



## Medication Safety and Prevention of Medication Errors

James Abernathy\*

Department of Nursing and Allied Health, Swinburne University of Technology, Hawthorn, Australia

### DESCRIPTION

Dosing errors are often categorized into different types to help report medication errors and identify the root cause of the errors to take steps to prevent future errors. The American Society of Health-System Pharmacists (ASHSP) prescribes, omits (orders un-administered drugs), timing, use of unauthorized drugs (not permitted by legitimate prescribers), incorrect dosages, incorrect doses. Dosage errors are characterized by categories such as dosage form and incorrect. Drug preparation, improper administration techniques, degraded drugs (expired drugs), and monitoring (failure to use experimental data to monitor toxicity).

Dosing mistakes are rarely blamed on a single person, are generally interdisciplinary and multifactorial, and the complexity of the dosing process, including the five core steps of dosing prescribing, order processing, dispensing, administration, and monitoring. It reflects. Evaluating the root cause of a dosing error is important for implementing changes to the dosing delivery system that can prevent the same error from occurring in the future.

Dosing errors are preventable errors that can occur in different scenarios by many different healthcare professionals, including:

- A pharmacist mislabels a medication
- A doctor prescribes the wrong medication or an incorrect dosage
- A nurse administers the wrong medication or incorrect dosage
- A doctor fails to take drug interactions into account when prescribing a new medication
- A doctor fails to review a patient's allergies when prescribing a new medication
- A medical professional fails to warn a patient of potential side effects when prescribing a new medication

In addition, it is important to note that dosing mistakes can occur throughout the patient's medical care and are not unique

to home prescription drugs. Errors can also occur with chemotherapeutic drugs and other medications.

In recent years, new technologies have been introduced to eliminate dosing errors in the healthcare market, such as electronic ordering and charting, bar coding to match patients to medical records, and computerized dosing distribution. Although these methods have shown to be promising, the rate of dosing mistakes remains high.

For nurses, dosing mistakes are an emotional traumatic experience that undermines self-esteem and self-confidence to function in the workplace. Jones and the driver used a quantitative and qualitative questionnaire to interview 202 nurses. 158 people reported dosing mistakes. Qualitative data analysis revealed multiple themes. For example, when making mistakes, nurses are worried about being depressed, guilty, embarrassed, regretted, providing safe care, and violating patient trust. A nurse involved in a dosing mistake experiences moral distress and wants to stop nursing practice.

There are steps we can take to avoid dosing mistakes, but if our doctor, nurse, pharmacist, or other health care professional makes a mistake, here's what we need to do:

1. Get medical attention. Drugs can be dangerous. It is especially important to find a doctor who can solve the problem if the bug further injures or worsens the condition.
2. Document the receipt. Keep a vial of the given medicine; get a copy of our medical records and prescription.

Dosing errors usually result from a combination of human error and system defects. Pharmacists, pharmaceutical companies, information systems (hardware/software, staff), and hospital staff can help reduce dosing mistakes. The American Academy of Orthopaedic Surgeons (AAOS) understands that mistakes are human and supports the establishment of non-disciplinary reporting systems to develop and encourage processes and systems that can detect mistakes before they cause harm.

**Correspondence to:** James Abernathy, Department of Nursing and Allied Health, Swinburne University of Technology, Hawthorn, Australia, E-mail: abernathyja@mes.au

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