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Medication administration error pdf

The error of medication is a failure in the treatment process that leads to, or has the potential to cause harm to the patient. Medication errors may occur when deciding which medications and dosage regimen (prescribing flaws-irrational, inappropriate, and ineffective prescribing, underrepresentation, overprescribing); Writing a recipe (recipe errors); production of formulation (incorrect strength, contaminants or adultery, incorrect or misleading packaging); issuance of the wording (wrong drug, incorrect wording, incorrect label); introduction or taking of medication (wrong dose, wrong route, wrong frequency, wrong duration); monitoring therapy (failure to change therapy when necessary, erroneous change). They can be classified using a psychological classification of errors as errors based on knowledge, rules, actions and memory. Although medication errors can sometimes be serious, they are usually not so and often trivial. However, it is important to detect them, as system failures that lead to minor errors can subsequently lead to serious errors. The message of error should be encouraged by creating an environment free of guilt, not punitive. Errors in appointment include irrational, inappropriate and ineffective appointments, underpresimation and over-prescribing (collectively called prescription errors) and errors in prescription writing (including promiscuity). How to avoid medication errors is essential in a balanced prescribing, which is the use of a medication that is suitable for the patient's condition and, within the created uncertainty, which is present therapeutic solutions, in a dosage regimen that optimizes the balance of benefits for harm. When the mechanism of action should be treated with a balanced mechanism of action, it is necessary to refer to the pathophysiology of the disease. In 2000, a panel of experts examining adverse events in the NHS, chaired by the Chief Medical Officer, reported that since 1985 there had been at least 13 episodes in which people (usually children) had been killed or paralysed by improper injection of spinal drugs; 12 used liquor alkaloids; 10 were fatal.1 Serious medication errors are rare, but it is beneficial that it took so long to recognize that corrective action was needed in this case.2 Despite this, this error continues to be made.3 Some basic definition of medication (drug product) is a product that contains a compound with proven biological effect, as well as excipients or excipients only; It can also contain contaminants; active compound, usually a drug or but there may be a cellular element.4A codicil to this definition provides that the medicinal product is one that is intended to be taken or injected by a person or animal for one or more of the following reasons: as a placebo; To prevent the disease; To make a diagnosis; To test on Negative effect; Change physiological, biochemical or anatomical function or anomaly; Replace the missing factor To improve the symptom; To treat the disease; to induce anesthesia. Medication (process) is an act of providing medication (object) to the patient for any of these purposes. This definition reminds us of the difference between the drug (active component) and the entire product, which also contains supposedly inactive excipients. The definition of a drug includes not only chemical compounds - drugs that are not pharmacological in themselves), stereoisomers that can only have adverse effects, or compounds that are used for diagnostic purposes (e.g. contrast media); it also includes cellular elements such as inactivated or faded viruses for immunization, blood products (such as platelets), gene therapy viruses and embryonic stem cells; Contaminants include chemical and biological pollutants and adultery, the first of which is accidentally present the latter intentionally added. Although the definition covers a wide range of compounds, it does not include medications when used for sensing systems for non-diagnostic purposes, such as the use of phenylephrine to study baroreceptor reflexes in a physiological or pharmacological experiment. Error Error Is Something Wrong Done Through Ignorance or Indiscretion; error, for example, in calculation, judgment, speech, writing, action, etc. '5 or ' failure to complete the planned action as intended, or the use of the wrong action plan to achieve a given goal'.6 Other definitions have been published.7 Error of medication Given these definitions, the drug error can be defined as a failure in the treatment process that leads to, or has the potential to cause, harm to the patient'.8.9 'the treatment process' includes all medications, as defined above. Mistakes in medicines can occur in: the choice of medication - irrational, inappropriate and ineffective appointment, under-representation and overprohrepresentation; Writing prescription errors, including promiscuity; The manufacture of the formulation used is incorrect strength, contaminants or adultery, incorrect or misleading packaging; refusal