MEDICATION ERRORS IN VOLUNTARY REPORTED INCIDENTS AT A UNIVERSITY HOSPITAL

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Study Aim
This study aimed to assess the prevalence, origin, type, and severity of reported medication incidents at a teaching hospital, utilizing a voluntary non-punitive reporting system.

Method
The present study is of a retrospective design. All voluntary non-punitive incident reports that occurred between January/2014 to March/2015 at a teaching hospital were retrieved from the quality department of the hospital. Detailed content analysis was conducted to obtain all relevant information. Data were coded anonymously and analyzed using SPSS version 20.

Results
There was an increase in reporting of medication errors overtime and almost all of the reporters were nurses. A total of 58 medication error reports including 86 medications were related to errors in medication management process starting from prescribing, dispensing to administration of medications. Two-thirds of those reports originated from the internal medicine department and the neonatal intensive care unit. The most common drug classes associated with those reports, anti-infectives, cardiovascular and chemotherapy agents.

Discussion
In the present research although the number of reported medication errors during the study period was relatively low, it has been noted that there was a yearly progress in reporting medication errors from 33, 35 during 2012 and 2013 correspondingly up to 58 during the study period (66% increase in reporting compared to 2013). Interestingly, 46.6% of medication errors included in the present study were reported between March and May 2014, this could be due to awareness programs and lectures held in the hospital in this regard in addition to several quality programs such as Joint Commission International (JCI) and National accreditation programs. Medication errors reported in the present study occurred more frequently during the administration phase by nurses. This result was consistent with the finding of other researchers and could be explained by the fact that nurses are the last health care professionals in the chain of medication provision, and probably have the greatest medical interaction with the patients. A closer examination of the reported medication errors revealed that the majority of these errors did not cause harm to patients but has the potential to be harmful if not captured before reaching patients.

Conclusions
Results of this study showed low percent of a broad variety of medication errors in multiple hospital departments. Additional research is required to identify possible improvements to optimize reporting and to enhance the response to each report.

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