Pharmacist Intervention and Medication Errors at DHQ Hospital Bannu KP, Pakistan

Surayia Shahab Rani a, Fahim Ullah Khan b, Hidayat Ullah Khan c, Najeeb Ullah d, Mir Sadiq Shah b, Jamil Ur Rehman b, Autif Hussain Mangi e, Muhammad Nasir Younis f and Hafiz Muhammad Irfan a

a Department of Pharmacy, University of Sargodha, Sargodha, Punjab, 40100, Pakistan.

b Department of Zoology, University of Science and Technology, Bannu, KP, 28100, Pakistan.

c Department of Chemistry, University of Science and Technology, Bannu, KP, 28100, Pakistan.

d Institute of Basic Medical Sciences, Khyber Medical University, Peshawar, KP, 25100, Pakistan

e Department of Biochemistry, University of Sindh, Jamshoro, 76090, Pakistan.

f School of Mechanical and Manufacturing Engineering, NUST, Islamabad, 44000, Pakistan.

Authors’ contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

Article Information

DOI: 10.9734/JPRI/2022/v34i25B35960

Open Peer Review History:

This journal follows the Advanced Open Peer Review policy. Identity of the Reviewers, Editor(s) and additional Reviewers, peer review comments, different versions of the manuscript, comments of the editors, etc are available here: https://www.sdiarticle5.com/review-history/82296

ABSTRACT

Deaths related to drug errors are common in Pakistan, but these are not accurately reported. Since medication management is the main responsibility of nurses, it is vital that they have a good understanding of high alert of medication error. Patient health care, particularly drug fortification, is the main exertion and the challenge for healthcare professionals around the world. The profession of a pharmacist is world-renowned for providing medical care to patients. Herein, we aim to assess the role of pharmacist according to medications error in Government sectors hospitals located in district Bannu Kp Pakistan.

We collected a total number of 368 outdoor prescriptions from July 2011 to December 2011 from District Head Quarter Hospital, Bannu (DHQB). We found 71% of drug-drug interactions (DDIs), 32% of inapt dosage faults and 35% of management errors among them. Male patients with angina pectoris and myocardial infarction had a higher MEs ratio than female patients. According to the

*Corresponding author: E-mail: fahimjani85@gmail.com;
findings, clinical pharmacists in hospital wards must provide prompt counseling to primary care doctors during the prescription process, as well as management recommendations to nursing staff and other auxiliary medical employees.

Keywords: DHQ Hospital Bannu; Cardiovascular disease patients; Anti-angina; Pharmacists.

1. INTRODUCTION

The mistakes concerned with the drugs are a universal issue; however, most of the research on MEs is carried out in developed countries including Southeast Asian countries. Pharmacists play a significant role in the care of a patient’s life throughout the world [1,2]. According to a report published by the National Drug Error Reporting and Prevention Coordinating Committee (NCCMERP), a medication error is any preventable incident that could mistreatment a patient when the medicine is under the supervision of the medical specialist. Such events cause by order communication, product labeling, packaging, and nomenclature, compounding, allotting, distribution, administration, education, tracking, and use are examples of activities related to expert practice, health care products, processes, and systems. Mesa rise due to lack of knowledge capability, performance and in experience staff and defects in systems [3,4]. In Pakistani hospitals, medication errors are a major concern, yet few are recorded. For determining the appropriateness of therapy, the prevalence and kind of drug errors are critical [5]. Approximately 7,000 to 9,000 deaths are reported each year in developing nations such as the United States as a result of MEs, while thousands of patients fail to disclose and thousands more suffer from various consequences and require medication [6,7]. Throughout the world, medication errors are regarded as a severe health and mortality issue. Medication mistakes are estimated to be responsible for about 0.1 million fatalities worldwide each year [8].

According to studies, the risk of medication errors in children is three times higher than in adults, with dose errors being the most common [9,10].

The aim of this study to improve therapeutic effectiveness and reduce drug mistakes, pharmacists are crucial.

2. RESEARCH METHODOLOGY

To study the drug inaccuracies, we executed a clinical study at DHQB. From July to December 2011, 368 prescriptions from indoor and outdoor heart disease sufferers were collected from a DHQB. All the prescriptions were collected on the basis of inclusion and exclusion criteria.

2.1 Inclusion Criteria

In this study, we examined men and women between the ages of 30 and 100 who were taking various combinations of the drugs prescribed to them.

2.2 Exclusion Criteria

Topical medicine, such as emollients, lotions, ear and eye drops, and so on, were eliminated. Patients who are treated with first assistance in an emergency are likewise exempt.