of wording - wrong drug, incorrect wording, incorrect labeling; The introduction or taking of the drug - the wrong dose, the wrong route, the wrong frequency, the wrong duration; mistaken change. The term failure in definition implies that certain standards must be set to judge failure. Anyone who deals with medicines should establish or be familiar with such They must take or comply with measures to ensure that non-compliance does not occur or is unlikely. Everyone involved in the the process is responsible for its part of the process. Adverse events and adverse reactions of the drug Adverse event is any abnormal symptom, symptom or laboratory test, or any abnormal combination of such abnormalities, any adverse or unplanned occurrence (e.g. accident or unplanned pregnancy), or any unexpected deterioration of simultaneous illness'.4 If an adverse event occurs while a person is taking the drug, it may be an adverse drug reaction (ADR). The term adverse drug event is sometimes used to describe this, but it is a bad term and should be avoided.4 If an adverse event is not related to the drug, it remains an adverse event; if it could be related to drugs he becomes a suspect ADR. ADR is a palpably harmful or unpleasant reaction as a result of an intervention associated with the use of a medicinal product'.4. Some drug errors lead to ADRs, but many don't; sometimes a drug error can lead to an unfavorable event that is not ADR (e.g. when a cannula penetrates the blood vessel and results from a hematoma). The overlap between adverse events, ADRs and drug errors is illustrated in Venn's chart on Figure 1.8 Open in a new tabDownload slideA Venn chart showing the link between adverse events, ADRs and drug errors; Box sizes do not reflect the relative frequencies of illustrated events (Reproduced from link 8, with permission of Wolters Kluwer Health/Adis ©, Adis Data Information BV (2006); All rights are reserved). The frequency and results of drug errors The exact frequency of medication errors is not known. The detection method may affect the estimated frequency.10 Most errors probably go unnoticed (iceberg error11); of those that are found minorities actually lead to ADRs, or at least serious. For example, in a UK hospital study of 36,200 prescriptions for medicines, error appointments were found at 1.5% and most (54%) were found to be a medical error. were associated with the choice of dose; errors were potentially serious in 0.4%.12 In a survey of 40,000 drug errors in 173 hospital trusts in England and Wales in the 12 months to July 2006, in a U.S. study ~, 1.7% of prescriptions from community pharmacies contained errors.14 Since ~3 billion prescriptions are issued each year in the U.S. ~50 million will contain errors. Of these, only ~0.1% are considered clinically important, which gives an annual rate of about 50,000 errors. Incorrect label information and instructions were the most common types of errors. However, it is important to detect errors whether it is important or not, as it can reveal a failure in the treatment process that may otherwise lead to harm. There is also evidence that death from the errors the medication increases. From 1983 to 1993, the number of deaths from drug errors and adverse drug reactions, Use in U.S. hospitals increased from 2,876 to 739,115, and from 1990 to 2000, the annual number of drug bug deaths in the UK increased from about 20 to just under 200.16 This increase is not surprising - in recent years hospitals have seen an increase in patient capacity , there are new drugs that are increasingly difficult to use safely and effectively, medical care has become more complex and specialized, and the population grow old, factors that tend to increase the risk of medication errors.17 When errors are detected, they can cause great discontent. According to a 2000 report citing British health protection organizations, 1 25% of all legal action in general medical practice was caused by errors in medicines and related to the following errors: prescribing and issuing errors (including incorrect, contraception or unlicensed drug, improper dosage or improper administration); Re-appointment without proper checks inability to control progress and pre-predict adverse effects (which, however, cannot be considered a drug error). Types of medication error and prevention Are the best way to understand how medication mistakes happen and how to avoid them, to consider their classifications that may be contextual, modal or psychological. Contextual classification relates to the specific time, place, medicine and people involved. Modal classification considers ways of causing errors (e.g. by omission, repetition, or substitution). Preference is given to psychological classification because it explains events rather than simply describing them. Its disadvantage is that it focuses on human rather than systemic sources of error. The following psychological classification is based on the work of Reason on errors in general.18 There are four broad types of drug errors (marked 1-4 in figure 2).8Inyng based on errors (due