MONITORING OF PRESCRIPTION FOR PRESCRIPTION AND MEDICATION ERRORS AND CORRECTION THEREOF IN ONE OF THE MULTISPECIALITY, TERTIARYCARE TEACHING HOSPITAL OF MAHARASHTRA STATE, INDIA

Introduction:

A prescription (℞) is a health-care program implemented by a physician or other medical practitioner in the form of instructions that govern the plan of care for an individual patient. Prescriptions may include orders to be performed by a patient, caretaker, nurse, pharmacist or other therapist. Commonly, the term prescription is used to mean an order to take certain medications. Prescriptions have legal implications, as they may indicate that the prescriber takes responsibility for the clinical care of the patient and in particular for monitoring efficacy and safety. Prescriptions are handwritten on preprinted prescription forms that are assembled into pads, or alternatively printed onto similar forms using a computer printer or are in an electronic format. Both pharmacists and prescribers are regulated professions in most jurisdictions. A prescription as a communications mechanism between them is also regulated and is a legal document. Prescription is of particular interest to researchers because it is an aspect of the doctor/patient relationship which is easily quantified. It has been studied from economic, sociological, behavioral and therapeutic angles (Hamley J. G. et al. 1981). The issue of medication error and improvement efforts has been in pharmacy professional literature since at least the early 1969’s (Barker K. N. and Mc Connell W. E. 1962).

What Is A Prescription Error Exactly?

National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) defines a "medication error" as follows:

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use."
A useful brief definition of medical error is that “It is a preventable adverse event” (Govind Pander 2007). Medical error can also be defined as “The failure of planned action to be completed as intended or the use of a wrong plan to achieve an aim.

Prescription mistakes can be a few different things. If a doctor gives the patient the wrong drug to take it is considered prescription error. Or if the doctor gives the wrong dosage of a drug to take then it could also be consider prescription error. There are also these types of errors.

· Medications improperly prescribed so that they react unfavorably toward one another.
· When the drugs are not labeled properly.
· When the order is filed wrong.
· Improper knowledge of abbreviations on the drug.
· Illegible handwriting that cause miscommunication between dosage and drugs

The section on prescription writing in the British National Formulary advises that the dose of drug, frequency of administration, and other directions should preferably be stated in plain English without abbreviation (British National Formulary, 1986). It has been reported elsewhere that prescriptions are often written incorrectly by doctors and their receptionists (Georgy D. A. 1987).

Unfortunately prescription mistakes occur at a startling rate in the United States. There are about seven thousand related deaths that have been caused by prescription error. Not only do prescription mistakes put the adult patient at risk but also endangers children who are prescribed the medication. Children are at risk for injury and wrongful death more than adults because of their reduced size and weight. Since children weight significantly less than adults, dosage is very important when it comes to medication. It is estimated that one in every eighteen children are the victim of prescription mistakes. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a non-profit organization founded in 1951 set the standard to be met in global healthcare. JCAHO’s patient safety goals are as follows (Vijay Rao 2007):

1. Improve the accuracy of patient identification
2. Improve the effectiveness of communication among caregivers
3. Improve the safety of using medication
4. Reduce the risk of health care-associated infections
5. Accurately and completely reconcile medications across the continuum of care
6. Reduce the risk of patient harm resulting from falls

However, many error are minor, some medication errors those associated with morbidity and mortality increase health care cost and can be a source of litigation. So reducing the problem of medication error requires vigilance at many levels in health care system. Medication error must not be taken lightly and effective system for ordering, dispensing and administering medication should be established with safeguard to prevent the occurrence of error. Thus pharmacist mission is to help ensure that patient make the best use of medication and should take the lead in multidisciplinary, assertive programs design to prevent medication error. The more effectively there do so; the more lives will be saved.

**Types of Errors** (Ronald G. Neville et al. 1989):

Prescription errors are broadly classified in following four types.

**Type A: 'potentially serious to patient'**
The prescription would be dangerous to the patient if dispensed. For example, dose of cardiac drug wrong by a factor of 10; confusion of handwriting between chlorpromazine or chlorpropamide.

**Type B: 'major nuisance'**.
The pharmacist has to contact the prescriber in order to dispense the prescription. Patient, doctor and pharmacist are thus all inconvenienced. For example, phenytoin prescriptions which omit to mention whether capsules or tablets.

**Type C: 'minor nuisance'**
The pharmacist has to make a professional decision before dispensing, although is able to do so describe without contacting the prescriber. This is annoying for pharmacists and can cause slight delays to patients. For example wrong pack size of dermatological preparation.

**Type D: 'trivial'**
The prescription does not strictly conform to the guidelines in the British national formulary although the prescriber's intentions are not in doubt. For example liquids instead of gel with antacid preparations.
What Are Ways to Prevent Errors?

Doctors are able to use standards when they prescribe medicine. These standards are called the five R’s (Rita Shane 2009) which helps doctors give out the right medications to the right people.

- Right medication
- Right dosage
- Right patient
- Right time
- Right route

It is estimated that nine out of ten prescription mistakes are preventable. If that many prescription mistakes are being made then it is an injustice to the patient, who is expecting the safe medical care they are paying for. If you have been the victim of medical error and pharmaceutical error then you may be entitled to compensation for your pain and suffering. Prescription error is considered a form of medical malpractice because it is due to the negligence of your doctor.