2.3 Statistical Analysis

The drugs without of medication error were placed as a control group. We applied student t-test (two-way anova) P < 0.05 (*P 0.05; **P 0.01; and ***P 0.001).

3. RESULTS

In DHQB, a total of 368 prescriptions were collected, and the DDI ratio was found to be 71%. The critical DDIs analysis was carried out on the QHQB prescriptions gathered, which are listed in Table 1.
## DRUG-DRUG INTERACTION (DDIs) AT DHQB

### Table 1. Percentage, level of severity, consequence of drug inaccuracy in prescription

| S.No | DDIs                                  | Percentage % | Level of Severance | Outcome                                           | Recommendations                                             |
|------|---------------------------------------|--------------|--------------------|---------------------------------------------------|------------------------------------------------------------|
| 1    | Ceftriaxone with Omeprazole            | 37(6%)       | Slight             | Down the conc. of ceftriaxone                     | Monitor for reactions                                       |
| 2    | Digoxin with Omeprazole                | 21(3.75%)    | Severe             | Rise conc. of digoxin                            | Avoid concurrent use                                        |
| 3    | Enoxaparin with Clopidogrel            | 25(4.5%)     | Severe             | Cause upper GI bleeding                          | Keep off using this combination at the same time           |
| 4    | Disprin with Clopidogrel               | 26(4.6%)     | Severe             | Enhance anti-coagulant effect                     | Abstain from this combination                              |
| 5    | Digoxin with Ceftriaxone               | 24(4.3%)     | Moderate           | Decline the level of digoxin                      | Monitor clinical status                                    |
| 6    | Digoxin with Frusemide                | 26(4.6%)     | Moderate           | Enhance cardiac arrhythmias, hypokalemia         | Desist using this recipe at same time                      |
| 7    | Frusemide with Anti-coagulants         | 15(2.7%)     | Moderate           | Rise the effect of anti-coagulantion             | Monitor for reaction                                        |
| 8    | Frusemide with Ceftriaxone             | 28(5%)       | Moderate           | Cause nephrotoxicity                            | Desist to this combination at the same time                |
| 9    | Frusemide with Captopril               | 10(1.7%)     | Slight             | Renal failure and hypotension                    | Monitor for reaction                                        |
| 10   | Frusemide with Spironolactone          | 19(3.4%)     | Slight             | Orthostatic hypotension                         | Monitor for postural hypotension                            |
| 11   | Digoxin with Atenolol                  | 12(2.1%)     | Slight             | Cause Bradycardia                               | Desist this combination                                    |
| 12   | Captopril with Spironolactone          | 06(1.1%)     | Moderate           | Hyperkalemia                                    | Abstain this combination at the same time                  |
| 13   | Ciprofloxacin with Metoprolol          | 10(1.7%)     | Moderate           | Enhance the plasma metaprolol level              | Abstain this combination                                   |
| 14   | Enoxaparin with NSAIDs                 | 14(2.5%)     | Severe             | Rise anti-coagulant effect                      | Abstain use of this combination                            |
| 15   | Captopril with NSAIDs                  | 18(3.2%)     | Slight             | Decrease anti-hypertensive effect of captopril  | The dose of captopril is needed to be adjusted in this combination |
| 16   | Dexamethasone with Aspirin             | 16(2.8%)     | Slight             | Rise GI ulceration                              | Keep off using this combination                            |
| 17   | Streptokinase with Anticoagulants      | 15(2.6%)     | Severe             | Rise anti-coagulant effect                      | Monitor for the respective effect                           |
| S.No | DDIs                                      | Percentage % | Level of Severance | Outcome                          | Recommendations                                      |
|------|------------------------------------------|--------------|--------------------|----------------------------------|-----------------------------------------------------|
| 18   | Paracetamol with Anticoagulants          | 10(1.8%)     | Severe             | Enhance prothrombin time         | Monitor for the respective effect                    |
| 19   | Metoprolol with Benzodiazepines          | 08(4.1%)     | Moderate           | Enhance benzodiazepine influence | Refrain from this combination.                      |
| 20   | Digoxin with Verapamil                   | 14(2.5%)     | Moderate           | Rise digoxin level               | Adjustment is needed in the combined dose.          |
| 21   | Heparin with Warfarin                    | 10(1.8%)     | Severe             | Rise anti-coagulant effect       | Keep away from this combination                      |
| 22   | Heparin with Anticoagulants              | 15(2.7%)     | Severe             | Rise anti-coagulant effect       | Need Monitoring of their performance                |
3.1 Age Wise MEs

A general quantity of acquired prescriptions become assorted by means of age and calculated percentage of MEs in keeping with age wise 40-55, 56-65, 66-75, and 76-97 as shown in Table 1.