to lack of knowledge) - for example, providing penicillin, it is not established whether the patient is allergic. In an Australian study, communication problems with senior staff and difficulties in accessing relevant information about doping contributed to knowledge-based errors.19 These types of errors should be avoided by being well-informed about the capital drug and the patient to whom it is given. Computerized prescribing systems, barcode drug systems, and cross-checking by others (such as pharmacists and nurses) can help intercept such errors.21Open in the new tabDownload slideA classification of types of drug errors based on psychological principles. For examples of prescription errors in category see text and table 1 (Reproduced from link 8, with permission Wolters Kluwer Healthcare / Adis ©, Adis Data Information BV (2006); All rights are reserved). Rule-based errors (using a bad rule or applying a good rule incorrectly) such as injecting a diclofenak into the side of the thigh rather than the buttocks. Appropriate rules and education help avoid such mistakes, as do computerized destination systems. Action-based errors (so-called receipts) - for example, picking up a bottle containing diazepam from the pharmacy shelf when intending to take one of them containing diltiazem. In the Australian study mentioned above, most of the errors were due to a slip in attention that occurred during routine prescribing, dosing or administering drugs. They can be minimized by creating an environment in which they are unlikely (e.g. avoiding distractions, by cross-checking, by clearly labeling drugs and using identifiers such as barcodes);22 the so-called Tall Man inscriptions (mixing the letters top and bottom in the same word) were proposed as a way to avoid incorrect labeling,23, but this method was not tested in real terms. A subset of action-based errors is a technical error, such as putting the wrong amount of potassium chloride in an infusion bottle. This type of error can be prevented with checklists, secure systems, and computerized reminders. Memory-based errors (so-called omissions) - for example, providing penicillin, knowing that the patient is allergic but forgetting. They are hard to avoid; they can be intercepted by computerized destination systems and cross-checked. For some examples of recipe errors, see Table 1. Examples of other types of drug errors in the same headlines are listed in Help 8. Table 1Signs prescribing faults and prescription errors Type errors. Example. Result. . Knowledge based Being unaware of the interaction between warfarin and erythromycin warfarin toxicity Rule based on the appointment of oral treatment in a patient with lung dysphagia aspiration or inability to treat actions based on distractions, Writing diazepam for diltiazem Sedation Technical letter is inaudible, so that Panadol (paracetamol) is distributed instead of Priadel (lithium) Loss of the Memory Effect based on Forgetting to specify the maximum daily dose for how to require drug poisoning or unnecessary treatment of hidden factors (knowledge and rules based on errors), slips (actions based on errors) and omissions (mistakes based on memory) were named There are several properties of systems (so-called hidden factors that make prescribers susceptible to errors. There is an increased risk of errors in nurses' medications.24 Among doctors, depression and exhaustion are essential.25.26 Mistakes are most likely to occur When tasks are performed within hours of busy, distracted staff, often in relation to unfamiliar patients.19 There is a particular risk of errors when doctors first arrive at the hospital, due to deficiencies in their knowledge16 and presumably also because they are not familiar with local prescription cards and other systems. Improving education and working conditions, including improved induction processes, should reduce the risk of errors associated with these factors; The national form of the recipe will help. Detection and error reporting One difficulty in detecting errors is that those who make them afraid of disciplinary procedures and do not want to report them.27 Creating an unadad, unadad environment can be a snocking this.28 Error report, including near misses, should be encouraged by using error reports to identify areas of the most similar incidents and to simplify and standardize steps in the treatment process. However, some voluntary reporting systems for medical errors have limited usefulness, as reports often lack detailed information and are under-reported and underreported.29 The drug error reporting system should be readily available, with clear information on how to report drug errors, and reporting should be followed by feedback; Detection can be improved by a combination of methods.30 Appointment malfunctions and prescription errors errors in appointment can be divided into irrational appointments, inappropriate appointments, ineffective appointments, underrepresentation and overprescribing, and prescription errors. The inadequacy of the term error to describe it all is obvious. The