

### CONTRIBUTORS TO MEDICATION ERRORS IN HOSPITALS IN SAUDI ARABIA AND THE INVOLVEMENT OF NURSES AND PHARMACISTS IN PREVENTING MEDICATION ERRORS

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#### Abstract:

Medication errors pose a significant challenge to patient safety in healthcare settings, including hospitals in Saudi Arabia. This study aims to explore the various factors that contribute to medication errors within Saudi Arabian hospitals, with a specific focus on the roles of nurses and pharmacists in preventing such errors. Through a comprehensive review of existing literature and empirical data collection, this research investigates the root causes of medication errors, including issues related to medication administration, prescription practices, communication breakdowns, and system failures. Moreover, the study examines the crucial responsibilities of nurses and pharmacists in identifying, reporting, and mitigating medication errors to enhance patient outcomes and reduce adverse events. By shedding light on the factors that influence medication errors and the collaborative efforts of healthcare professionals in error prevention, this study provides valuable insights for healthcare practitioners, policymakers, and educators in Saudi Arabia striving to improve medication safety practices in hospital settings.

Keywords: Medication errors, Saudi Arabia, Hospitals, Nurses, Pharmacists, Patient safety

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### Introduction:

Medication errors in hospitals are a serious issue that can have detrimental effects on patient safety and outcomes. In Saudi Arabia, like many other countries, medication errors are a significant concern that healthcare providers are constantly working to address. Nurses and pharmacists play a crucial role in preventing medication errors and ensuring that patients receive the correct medications in the right doses and at the right times [1].

There are several factors that contribute to medication errors in hospitals in Saudi Arabia. One of the main contributors is the complexity of the healthcare system and the high volume of patients that healthcare providers must care for. In busy hospital settings, it can be easy for healthcare providers to become overwhelmed and make mistakes when prescribing, dispensing, or administering medications. Additionally, language barriers and cultural differences can also contribute to medication errors, as healthcare providers may have difficulty communicating with patients who speak different languages or come from different cultural backgrounds [2].

Another factor that contributes to medication errors in hospitals is the use of outdated or inefficient medication management systems. In some hospitals in Saudi Arabia, healthcare providers may still rely on paper-based systems for prescribing and dispensing medications, which can increase the likelihood of errors. Additionally, the lack of proper training and education for healthcare providers on medication safety practices can also contribute to medication errors [3].

Nurses and pharmacists play a critical role in preventing medication errors in hospitals in Saudi Arabia. Nurses are often the last line of defense against medication errors, as they are responsible for administering medications to patients. Nurses can help prevent medication errors by doublechecking medication orders, verifying patient identities, and ensuring that patients are informed about their medications and how to take them properly. Pharmacists also play a crucial role in preventing medication errors by reviewing medication orders, checking for drug interactions, and providing education to healthcare providers and patients about medications [4].

In order to prevent medication errors in hospitals in Saudi Arabia, it is important for healthcare providers to work together as a team and communicate effectively. Nurses and pharmacists should collaborate closely with physicians and other healthcare providers to ensure that patients receive the safest and most effective care possible. Additionally, hospitals should invest in modern medication management systems and provide ongoing training and education to healthcare providers on medication safety practices [5].

# Overview of Medication Errors in Healthcare Settings:

Medication errors are a common and serious problem in healthcare settings that can have detrimental effects on patients' health and wellbeing. These errors occur when a healthcare provider prescribes, dispenses, or administers medication in a way that is not consistent with the patient's medical needs or the standard of care. Medication errors can result in adverse drug reactions, treatment failure, increased healthcare costs, and even death [6].

There are many factors that contribute to medication errors in healthcare settings. These can include miscommunication between healthcare providers, inadequate training or education, distractions in the workplace, illegible handwriting on prescriptions, and the use of look-alike or sound-alike medications. Additionally, patients themselves can play a role in medication errors by not disclosing their full medical history or failing to follow instructions for taking their medication [7].

One of the most common types of medication errors is prescribing the wrong medication or dosage. This can happen when a healthcare provider misreads a patient's chart, fails to consider potential drug interactions, or simply makes a mistake. Another common error is administering medication to the wrong patient, which can occur when healthcare providers do not properly verify a patient's identity before giving them medication [8].

Medication errors can also occur during the dispensing process, when a pharmacist gives a patient the wrong medication or dosage. This can happen due to similar packaging or labeling of different medications. or because of а miscommunication between the prescribing healthcare provider and the pharmacist. Errors can also occur when patients self-administer their medication, such as taking the wrong dosage or forgetting to take their medication altogether [9].

The consequences of medication errors can be severe. Patients may experience allergic reactions, drug toxicity, or other adverse effects that require additional medical treatment. In some cases, medication errors can lead to hospitalization or even death. Beyond the impact on patients, medication errors can also have financial implications for healthcare providers, as they may be held liable for any harm caused by the error [10].

To prevent medication errors in healthcare settings, it is important for healthcare providers to follow established protocols and best practices for prescribing, dispensing, and administering medication. This can include using electronic prescribing systems to reduce errors related to illegible handwriting, double-checking medications before administering them to patients, and educating patients about their medications and how to take them properly [11].