3.2 Disease Wise MEs

3.2.1 Angina pectoris

A summate of 368 prescriptions, 81 prescriptions were documented for sufferers with angina pectoris. After prescribing by a medical doctor, the percentage of men taking medicine incorrectly increased to 37%, compared to 36.9% for women, as illustrated in Fig. 1.

The angina pectoris suffers has been equated with sufferers who had no MEs. The manage institution become angina pectoris without MEs.

3.3 Myocardial Infarction (MI)

The 368 prescriptions had been accomplished for the suffering of the myocardial infarction. As shown in Fig. 2, statistical examination of the data revealed that men had a higher rate of incorrect prescriptions than women.

---

**Fig. 1. MEs in angina patient’s prescriptions**

**Fig. 2. The erroneous prescription of MI**
3.4 Hypertension

Patients with hypertension provided 166 prescriptions out of a total of 368. As indicated in Fig. 3, we discovered that females have a higher MDEs ratio than males.

3.5 Deep Venus Thrombosis (DVT)

We were able to get 19 out of 368 prescriptions for DVT patients. As seen in Fig. 4, men patients showed significant MEs than women patients.

4. DISCUSSIONS

The numbers of cardiovascular MEs per 100,000 people increased by 104.6% (P<0.001) between 2000 and 2012, and the ratio elderly had the greatest rate [11]. We noticed a significant amount of 354 (63.21%) DDIs in the DHB KP Pakistan by checking the prescription. According to another study, DDIs are a possible threat, and the prescribing doctor must be aware of this risk [12]. According to another study, DDIs are a potential issue that should be considered by the prescribing clinician [13].
Digoxin and Omeprazole medications pervert were noticed to be 21 (3.75%) in DHQB. The DDIs between Furosemide and Anticoagulant, which are related with the enhanced anticoagulant effect, were confirmed in 15 (2.75%) prescriptions.

In DHQB, there were 14 DDIs (2.5%) between Enoxaparin and NSAIDs. The severe excess of DDIs at DHQB, blockers, and Metformin elucidate 34 (4.8%), typical limits 28 (5%), and the ratio was 55 between Furosemide and Ceftriaxone (7.7%).

The MEs in the prescriptions of Angina and Myocardial suffer were 18 ± 4.9 (27.7%), 41 ± 1.4 (25.4%), 13 ± 2.00 (37%) and 21 ± 8.4 (31.8%).

The MEs in prescriptions for Angina and Myocardial Infarction were 18 ± 4.9 (27.7%), 41 ± 1.4 (25.4%), 13 ± 2.00 (37%) and 21 ± 8.4 (31.8%). After further investigation, we observed that hypertension patients’ prescriptions had a high percentage of MEs, and that the percentage of MEs in women’s prescriptions was significantly higher than in men’s. We found that MEs in deep Venous thrombosis had a very substantial 3 ± 1.41 ratio (42.8%) [14-16]. A major ME was found in the obtained prescriptions for AFib, AV blocks, and AFL. Multiple medication use (DDIs) is a leading source of adverse drug events, which can result in a higher risk of hospitalization and higher medical costs [17]. ADEs due to the discrepancies between these patients who were transferred between hospitals and nursing homes can be reduced by pharmacist medication reconciliation and discussion with doctors [18].

Our findings imply that appointment of pharmacists to a ward with clinical practice abilities can help to reduce MEs. It is necessary to check with a pharmacist before using medicine. DDIs and adverse drug testing software should be used to identify and evaluate MEs found in prescriptions, and hospital and community pharmacists should retain computer records. MEs could be controlled in the pharmacy by organizing medications into therapy groups. MEs can be potentially reduced by establishing a Drug Information Center (DIC). Requests for various types of drug records should be placed in the wards and out-of-affected-person departments. Nurses have a limited understanding of pharmacology, although they are well-versed in medicine administration [19]. Our findings imply that the pharmacist’s role is critical in CVS patient drug prescriptions since such a combination of pharmaceuticals has significant interaction effects and that physicians should take special caution when prescribing these drugs to CVS patients.

5. CONCLUSION

Medication errors are common in inpatient prescriptions, with errors in dose, time, omission, pace, drug preparation, unapproved drug, administration technique, dosage form, and route all being possible. Prescriptions are properly intervened by pharmacists, who play an active role in reducing pharmaceutical errors.

