

Reduced medication error due to revised strategy for prescription audit in tertiary care hospitals

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Medication error is unwanted, unintended and preventable event occurs while Prescription, Transcription, Indenting, Dispensing, Administration, Storage and Documentation of Medication while under the observation of healthcare professionals.

The burdens of MEs on the health system are significant. It is observe that Deaths occurring due to MEs in the Worldwide, which is greater than deaths due to breast cancer, road traffic accidents, and acquired immune deficiency syndrome. MEs lead to longer hospital stays and greater healthcare spending.

In tertiary care hospital there is need to build up a strong medication management system and prescription audit process. To reduce the medication error in hospital set up need clinical pharmacist team, who is going to report and analyzed the medication errors monthly.

Process contained some points as follows:

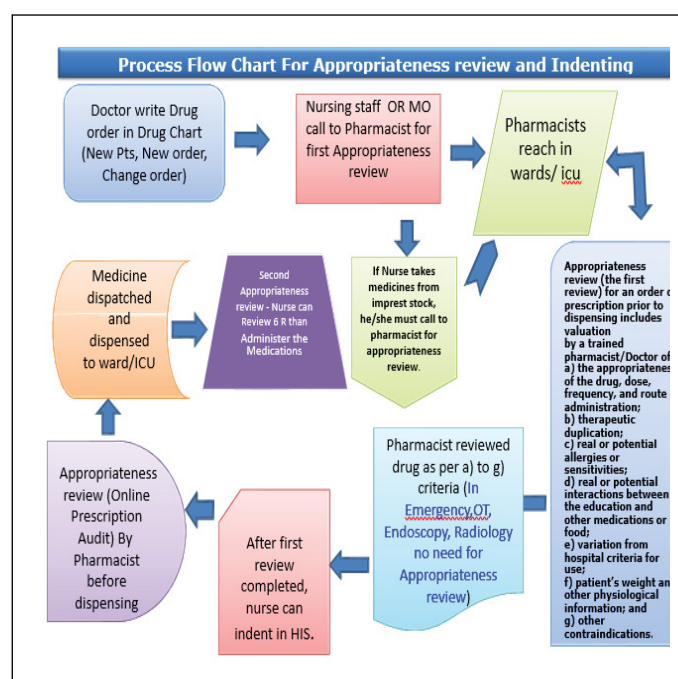
- 1) Online pharmacist for 24 x 7.
- 2) Target for 100% medication reconciliation with PAT verification.
- 3) Revised process for appropriateness review.
- 4) Ward pharmacist with CUG number.
- 5) Telephonic intimation and text messages for ward pharmacist for new admission, new or change in prescription, discharge patients.
- 6) Restriction for nursing to indent medicine before PAT (Prescription Audit Team) verification.
- 7) Pharmacist ward round with consultant.

Trend of type C medication error analysis before and after implementing new strategies for PAT verification was seen significant. In revised strategy online clinical pharmacist for solved query and guide nursing for administration dose on telephonic conversation, 100% medication reconciliation for new admission and transfer patient with PAT verification, on-call clinical pharmacist for auditing new prescription or change in prescription.

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