



Double Check Changed NDCs

Anytime a change is made to a prescription after it is entered into the pharmacy computer system, particularly if your workflow includes a verification of the order entry prior to the production phase, an independent check of the revised order entry against the original prescription should be conducted. If this is not done, you increase the risk that an error introduced with the change can reach a patient.

The Institute for Safe Medication Practices has received a number of reports describing events in which the wrong medication was dispensed after a technician or pharmacist changed a national drug code number after the original order entry and corresponding verification had been completed. The NDC number was changed to match a product selected from stock which, in each case, was the wrong product or dosage strength. For example, a pharmacist incorrectly retrieved morphine 30 mg instead of morphine extended release 30 mg, and changed the NDC in the computer system to that of the immediate release product. In another case, a pharmacy technician retrieved cyclobenzaprine 10 mg instead of 5 mg; the technician then changed the NDC in

the computer system to the 10 mg product and relabeled the prescription. Each of the reports we received indicate that an independent check of the change in NDC was not conducted prior to the production phase. In each case, the wrong product was dispensed but the error was fortunately caught before the drug was administered to the patient.

Examine your processes for reviewing changes made after entering a prescription. If not already present, build in an independent double-check using the original prescription anytime a change is made to a prescription that has already undergone some sort of verification. This verification step should occur before the prescription can proceed to the next step in your pharmacy workflow.

RISKS WHEN COPYING OLD PRESCRIPTIONS

ISMP has received a number of reports describing dispensing errors that occurred when a patient's previous prescription was copied and edited in the pharmacy computer system. The latest example involves a patient with a new prescription for oxyCODONE 5 mg. A few months earlier, this same patient

had received a prescription for oxyCODONE 30 mg. To expedite the dispensing process for the new prescription, the pharmacist chose to copy the previous oxyCODONE 30 mg prescription but failed to edit and select the correct dosage strength. The patient received oxyCODONE 30 mg and used this strength for a month. The pharmacy's analysis of the event found that the final prescription verification was conducted by the pharmacist immediately after he completed the order entry and filling of the prescription; this limited the effectiveness of the check process.

Care must be taken when copying and editing old prescriptions when entering a new prescription. Whenever possible, have a pharmacist not involved in the order entry and production of the prescription conduct the final verification. Pharmacy computer system vendors also have a role to play in preventing this error. When copying an old prescription, the computer system should not allow the user to proceed unless critical elements of the prescription, including drug name, drug strength, suffix, quantity, directions, and refills, are confirmed. This will result in more checks and may slow the process but is necessary to reduce the risk of medication errors. Even if your computer system can't incorporate this change, your manual process used to verify prescriptions should include these additional steps. Providing patient counseling and opening the bag of filled prescriptions at the point-of-sale to verify that the medications are correct and for the right patient are some of the most effective strategies to catch dispensing errors. ■

This article is from the Institute for Safe Medication Practices (ISMP). The reports described were received through the USP-ISMP Medication Errors Reporting Program. Errors, near misses, or hazardous conditions may be reported on the ISMP website at www.ismp.org. ISMP can be reached at 215-947-7797 or isminfo@ismp.org.