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A Case Report on Patient Following Prescribing and Administration Error

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Introduction:

Any avoidable circumstance that might result in improper pharmaceutical usage or patient injury when the medicine is under the healthcare provider's, patient's, or consumer's control is referred to as a medication error. Medication errors are frequent incidents in health care settings. Medication errors are the most common issue among medical professionals in different ways including Prescribing, intending, dispensing and administration errors. The main reason for medication errors was found to be poly-pharmacy and multiple co-morbidities such as hypertension, diabetes mellitus, dyslipidemia, cardiovascular, renal and hepatic diseases in geriatric patients. Anonymous selfreporting, incident reporting, critical incident method, chart review method, direct observation method etc can be adopted in to the system to monitor the medication errors. Patient education, prior approval, electronic technology like bar coding, electronic prescription records, E-prescribing, electronic Drug Utilisation Review, automated medication dispensing, and internal quality control procedures are just a few of the many ways that are available to prevent medication errors in various countries. The prevention and correction of administration error can be accomplished through patient counselling.[1]

The drug prescribing process is still based on handwritten medical chart entries. Several steps in this complex and unchecked process can lead to high frequency of errors. These undetected medication errors in patients' drug documentation may be a significant source of ADEs. Medication errors are common and can cause serious adverse effects and even death. Registered Nurses (RNs) are particularly exposed to the risk of committing medication errors since they are involved in the entire medication process and are usually the ultimate link within- patient.In the majority of hospitals across the world, medical chart entries are still made by hand to order

and administer medications. There are a number of processes in this intricate procedure that, if left unchecked, might result in frequent mistakes that are pertinent. These hidden prescription mistakes in patients' drug records might be a major contributor to adverse drug events (ADEs). It's typical for people to make medication mistakes, which can have fatal consequences. As the final connection between the patient and the pharmaceutical process, registered nurses (RNs) are particularly vulnerable to the danger of making medication mistakes. Mistakes with medications raise the expense of healthcare, lengthen hospital stays dramatically, and nearly double the chance of mortality. Lack of understanding of drug interactions is one of the readily discernible variables linked to high rates of medication mistakes.

Lack of drug information, incorrect diagnosis, drug-drug interactions, wrong dose calculations, incorrect drug administration, poor handwriting leading to error in drug orders, and external factors like interruption, work load, job-related stress, improper training, are some of the other most common causes of medication errors. [2]

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