Appendix A: Examples of PADEs

Prescribing The physician ordered lisinopril, 5 mg tablet, once daily even though the patient was not hypertensive and had no indication for the drug. The order was intended for another patient and the nurse intercepted the error.
Transcribing A 74-year old man with diabetes mellitus, hypertension and recurrent urinary tract infections was admitted to the medical ward. Meropenem, 500 mg intravenously, every eight hours was ordered. In the morning round, the infectious disease consultant verbally asked the intern to change meropenem to imipenem 500 mg intravenously every six hours. However, the intern mistakenly transcribed it as meropenem. This error was caught, corrected, and noted as an error in the patient's medical record.
Dispensing An order of metoclopramide 10 mg was sent to the pharmacy. The nurse obtained the drug from the pharmacy, but from the appearance of the solution, she suspected that the preparation was not metoclopramide. The nurse contacted the pharmacy and the pharmacist found that it was the wrong medication, although the label was stated that it was metoclopramide.
Administering A nurse handled two capsules for two different patients in Room #8 and Room #9. She almost accidentally gave the wrong medication (switched) to each patient. However, the patient in Room # 9 knew her medication and she said, "This is not my medicine," and the error was intercepted by the patient.