A Study on Quality Management Practices: Medication Errors

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INTRODUCTION

- Medication errors are unintended mistakes in prescribing, dispensing, and administration of medicines that could cause harm to a patient.
- These present a major public health problem.
- Such errors tend to decrease the patients' confidence in healthcare systems and increase healthcare costs.
- These may prolong the patients' hospital stay and also tend to increase the risk of death almost 2 fold.

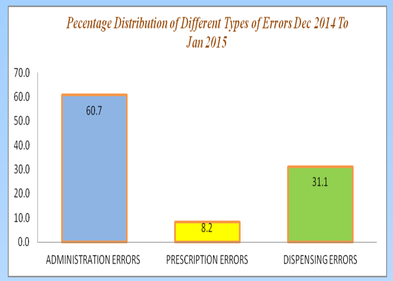
OBJECTIVES

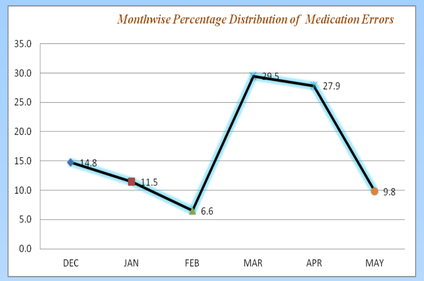
- To quantify the number of medication errors occurring in the hospital.
- To find out major causes that lead to errors in medication.
- To suggest a few measures to reduce the occurrence of errors in medication administration.

RESEARCH METHODOLOGY

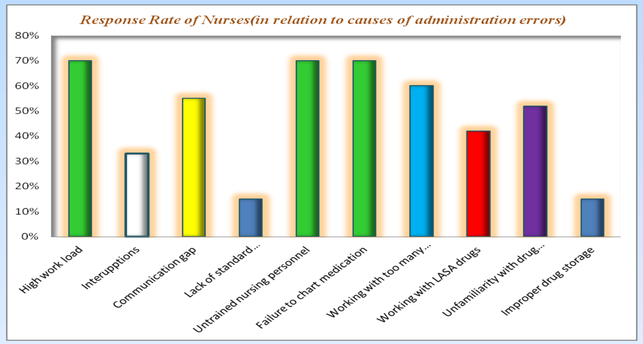
- A descriptive study has been carried in a 513- bedded tertiary care hospital from December 2014 to May 2015 .
- Study Subjects: 1) Nurses
  2) In-Patient Pharmacists
  3) Physicians
- Data Collection Tool: Self-Administered questionnaire

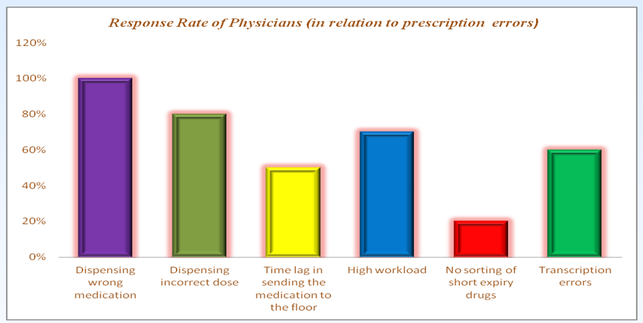
FINDINGS

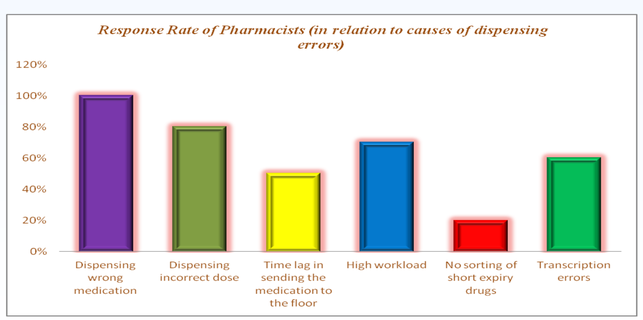




In order to find out the causes of medication errors in the hospital, questionnaires were filled by nurses , physicians & pharmacists , the findings of which are as under :







RECOMMENDATIONS

In order to reduce the frequency of occurrence of errors in the hospital, the following are some of the recommendations:

- Increasing nursing manpower
- Extending the training period for the new staff
- Making the culture of the hospital less punitive in nature
- Continuing education programs for doctors, nurses and pharmacists.
- Use of technology such as more advanced infusion devices , automated dispensing cabinets etc.
- Quality improvement programs should provide guidance for patient support, staff counseling and education, and risk management processes when a medication error is detected.
- Incident reporting policies and procedures and appropriate counselling, education, and intervention programs should be established.

CONCLUSION

While it is unrealistic to expect a zero error rate, a culture that supports identification and reporting of the adverse events is more likely to enhance the quality enhancement initiatives. Surveys and studies like the one described above can be helpful in providing a basis to begin discussions on bringing about an improvement in the system.