DISCLAIMER

The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

CONSENT

It is not applicable.

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Salmasi S, Khan TM, Hong YH, Ming LC, Wong TW. Medication Errors in the Southeast Asian Countries: A Systematic Review. Plos One. 2015;10:e0136545.

2. Phatak A, Prusi R, Ward B, Hansen LO, Williams MV, Vetter E, et al. Impact of pharmacist involvement in the transitional care of high-risk patients through medication reconciliation, medication education, and postdischarge call-backs.
3. Krishnaswami A, Steinman MA, Goyal P, Zullo AR, Anderson TS, Birrcher KK, et al. Deprescribing in Older Adults With Cardiovascular Disease. J Am Coll Cardiol. 2019;73:2584-2595.

4. Motzer FR, Fritzen JS, Hilmer SN, Paniz EV, Paniz VM. Potentially inappropriate medication in the elderly: a systematic review of validated explicit criteria. Eur J Clin Pharmacol. 2018;74:679-700.

5. Saleem, Raheela, Abdullah Dayo, Muhammad Ali Ghoto. Medication Errors and Pharmacist Intervention at Government Hospital of Hyderabad, Pakistan. Journal of Pharmaceutical Research International. 2021;37-43.

6. Thomas EJ, Brennan TA. Incidence and types of preventable adverse events in elderly patients: population based review of medical records. BMJ. 2000;320:741-4.

7. Wittich CM, Burkle, CM, Lanier WL. Medication errors: an overview for clinicians. In Mayo Clinic Proceedings. Elsevier. 2014;89(8):1116-1125.

8. National Coordinating Council for Medication Error Reporting and Prevention. About medication errors: What is a medication error. NCC MERP; 2020.

9. Michaels AD, Spinler SA, Leeper B, Ohman EM, Alexander KP, Newby LK, et al. Medication errors in acute cardiovascular and stroke patients: A scientific statement from the American Heart Association. Circulation. 2010;121:1664-82.

10. Hepler CD, Strand, L.M. Opportunities and responsibilities in pharmaceutical care. Am J Hosp Pharm. 1990;47:533-43.

11. Kamboj AK, Spiller HA, Casavant MJ, Hodges NL, Chouinirath T, Smith GA. Non-Health Care Facility Cardiovascular Medication Errors in the United States. Ann Pharmacother. 2017;51:825-833.

12. Fux R, Greiner D, Geldmacher M, Morike K, Gleiter CH. Multiple drug prescribing by general practitioners in a German region: Implications for drug interactions and patient safety. Int J Clin Pharmacol Ther. 2006;44:539-47.

13. Martinbianco J, Zuckermann J, Dos Santos L, Silva MM. Profile of drug interactions in hospitalized children. Pharm Pract (Granada). 2007;5:157-61.

14. Hyttinen V, Jyrkka J, Saastamoinen LK, Vartiainen AK, Valtonen H. The association of potentially inappropriate medication use on health outcomes and hospital costs in community-dwelling older persons: a longitudinal 12-year study. Eur J Health Econ. 2019;20:233-243.

15. Hyttinen V, Taipale H, Tolpanen AM, Tanskanen A, Tihonen J, Hartikainen S, et al. Incident Use of a Potentially Inappropriate Medication and Hip Fracture in Community-Dwelling Older Persons With Alzheimer's Disease. Ann Pharmacother. 2017;51:725-734.

16. Aguiar, J.P., Brito, A.M., Martins, A.P., Leufkens, H.G.M. & Alves da Costa, F. Potentially inappropriate medications with risk of cardiovascular adverse events in the elderly: A systematic review of tools Addressing Inappropriate Prescribing. 2019;44:349-360.

17. Muhlack DC, Hoppe, LK, Weberpals J, Brenner H, Schottker B. The Association of Potentially Inappropriate Medication at Older Age With Cardiovascular Events and Overall Mortality: A Systematic Review and Meta-Analysis of Cohort Studies. J Am Med Dir Assoc. 2017;18:211-220.

18. Boockvar KS, Carlson LaCorte H, Giambanco V, Fridman B, Siu A. Medication reconciliation for reducing drug-discrepancy adverse events. Am J Geriatr Pharmacother 2006;4:236-43.

19. Nakahara R. The Ideal Role of Pharmacists: A Nurse's Perspective. Yakugaku Zasshi. 2020;140:415-418.

© 2022 Rani et al.; This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.