

Patients, prescribers responsible for knowing proper pills

By Agnes Oblas

Nursing students are indoctrinated in the five R's of medication dispensing: The right patient, the right medicine, the right dose, the right time, the right route (by mouth? by injection?).

I suppose the need for that kind of brainwashing came about because a prerequisite for medical students obtaining their medical degree is that of illegible handwriting. I know because I have had to decipher some of the worst chicken scratch imaginable.

Fortunately, when you work side by side with a doctor for a few years, you begin to learn what the scribbles represent.

But what happens when a doctor (or heaven forbid even a nurse practitioner with prescribing privileges) writes a prescription that is not legible. The patient takes it to a pharmacy where the



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pharmacist believes he/she is reading the prescription correctly when in fact the patient goes home with the wrong medicine.

Not knowing that a mistake has occurred, the patient innocently suffers the consequences, sometimes significant, sometimes only minor. You can blame the original writer of the prescription or you can blame the pharmacist, but I maintain patients share some of the responsibility.

Patients who resist a more active

involvement in their personal health and well-being by not knowing the names of the medicines that have been prescribed and or the purpose of each medicine put themselves at risk.

If you take more than one medicine (and these days two or three medicines are frequently prescribed simultaneously for one medical problem), you really ought to know the names and doses or at least carry a list with you in your wallet or purse.

Remember how your Mom always said to wear clean underwear just in case you're in an accident and end up in an emergency room? Well, regardless of the condition of your underwear, medical personnel in all types of encounters need to know what medications a patient is taking particularly if that patient is unable for whatever reason to communicate.

Do not expect anyone to be able to identify your pills by color and/or shape. Avapro is not Avelox, Clonidine

is not Klonopin, Panlor is not Pamelor. You get the picture.

Approximately 3 billion prescriptions are dispensed per year in this country. The sheer volume of these prescriptions makes mistakes inevitable.

Those of us who write prescriptions can do our part by writing legibly, and patients can do their part to minimize the risk of mistakes by knowing their medicines by name, questioning the prescriber or pharmacist if a new bottle of pills looks different than previously, or if the instructions on the bottle read differently than the prescriber had instructed directly to the patient.

Always check your prescriptions before you leave the pharmacist's counter and don't be afraid to ask questions.

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