

# MEDICATION SAFETY AMONG IN-PATIENTS – A WARD BASED STUDY

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Medication safety is important to ensure patient safety. Medication errors happen when prescribing, transcribing, dispensing and administering of drugs. This study was carried out to assess the occurrence of prescribing and some selected drug administration errors among in-ward patients.

A descriptive cross sectional study was conducted among in-ward patients at a selected base hospital in Sri Lanka. Participants were selected randomly from two medical wards. Data was collected from the latest inward prescription. Medication history and clinic records were other sources of information. Additionally, drug charts were matched with the prescription to assess if drugs were administered as instructed by prescribers. The total number of prescriptions was used as the denominator for calculating percentages.

Four hundred prescriptions which included 2182 drugs were analyzed. There were 237 men and 163 patients women. The mean (standard deviation) number of drugs per prescription was 5.5 (3.0). One or more errors were observed in 146 (36.5%) prescriptions. There were 134 (33.5%) prescribing errors and 12 (3%) drug administration errors. Most of the prescribing errors were related to wrong frequency 41 (10.2%), duplication of drugs 40 (10%), drug omissions 17 (4.2%) and unacceptable drug combinations 24 (6%). The 12 drug administration errors mostly included wrong frequency errors 7 (1.7%).

Prescribing and drug administration errors happen in hospitals and this may affect patient safety. Healthcare professionals should be made aware of this danger and the healthcare system should be improved to minimize these medication errors.