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Drug Dispensing Errors at a University Hospital in Brazil

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***SUMMARY*. The aim of the present study was to investigate drug dispensing errors at a university hospital in Brazil. The medications were dispensed individually using a copy of the prescription and separated by administration time within 24 h of care. A total of 259 prescriptions were analyzed, involving 1963 medications and 4099 doses. There were 61 errors in 48 prescriptions, 3.2 % of the medications and 1.7 % of the doses dispensed. The most frequent errors were the omission of the prescribed drug (23 %), dispensing of non-prescribed drugs (14.8 %) and drugs dispensed in the absence of information (14.8 %). One third of the incidents involved potentially dangerous drugs. The risk of error was 3.2-fold greater with prescriptions containing more than 10 medications. The lower incidence of error in comparison to rates described in the literature may be due to the four-step dispensing process employed, which may be useful for hospitals with similar characteristics. However, this relatively low incidence should be analyzed with caution, given the large amount of doses dispensed on a daily basis. A pharmacist should be present to analyze the prescriptions and verify the doses.**

KEY WORDS: Drug dispensing, Drug-dispensing system, Medication errors.

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