"IDENTIFY THE FACTORS OF MEDICATION ERROR AMONG PATIENTS IN FIC HOSPITAL FAISALABAD"

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ABSTRACT: In the present medicinal services setting persistent wellbeing and counteractive action is one of the fundamental pointers of social insurance administrations. Patients' wellbeing is controlled by medical attendants' part in the clinic since they are bleeding edge People and more familiar bedside nursing care than some other wellbeing work force in the healing center. Prescription is a mind boggling procedure and it includes the patient and the human services experts at different levels. There are a few inclining variables for the event of solution mistakes beginning from ill-advised medication choice to blunders in organization strategy by the medicinal services suppliers. A few strategies can be utilized to identify the event of mistakes. Medicine mistakes are basic in Emergency, Operation theatres and ICU (pubmed, 2013). 2-In healing facilities, pharmaceutical blunders happen at a rate of around one for each patient for every day (AJHP, 2016). The Study is to "Recognize THE FACTORS OF MEDICATION ERROR AMONG PATIENTS IN FIC HOSPITAL FAISALABAD" The motivation behind this review is to keep patients from drug blunder and their consequences for strength of the patients and medical caretakers will likewise realize that how they can enhance their nature of care of nursing. A Quantitative cross sectional review configuration would be utilized to answer the distinguished inquiries with respect to this review which was set up by me to recognize the issue as indicated by title of venture. The information dissected utilizing SPSS variant 16. Clear measurements would be performed to break down information.

Key words: Identify, factors, medication errors, patients, nurse, improve knowledge and practice.

INTRODUCTION

Solution is an intricate procedure and it includes the patient and the social insurance experts at different levels. Avoidance of pharmaceutical blunders is vital in any case, mistakes may happen even in a painstakingly observed social insurance setup. The drug blunders extend from gentle to harmful responses. 1- There are a few inclining elements for the event of prescription blunders beginning from uncalled for medication determination to mistakes in organization method by the human services suppliers. A few techniques can be utilized to identify the event of mistakes. Prescription mistake are regular in Emergency, Operation theater and ICU. 2-In doctor's facilities, prescription blunders happen at a rate of around one for every patient for every day. An apportioning blunder is one made by drug store staff while appropriating prescriptions to nursing units. A couple of components that impact on nature of care in center and it is indispensable to recognize those components and how they impact on nature of care are in like manner astoundingly major. (1)Over weight of work in view of over-loading of Patients it is the major influencing segment on nature of care in social protection structure generally government mending focuses are over-weight with patients and the center and workplaces are less than the need. In view of these patients and what's more staffs are moreover persisting burden since they can't manage legitimate solution as per privileges of the patients.

Material and Method

Research Design :The design of the study was cross sectional study.

Research tool:Research tool was self made questionnaire.

Sampling technique:Convenient sampling was used for this study.

Target population:My target population was nurses of FIC hospital Faisalabad.

Inclusion criteria:Charge nurses and head nurses FIC hospital Faisalabad.

Exclusion criteria:Pharmacist, doctors, paramedics

Sample Size: Total nurses is included which are 114 (100%)

Results

Out of the 114 , 23(20.2%) say yes ,91(71.8%) say no to see incidence in their carrier in 2017,22(19.3%)say yes to face medication error ,92(80.7%)say no ,112(98.2%) say yes to when the nurse proper not checked the patient name band 2(1.8%) say no,111(97.4%) say yes to when physician writing difficult to read 3(2.6%) say no,112(98.2%) say yes to medicine labels are in poor writing and damaged2(1.8%) say no,114(100%) say yes to confusion between two same drugs name 0%say no,114(100%) say yes to when physician prescribe the wrong dose on file (0%) say no,113(99.1%) say yes to when nurse calculate the wrong dose 1(0.9%) say no to it,112(98.2%) say yes to nurses are exhausted due to overloading 2(1.8%) say no,110(96.5%) say yes to shortage of nurses and other staff 4(3.5%) say no, 110(96.5%) say yes (nurse) always follow the rights of medicine 4(3.5%) say no,114(100%) say yes to rights you not followed 0% say no,114(100%) say yes to Right patient follow 0% say no,113(99.1%) say yes to Right name 1(0.9%) say no,113(99.1%) say yes to Right dose 1(0.9%) say no,113(99.1%) say yes to Right time 1(0.9%) say no,111(97.4%) say yes to Right route 3(2.6%) say no,32(37.5%) say yes incidence occur have you inform to physician 77(67%) say no,11(9.6%) say yes to report of medication error entered and submitted to higher authority 103(90.4%) say no,7(6.1%) suggestion regarding medication error minimization 107(93.9%) not given,

Conclusion

Blunders and blames in recommending are preventable. Mediation methodologies ought to be principally centered around instruction and the production of a sheltered and helpful workplace, to fortify frameworks and limit damage to the patient. Frameworks arranged intercessions increment familiarity with hazard among social insurance staff. Mediations gone for enhancing learning and preparing, and diminish mistakes, and the presentation of strict input control and checking frameworks are profoundly prudent. In any case, extensive scale data on the gainful impacts of mediations gone for decreasing mischief from endorsing deficiencies and medicine mistakes is not yet accessible and is required.

Suggestion

- To reduce medication error take some necessary action increase the man power proper,
- Training of nurses and other relevant staff
- Computerized medicine prescription system develops in hospitals,
- General safety strategies and safety system design strategies for improving patient safety
- Implementation of processes, policies, and rules to improve use in healthcare organizations.
- Establish error recovery processes that make it easy to recover or back out if a wrong action is taken.
- Similar overall strategies are also the basic foundations of many recommendations to reduce errors related to medication use in healthcare organizations.(medscape, 2000)

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