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DECREASING MEDICATION ERRORS AND ENHANCING PATIENT SAFETY IN TERTIARY CARE HOSPITAL: A CASE STUDY

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Abstract

Medication Error have been examined as a wellbeing experts' liability (because of missteps in remedy, planning or administering). Nonetheless, in some cases, patients themselves (or their guardians) commit errors in the organization of the medicine. The study of disease transmission of patient drug blunders has been hardly checked on notwithstanding its effect on individuals, on remedial adequacy and on gradual expense for the wellbeing frameworks.

Keywords: Adverse drug reaction**,** Prescription error**,** Healthcare organization, Drug error, Clinical pharmacist, Route of Administration

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INTRODUCTION:

Episodes and mistakes during the course of medicine organization keep on being a significant patient wellbeing issue in medical care settings universally. Interferences to the medicine organization process have been recognized as a main source of prescription error. Writing perceives that a few interferences are undeniable; in this way with an end goal to diminish error, it is fundamental comprehend the way in which undergrad attendants figure out how to oversee interferences to the drug organization process. A prescription error any preventable occasion that might cause or prompt unseemly drug use or patient mischief while the medicine is in the control of the medical care proficient or patient. A recommending mistake is a drug blunder connected with a blunder in endorsing. Numerous ADRs are viewed as by and large to have been 'avoidable' with more consideration or planning. At the end of the day, an unfavorable occasion considered by one prescriber to be a lamentable ADR may be viewed as by one more to be a recommending blunder. An organization mistake is connected with a disappointment in the errand of giving the medication to the patient, despite the fact that the solution that coordinates the organization is right and the right medication has been provided (for example the medication is given by some unacceptable course). An apportioning error happens when the remedy is right yet some unacceptable medication is provided, regularly be a drug specialist.

CAUSES OF PRESCRIBTION ERROR:

The causes of defining crimes can be accessibly divided into those that relate to the individual prescriber and those relating to the system in which they work. In the history it was common to seek to attribute blame for crimes on individualities it's now recognized that utmost crimes affect from a combination of individual (active) and systems failures. Healthcare organizations decreasingly encourage reporting of crimes within a ‘no blame culture’ so that they can be subject to ‘root cause analysis. A well given base for analysis is mortal Error proposition which seeks to categorize crimes into those conduct that are unintended, skill- grounded and avoidable by further thorough checking routines, and those that are intended and related to lack of knowledge or experience. Resource constraints mean that prescribers will always work insub-optimal circumstances emphasizing the need for rigorous training and attention to detail when defining which, will both enable them to manage with these failings more effectively.

CASE REPORT:

A 81yr old female weighing 88 kg was admitted is a tertiary care hospital with the complain of left leg ulcer for 3 months, unable to wave properly and disturbed in sleep due to pain. Her immunization was complete and up to date and she had not received any vaccination prior to admission. On examination she was conscious with a normal body temperature and her blood pressure was found to be 130/ 80 mmhg. Systemic examination was noted. Abnormal laboratory finding revealed low hemoglobin 10.1g/dl (normal range 12 – 15 g\dl), Raised white cell count 6200L (normal range 4000 - 11000) blood sugar 121mg/ dl (normal range 80 – 140) blood urea is 34 (normal range 15 – 40). And other lab values was negative n normal within the range. Based on the symptoms and clinical findings, the physician diagnosed as diabetes mellitus, hypertension and the patient was treated with T. cardace 5mm OD, T. prazopress XL (5 mg) BD, T. seloken XC (50 mg) BD T. thyronorm (50 mcu) OD , T. ecosprin (75 mg) OD, T. istamet (50/500 mg) BD, T. amanly (2mg) OD, T. stiloz (50 mg) BD, T. vitc (1 tab) OD, T.folvite (5 mg) OD, syp dupalac (10 ml) OD , T.

pan (40 mg) OD , T. dolo (650 mg) SOS. The patient was advised to regular follow up for the medicine.

DISCUSSION:

While there's no invariant description of a drug error. The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as "any preventable event that may beget or lead to unhappy drug use or patient detriment while the drug is in the control of the healthcare professional, patient, or consumer. similar events may be related to professional practice, health care products, procedures, and systems, including defining; order communication; product labelling, packaging, and title; compounding; allocating; distribution; administration; education; monitoring; and use. " still, there's no extensively accepted invariant description. Unfortunately, untoward medical crimes and underreported drug crimes affect in significant morbidity and mortality.

Drug errors are most common at the ordering or defining stage. Typical crimes include the healthcare provider writing the wrong drug, the wrong route or cure, or the wrong frequency. These ordering crimes regard for nearly 50% of drug crimes. Data show that nurses and druggists identify anywhere from 30% to 70% of drug-ordering crimes. It's egregious that drug crimes are a pervasive problem, but the problem is preventable in almost cases.

Errors by pharmacists are usually judgmental or mechanical. Judgmental errors include failure to detect drug interactions, inadequate drug utilization review, inappropriate screening, failure to counsel the patient appropriately, and inappropriate monitoring. A mechanical error is a mistake in dispensing or preparing a prescription, such as administering an incorrect drug or dose, giving improper directions, or dispensing the incorrect dose, quantity, or strength.

CONCLUSION:

The roles of clinical pharmacist in this case report highlights the importance of avoiding over doses and drug error in the tertiary hospital prompt the proper dose of drugs and route of administration treatment with proper administration of drugs with correct doses avoiding the drug error in hospitals for the better life of the patients.

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