



How Do Medication Errors Occur?

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DESCRIPTION

Dosing errors are defined as avoidable dosing misuse. These errors can occur at any point in the process, including drug ordering, posting, dispensing, administration, and monitoring. Some errors result from psychologist James Reason describing it as an unsafe act. This is an action that violates a policy or procedure but can be done to save time. Dosing mistakes may or may not have serious consequences. Some dosing mistakes change a patient's outcome, but the change is harmless. Other dosing mistakes can cause damage, but they do not. However, serious un-captured dosing mistakes actually harm the patient. In one study, it is estimated that 30% of patients with drug-related injuries died or were disabled for more than 6 months. Like dosing errors, ADE can occur at any stage of the dosing process. In theory, all dosing mistakes can be avoided. The same is not true for ADE. Avoidable ADRs could have been avoided if appropriate and reasonable measures were taken. For example, an anaphylactic response to penicillin is a preventable ADE if the patient's allergy to penicillin is recorded in medical records, or if the patient can recognize and inform the doctor of a previous penicillin response. However, an allergic reaction to penicillin in patients who are unaware of their allergy to penicillin will be an unavoidable side effect.

Providing medication to patients by healthcare providers is a complex process. Errors can occur at every step along the way, from prescribing to the final delivery of the drug to the patient. The most common causes of dosing mistakes are misdiagnosis, prescribing mistakes, dosing mistakes, inadequate drug dispensing practices, drug and drug device related problems, improper drug administration, communication failures and lack of education in patients.

One of the biggest cause for drug alteration is the drug that was misprescribed. Patient deaths are increasing due to drug errors. For example, 198,000 in 1995 to 218,000 in 2000.

Avoidable errors occur because the system for safely prescribing and ordering medicines is not used properly.

- A widely recognized source of errors is unreadable handwritten prescriptions.
- The error may be due to inadequate or missing information on co-prescribed medications, previous dose-response relationships, laboratory values, and allergic susceptibility.

- Prescribing mistakes can occur if the wrong drug or dose is selected, or if the regimen is too complex.
- Similar names can lead to errors when communicating recipes verbally.
- Similarly, if the prescription is handwritten, a drug with a similar name can be mistakenly dispensed.
- Errors can occur because the prescription is not submitted to the pharmacy or the patient does not fill out the prescription.
- Physician sampling of drugs can cause drug errors due to lack of both proper documentation and verification of drug use.

The term dispensing error refers to a medication error associated with dispensing a drug by a pharmacy or healthcare professional. These include order errors (e.g., wrong drug dispensing, wrong dosage, or wrong input to the computer system) and omission errors (e.g., patient counseling failures, interaction checks, or labels. Ambiguous words) are included. Errors may be detected and corrected before the drug is given to the patient. Most common dispensing errors are dispensing the wrong drug, dose intensity, or dosage form.

Errors in drug administration can be caused by the healthcare provider or the patient himself. Many of the problems with drug delivery are due to false communication. Patients are often unaware that mistakes can occur often and do not play a positive role in understanding, what is being communicated to them.

Errors are most common when communication is unclear with respect to the following:

The name of the drug, the appearance of the drug, why the patient is taking the drug, the amount and frequency of taking the drug, and the best time to take it, time to take, what side effects may occur, what to do if you miss a dose, common drug or food interactions, and whether this new drug will replace another treatment. Complementing is common. Over-the-counter medications can lead to medication errors because the label may not be read or understood properly and is often unnoticed by the healthcare provider when the patient is taking the over-the-counter medication. The types of errors above are primarily commission errors. There are also dropout errors, such as not

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taking the prescribed medication or not taking the medication on time. It is much more difficult to identify with a systematic reporting tool, but dropout errors must also be addressed through process improvement efforts to truly improve patient safety comprehensively.