inability to prescribe an anticoagulant to the patient in whom it is indicated (under-prescribing) or the appointment of one when it is not specified (reprecation) are different types of errors from errors that are made when writing a prescription. Therefore, I prefer to use the terms appointment of errors and prescription errors.9 The term appointment of errors ambiguously covers both types. The purpose of errors by the Irrational and inappropriate purpose of 'Rational' is defined in the Oxford English Dictionary as based on, derived from, reason or reasoning and appropriate as specially adapted or appropriate, correct '5 One might expect a rational destination to be appropriate, but this is not always the case. A rational approach can lead to a misappropriation if it is based on missing or incorrect information. If, for example, one does not know that the other prescriber has already prescribed paracetamol unsuccessfully for headaches, the prescription for paracetamol may be rational but inappropriate. Consider an example from my own practice.31 a woman with Liddle syndrome is presented with severe symptomatic hypocalcemia. Her reasoned as follows: she has potassium exhaustion; - Spironolacone is a potassium-sparing drug; - Spironolacton will lead it to the preservation of potassium; - its concentration of potassium in the serum is normalized. Her doctor had to reason as follows: - she had potassium depletion due to Liddle syndrome, channelopathy, which affects the epithelial channels of sodium; - there is a choice of potassium sparing drugs; -spironolacone acts through the receptors of aldosterone, amyloride and triamterene through sodium channels; - Liddle syndrome requires action through sodium channels. This highlights the importance of understanding the link between the pathophysiology of the problem and the mechanism of action of the drug (see below). Ineffective prescribing Ineffective prescribing is the prescribing of a drug that is not effective for specifying in general or for a particular patient; it differs from under-representation (see below). In a study of 212 patients, 6% of the 1,621 medications were rated as ineffective.32 Of the 196 U.S. out-of-age patients age 65 and older who were taking five or more medications, 112 (57%) said. Take drugs that were ineffective, unspecified, or duplicative.33 And in a Scottish study, 49% of general practice prescribed homeopathic remedies, 5% of practices that accounted for 50% of remedies prescribed.34One would expect ineffective prescribing to be minimized by guidelines, but there is conflicting evidence; Prescribing guidelines may be ineffective if not accompanied by education or financial incentives.35 Underreceiving underpressis is an inability to prescribe a drug that is specified and appropriate, or the use of too low a dose of the drug. The true extent of under-representation is not known, but there is evidence of significant under-representation of some effective treatments, such as angiotensin enzyme conversion inhibitors for patients with heart failure36 and statins for hyperlipidemia.37 Sources of undertreatment include fear of side effects or interactions, inability to recognize therapy, and doubts about likely efficacy. Cost can play part.38 There is a tendency to avoid treatment in older people.39.40, and this can lead to undesirable consequences.28 including the so-called mismatch of risk-treatment, in which those who are most at risk are less aggressively treated, an effect that may be partly associated with age.41 However, other factors may contribute to this type of inconsistency, such as distraction from concomitant diseases. to harm the balance and reluctance to pursue or exacerbate polypharmacy.42B attitudes of under-representation to polypharmaceutical in 150 elderly patients, the likelihood of under-prescribing significantly increased with the prescribed number of drugs.43 This led to the abandonment of the use of adrenoceptor antagonists after myocardial infarction, ACE inhibitors for heart failure, anticoagulants in atrial fibrillation and bisphosphonates in osteoporosis. Overprescribing Overprescribing is an prescribing drug at too high a dosage (too much, too often or too long). In some cases, treatment is not required at all. For example, among hospital patients who received a proton pump treatment inhibitor it was indicated only half.44 Polypharmacy, defined as the use of five or more drugs, occurs in 10% of people over the age of 65 in the UK.45 And although not all polypharmacy is inappropriate, some undoubtedly lead to ADRs and drug interactions. The overuse of antibiotics is well known and much discussed. A systematic review of 55 studies showed that no strategy or combination of strategies was better than any other and none of them was highly effective, although the authors singled out active clinicians' education as a strategy for continuing.47In the Spanish language study, those who were repurposed were more likely to be in rural practice, further away from specialized centres, caring for children without postgraduate education