



Medication Errors

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Medication error is one of the major causes of death in the world. According to a survey about 7000 in patients die of medication errors in USA annually. This figure speaks about the essentiality of preventing such unpredictable deaths. Therefore Drug administrative authorities and drug law enforcing wings of weveral governments are now concentrating on the prevention of such errors. Beforeing taking measures in controlling such deaths due to medication errors, it is necessary to analyse the problems and the causes of it.

Medication errors are unintended mistakes in in the prescribing, dispensing and administration of a medicine that could cause harm to a patient. They are the most common preventable cause of undesired adverse events in **medication** practice and presently a major public health burden.

Medication errors occur due to various causes. They occur not only due to wrong prescription but also includes wrong dispensing, administration, etc. Many factors can lead to medication errors. The Institute for Safe Medication Practices (ISMP) has identified 10 key elements with the greatest influence on medication use, noting that weaknesses in these can lead to medication errors. They are:

- Patient information
- Drug information
- Adequate communication
- Drug packaging, labeling, and nomenclature
- Medication storage, stock, standardization, and distribution
- Drug device acquisition, use, and monitoring
- Environmental factors
- Staff education and competency • patient education
- Quality processes and risk management

Avoiding Medication Errors:

There are several ways for safety way of drug administration. They can be listed as below:

- Right patient (using two identifiers)
- Right drug
- Right dosage
- Right time



- Right route
- Right reason for the drug
- Right documentation
- Right to refuse medication
- Right evaluation and monitoring

Steps to be taken to promote safe medication use include:

- ✓ Reading back and verifying medication orders given verbally or over the phone.
- ✓ Asking a colleague to double check your medications when giving high-alert drugs
- ✓ Using an oral syringe to administer oral or NG medications
- ✓ Assessing patients for drug allergies before giving new medications
- ✓ Becoming familiar with your facility's "do not use" list of abbreviations.