been double checked for accuracy. There are times when we may be rushed or on a time restraint which may cause us to include one more pill in a bottle than prescribed, however if we are using the buddy system or a team member to verify prescriptions then I think this would allow that team member to capture the mistake like in the first couple of scenarios.

The second strategy I would suggest for properly administering medication would be confirming with the source that provided or wrote the prescription. I sometimes feel that physicians have their own unique penmanship when it comes to writing orders. It is hard enough trying to understand the medical language that is spoken in the office, but it can be even harder to decipher some of the words on the prescription. So the correct thing to do would be to contact the office that wrote it so it can be filled properly and you will not have to worry whether or not you filled the prescription correctly. In doing this you will be for certain that this is what the doctor ordered!

### Response 2

After reviewing the examples, I have come to the conclusion that most errors in dispensing medications is either when the prescriber has misused an abbreviation or when there has been a huge calculation error in dosage. The calculation error seems to be most prominent when there is a new drug that the pharmacist is not entirely familiar with yet.

When dispensing medication I like to always double check my own work before I pass it on to the next person. At the pharmacy I work at one person input the prescription information

and from there it gets passed on to the next technician in production. I like to always do a quick over look of all the information just before it leaves my hands even though I know that it always gets verified by the pharmacist. This way it is getting triple checked. Another thing I always do is if a prescription is hard to read or there is any confusion as to what the directions are I always ask the pharmacist. If they are unable to understand it too, then I always call the physician's office for clarification. However, sometimes it may seem easy to become complacent because you will get to know certain doctors handwriting and think you know what they are intending to write. At this point it is even more important to take the time to make sure the script is filled how it is written, and not what you think it says.

## **Discussion Question**

### **Week 5 DQ 2**

**Due Week 5 Day 4 (Thursday, October 20)**

What are the essential components of a prescription order? In what ways do computers ensure accurate filling and dispensing of prescriptions? What existing or potential technological advances might make pharmacy technology a more accurate and safe practice?

Remember to structure your response into paragraphs with correct spelling/grammar and meeting the 150-word minimum.

The essential components of a prescription order are that the script is signed by the prescriber, the name, address, phone number of the prescribers office, date the script is written, name and address of the patient, medication prescribed, dispensing direction to the pharmacist, and directions for medications being described for the patient, refills, quantity being dispensed, whether the prescription can be substituted or not, and the prescriber's DEA.

The ways a computer ensure's accurate filling and dispensing prescriptions is there is no struggling with trying to figure out what the doctor has written for, if the prescriber put the decimal point in the correct place, or abbreviations can not be misunderstood, and when the prescriber inputs the information into the computer, the computer can also provide information to the prescriber about possible drug complications that the prescriber might not otherwise think of.

The technological advances are the E-scripts, This way when the doctor send the script from their blackberry over to the pharmacy, there is no question on what it says because it is all typed out. Occasionally the doctor will chose two sets of directions, and we have to call to see which set of directions we are to be using, or the doctor will forget to put directions all together. I have also seen where the doctor has missed putting in a quantity and we call them to get the quantity. I do like the E-scripts because it is better to read what the doctor is asking for, and this will account for less mistakes on the technicians part.

## Response 2

The essential components of a prescription is the physician signature, office address, office phone number, patient name, patient birthday, name of prescription, directions (sig notes), DEA number, amount of refills, dispense as written (DAW) or substitution allowed approval. Computers will allow there to be less confusion as to what the prescription is intended to be especially when dealing with penmanship. Another plus to using computers is that most medication already have saved templates that give the directions for common medicines for doctors. This way there is less room for error on directions.

One thing our pharmacy gets more then written or printed prescriptions is electronic scripts from the prescribers. This is a fast and easy way for the pharmacy to have the medicine ready for the customer. I think this way has a good overall accuracy rating from what I have seen from doctors.