and part-time or part-time work. , Doctors' income may have effect.49 Prescription errors All the factors that lead to drug errors generally contribute to prescription errors. These include a lack of knowledge, using the wrong drug name, dosage form, or abbreviation, and incorrect dosage calculations.50 In a U.S. study of about 900 drug errors in children, ~30% had prescription errors, 25% were dosing errors and 40% were administration errors.51 In one study the most common form of prescription error was writing the wrong dose.12 In six Oxford hospitals the most common errors on prescription charts were spelling the patient's name and incorrectly writing the wrong dose.12 In six Oxford hospitals the most common errors in prescriptions were the name written. 12 In six Oxford hospitals, the most common errors on prescription cards were the patient's name and incorrectly wrote the wrong dose. that together made up ~50% of all errors.16 In the hospital study of 192 prescription cards, only 7% were correctly filled; 79% had errors that posed minor potential health risks and 14% had errors that could have caused serious harm.52Table 1 lists some examples of prescribing faults and prescription errors under the headlines of four types of errors. Remedies Above. The principle of hedgehog and balanced appointment The main obstacle to rational, proper and effective appointment is the inability to apply what I call the hedgehog principle. The Greek poet Archiloch (seventh century BC) wrote that the fox knows many things, hedgehog is one big thing. What he meant is not clear, since the text is fragmentary, but Isaiah Berlin suggested that it could be construed as as between those who associate everything with a single central vision of hedgehogs, and those who pursue many of the fox goals. 53 As a prescriber I am a hedgehog, and one big idea to which I subscribe is the need to marry the mechanism of action of the drug to the pathophysiology of the disease. The use of amyloid to treat hypocalcemia in Liddle syndrome (as described above) is a perfect example of this principle. If in addition, one draws attention to the balance of benefit and harm, one achieves a balanced prescription, is defined as the use of a medication that is appropriate for the patient's condition and, within the limits created by the uncertainty that attends therapeutic decisions, in a dosage regimen that optimizes the balance of benefits for harm.54 Note that this definition includes two components of the principle of hedgehog: disease and medication. Achieving a balanced prescription Nine questions should be asked before writing a prescription (adapted from the index of appropriate medication55.56): Indication: is there an indication of the drug? Effectiveness: Is the drug effective for the condition? Diseases: Are there important co-morbidities that can affect the reaction to the drug? Other similar drugs: the patient is already taking another drug with the same effect? Interactions: exist clinically important drug-drug interactions with other drugs that the patient takes? Dosage: what is the correct dosage regimen (dose, frequency, route, formulation)? Orders: What are the right directions for providing the drug and are they practical? Period: What is the appropriate duration of therapy? Economy: Is the drug cost-effective? Mnemonic for this list is i.e. I dope?. Each item relates to an important assignment process, and in the absence of evidence that the schedule improves the purpose, it makes sense to use it. Conclusion: recipe for better destination We all make mistakes from time to time. There are many sources of medication bugs and different ways to avoid them. However, we should start by saying that a bug is possible and take steps to minimize the risks. The main components of this are monitoring and identifying errors, reporting them in guilt-free environments, analysing their root causes.57 changing procedures in accordance with lessons learned and further monitoring. How can we improve prescribing and reduce medication errors? Five prescriptions can help: Rx Education to be taken as often as possible (re-prescription-training should be lifelong).Rx Special training modules for graduates and students to be accepted as needed.Rx Correct assessment: in the final undergraduate exam, which will be taken once or twice; In graduate school, Must be taken from time to time; This may be due to the license to prescribe.Rx National recipe recipe for hospitals to be applied uniformly and used as a teaching tool.Rx Guidelines and computerized prescribing systems to be adopted if stated (their roles and proper implementation are not yet clear). Conflict of interest: No one is declared. Links 5Oxford English Dictionary online Access 10 April 2009 6, , . For Err is a human: Creating a safer health system, 13NHS drug bug 'crackdown' urgedAccessed 21 August 2008 14, , . National Observational Study of the Accuracy and Safety of Prescriptions in 50 Pharmacies, vol. (pg. -) 18. , Cambridge University Press21, . . . 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