



## Medication Safety

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### Abstract

*Drug therapy is the most common healing mediation in medicine to recover patient well-being. In spite of the concentrating to help patients, there are numerous examples of inappropriate medication procedures and practices that compromise drug efficacy and lead to preventable medication errors, thereby jeopardizing patient health. Insecure medication practices leading to medication errors are one of the leading reasons of healthcare-related illness and mortality that globally published drug safety fact files. Understanding these characteristic risks will allow healthcare suppliers to better manage drawbacks and efforts to guarantee drug security in healthcare delivery. When safety policies and risk organization skills are integrated into health methods and medication rehearses, safer hospitals and main care can be achieved. Safety and danger management are integrated into healthcare arrangements and processes.*

### Introduction

Medicines have proven to be very useful in the treatment and prevention of disease. This success has led to a dramatic increase in drug use in recent times. Unfortunately, this increased and expanded use of the pharmaceutical business has also led to a rise in the hazards, faults, and adverse actions related with the use of pharmaceuticals.<sup>[1]</sup>

Patient safety includes identifying, analyzing and handling patient-related dangers and occurrences to make patient care harmless and to minimize damage to the patient. Drug safety is part of patient safety and is defined as "no accidental injury while taking medication". Activities to avoid, prevent, or modify side effects that may result from drug use. "Unsafe medication practices and medication errors (MEs) are the most important preventable factors

compromising patient safety. A strong organizational culture focused on patient security and quality allows healthcare suppliers to better prepare for health disasters, encourage public health and add to achieving worldwide health reporting.<sup>[2]</sup>

### Explanation

Medication errors often result from gaps in the medication process and practice, from prescription and order to transcription and documentation, preparation and provision to administration and checking. Patients at points of supply transition, e.g. admissions from a public or main care facility, transmission from one area of a clinic to another, or liberation from a hospital to alternative care facility, are mainly susceptible to medication faults.<sup>[3]</sup>

In addition, prescription drugs may be contraindicated in certain patients or in combination with attendant medicines. Danger of harm is additional increased in high-risk circumstances associated with the usage of high-risk drugs. Health specialists involved in the use of medicines in a variety of settings include health care workers, nurses, pharmacy staff, paramedics, midwives, physical or respiratory therapists, dentists, anesthesiologists, etc.<sup>[4]</sup>

Other health care providers, as well as the patient's family members and other caregivers, may also play a role in supporting the patient or health care provider in many aspects of drug use. Impaired communication between these individuals can increase the risk of patient harm. Therefore, an approach to drug safety based on teamwork and interprofessional collaboration, and a culture of continuous learning and integration into practice is essential. Preventing drug-related damage for the patients who are hospitalized or entering primary care, containing during treatment changeovers, is a highest priority for patient security. Not all drug divergences that occur during changes of care cause instant patient harm, but unrecognized and unsettled inconsistencies can result in long-term adverse drug event, emergency department visits, and readmissions, such as every 30 days may increase risk.<sup>[5]</sup>

Achieving drug safety is a challenge due to the difficulty and massiveness of the healthcare system and rapid advances in drug therapy. Currently, patients are treated by multiple prescribing physicians at multiple centers and may be started on numerous medications, some of which carry high danger. Healthcare professionals also work in progressively siloed environments, concentrating on the own departmental specialties, leading to fragmented information sharing and a lack of cross-functional collaboration. All of these aspects increase the likelihood and tendency for accidental medication faults. Consequently, it has become important for the next age group of healthcare specialists to recognize the scale of the trials in

safeguarding drug security and to develop their own innovative solutions based on current strategies.<sup>[6]</sup>

Multiple drug use or polypharmacy is on the rise. This inevitably leads to an increase in drug-related adverse events harming patients. Various measures have been taken to encourage rational prescribing and reduce inappropriate polypharmacy, especially in older patients. Due to insufficient evidence that current interventions related to polypharmacy significantly improve patient clinical outcomes, conducting sound study in this space is a importance. Multiple interventions connecting manifold stakeholders and variations in the healthcare system should be the concentration of future investigation to guarantee drug safety in this phase of upkeep.<sup>[7]</sup>

### Conclusion

Drug safety is part of patient safety and is defined as "no accidental injury while taking medication". Activities to avoid, prevent, or modify side effects that may result from drug use. When safety plans and risk managing skills are integrated into health arrangements and medication rehearses, safer hospitals and main care can be achieved. Safety and danger management are integrated into healthcare methods and processes.

Some situations, such as patients, certain drugs, and settings of care, have higher characteristic safety dangers. High-risk drugs are frequently drugs with narrow healing indices and great efficacy, but certain patient groups, particularly offspring, the elderly, and pregnant females, are physiologically error-prone. Disorganized, understaffed, and untrained staff also increase the risk of medication errors. Warning systems, checklists and the use of computerized technology are strategies that can reduce the level of risk. Drugs are used to treat disease, relieve symptoms, and relieve symptoms. Medicines are usually safe when used as directed or labeled. However, taking drugs comes with risks.

### Reference

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