

# OFFICIAL PUBLICATIONS

---

## **Drug Formulation: Statement on Medication Size, Shape & Colour (1995)**



Canadian Society of Hospital Pharmacists  
Société canadienne des pharmaciens d'hôpitaux

## Drug Formulation: Statement on Medication Size, Shape & Colour

Published by the Canadian Society of Hospital Pharmacists (CSHP), Ottawa, Ontario. 1995 edition. Use of this document was approved by CSHP Council in 1995.

This paper was retired by the CSHP Board in March 2015. Though its content is considered outdated, the paper is made available so that readers have access to information that is suitable for referencing or conducting historical research.

If you are interested in a current version of this paper, please check CSHP's website: there is no guarantee that such a version exists.

### Suggested citation:

Canadian Society of Hospital Pharmacists. Drug formulation: statement on medication size, shape & colour. Ottawa (ON): Canadian Society of Hospital Pharmacists; 1995.

### © Canadian Society of Hospital Pharmacists 1995

All rights reserved. Publications of the Canadian Society of Hospital Pharmacists can be obtained from:

30 Concourse Gate, Unit 3  
Ottawa ON K2E 7V7  
Telephone: 613.736.9733  
Fax: 613.736.5660  
Internet: [www.cshp.ca](http://www.cshp.ca)

An electronic copy of this document is available, for personal use, to:

- members of CSHP, at CSHP's website: [www.cshp.ca](http://www.cshp.ca)
- non-members of CSHP at a cost, by contacting the Publications Administrator at the above address

Requests for permission to reproduce or translate CSHP publications – whether for sale or for non-commercial distribution – should be addressed to the CSHP Publications Administrator using the above contact information.

This publication represents the view of Canadian Society of Hospital Pharmacists and was approved after careful consideration of the evidence available. All reasonable precautions have been taken by the Canadian Society of Hospital Pharmacists to verify the information contained in this publication.

The Canadian Society of Hospital Pharmacists is not a regulation-setting organization.

This published material is being distributed without warranty of any kind, either expressed or implied. Although the intended primary application of this publication is stated in its introduction, it is important to note that it remains the responsibility of the user of the publication to judge its suitability for his or her particular purpose within the context of his or her practice and the applicable legislative framework. In no event shall the Canadian Society of Hospital Pharmacists or any persons involved in the development and review of this publication be liable for damages arising from its use.

CSHP Official Publications are subject to periodic review, and suggestions for their improvement are welcomed. Where more than one version of a publication exists, the most recent version replaces the former version(s). Users of the CSHP's publications are advised to check CSHP's website for the most recent version of any publication.

All inquiries regarding this publication, including requests for interpretation, should be addressed to the Canadian Society of Hospital Pharmacists using the above contact information.

# Drug Formulation: Statement on Medication Size, Shape & Colour

THE CSHP SUPPORTS THE PRINCIPLE OF STANDARDIZED SIZE, SHAPE AND COLOUR OF BIOEQUIVALENT ORAL SOLID DOSAGE FORM MEDICATIONS, WITH UNIQUE PRODUCT IDENTIFICATION MARKINGS FOR EACH MANUFACTURER SHOULD BE VISIBLY IMPRINTED.

## BACKGROUND

The legality of using the same size, shape and colour for bioequivalent products is being challenged. CSHP is concerned with the potential ramifications should this "Safety Check" for the patient and health care practitioners be ruled illegal.

Bioequivalent products from different manufacturers usually do have different markings. This is essential for absolute determination of the source of a product should the need arise. However, forcing bioequivalent products to appear different in their size, shape and colour is not in the best interest of public health and safety. Changes to the appearance of a patient's prescription alert the patient and their caregivers to the change. If the change was not expected, it provides a basis to question the change. If the size, shape or colour were constantly changing as a result of changing manufacturers, patients would not be sensitive to the changes and the value of this alert would be lost. The following provide some examples of how standardized size, shape and colour protect public health and safety.

**1. Physician error** - The dose may have been changed by the physician by accident. The change in colour alerts the patient to ask, "Why?". If it was unintended the physician can correct the dosage and prevent the patient from having their already titrated dosage inappropriately adjusted. It would likewise prevent the follow-up visits to re-titrate the dosage and any unfortunate sequelae of receiving a subtherapeutic or excessive dose.

**2. Pharmacist error** - The wrong dose or medication may be dispensed in error. The change in colour alerts the patient to ask, "Why?". If it was unintended the pharmacist can dispense the correct

dosage and prevent the patient from having their already titrated therapy inappropriately changed. It would likewise prevent the follow-up visits to re-titrate the dosage and any unfortunate sequelae of receiving a sub-therapeutic or excessive dose or the wrong medication.

**3. Communication error** - The change in dose or medication intended by the physician may be dispensed correctly, but the patient may not have had the change explained with sufficient clarity. The change in colour alerts the patient to ask, "Why?". If it was intended the pharmacist can provide assurance of the appropriateness of the change and reinforce the reasons and expectations of the change. It would enhance the patient's understanding of their therapy and promote improved compliance with the associated potential improvements in effectiveness.

**4. Administration error** - Often a nurse or family member selects medication to be administered at a particular time. In these cases the patient rarely has access to the originally labeled container. The change in colour alerts the patient to ask, "Why?". If it was unintended the nurse or family member can re-select the correct medications and prevent the patient from having their already titrated therapy inappropriately changed. It would likewise prevent the follow-up visits to re-titrate the dosage and any unfortunate sequelae of receiving a sub-therapeutic or excessive dose of the wrong medication.

CSHP Mission:

CSHP is the national voice of pharmacists committed to the advancement of safe, effective medication use and patient care in hospitals and related healthcare settings.