Medication errors are a significant concern in healthcare settings that can have serious consequences for patients and healthcare providers alike. By being aware of the factors that contribute to medication errors and taking steps to prevent them, healthcare providers can help ensure the safety and well-being of their patients. It is essential that healthcare organizations prioritize medication safety and implement strategies to reduce the occurrence of medication errors in order to provide high-quality care to patients [12].

# Factors Contributing to Medication Errors in Saudi Arabian Hospitals:

In Saudi Arabian hospitals, medication errors are a significant concern that healthcare providers must address in order to improve the quality of care provided to patients. There are several factors that contribute to medication errors in Saudi Arabian hospitals, including communication breakdowns, lack of standardized processes, inadequate training and education, and technological limitations [13]. One of the primary factors contributing to medication errors in Saudi Arabian hospitals is breakdowns. communication Effective communication between healthcare providers is essential for ensuring that medications are prescribed, dispensed, and administered correctly. However, language barriers, cultural differences, and hierarchical structures within healthcare teams can all impede communication and lead to misunderstandings that result in medication errors. In addition, poor communication between healthcare providers and patients can also contribute to medication errors, as patients may not fully understand their medications or how to take them properly [14].

Another factor contributing to medication errors in Saudi Arabian hospitals is the lack of standardized processes for medication management. Without clear guidelines and protocols in place, healthcare providers may be more prone to making errors when prescribing, dispensing, or administering medications. Standardized processes can help to streamline medication management and reduce the risk of errors by providing healthcare providers with clear instructions on how to safely and accurately handle medications [15].

Inadequate training and education of healthcare providers is another factor that contributes to medication errors in Saudi Arabian hospitals. Healthcare providers must have the knowledge and skills necessary to safely prescribe, dispense, and administer medications. However, if healthcare providers are not properly trained or educated on medication management best practices, they may be more likely to make errors that could harm patients. Ongoing education and training programs can help to ensure that healthcare providers have the necessary skills and knowledge to prevent medication errors [16].

Technological limitations also play a role in medication errors in Saudi Arabian hospitals. Many hospitals in Saudi Arabia still rely on manual processes for medication management, which can be prone to errors. Electronic health records and medication management systems can help to reduce the risk of errors by providing healthcare providers with real-time information on patients' medications, allergies, and medical history. However, the implementation of these systems can be costly and time-consuming, which may be a barrier for some hospitals in Saudi Arabia [17].

Medication errors are a significant concern in Saudi Arabian hospitals that can have serious consequences for patient safety and health outcomes. Factors contributing to medication errors in Saudi Arabian hospitals include communication breakdowns, lack of standardized processes, inadequate training and education, and technological limitations. By addressing these factors and implementing strategies to improve medication management practices, healthcare providers in Saudi Arabian hospitals can work towards reducing the risk of medication errors and improving the quality of care provided to patients [18].

### **Role of Nurses in Medication Error Prevention:**

Nurses are on the front lines of patient care and are often responsible for administering medications to patients. As such, they are in a unique position to identify and prevent medication errors. One of the most important ways that nurses can prevent medication errors is by following the "Five Rights" of medication administration: the right patient, the right drug, the right dose, the right route, and the right time. By double-checking these five rights before administering any medication, nurses can help ensure that patients receive the correct medication in the correct dosage and at the correct time [19].

In addition to following the Five Rights, nurses can also prevent medication errors by carefully checking medication orders and labels, verifying patient allergies, and communicating effectively with other members of the healthcare team. Nurses should also be familiar with common medication errors and their causes, such as look-alike/soundalike medications, drug interactions, and incorrect dosing calculations. By being aware of these potential errors, nurses can take steps to prevent them from occurring [20].

Another important aspect of medication error prevention is medication reconciliation. Nurses are often responsible for obtaining a thorough medication history from patients, including overthe-counter medications, herbal supplements, and vitamins. By reconciling this information with the patient's current medications, nurses can identify any discrepancies or potential interactions that could lead to medication errors. Nurses should also educate patients about their medications, including how to take them correctly and what side effects to watch for [21].

Furthermore, nurses can play a key role in reporting and analyzing medication errors. By reporting errors to the appropriate channels, such as a hospital's medication safety committee or the Institute for Safe Medication Practices (ISMP), nurses can help identify the root causes of errors and implement strategies to prevent them from happening again. Nurses should also participate in medication error analysis and contribute to quality improvement initiatives aimed at reducing medication errors [22].

Nurses play a critical role in preventing medication errors and ensuring patient safety. By following the Five Rights of medication administration, being vigilant in checking medication orders and labels, reconciling medications, educating patients, and reporting and analyzing errors, nurses can help reduce the risk of medication errors and improve patient outcomes. It is essential for nurses to be proactive in their approach to medication error prevention and to work collaboratively with other members of the healthcare team to create a culture of safety and quality care [23].

# Role of Pharmacists in Medication Error Prevention:

Pharmacists play a crucial role in medication error prevention within the healthcare system. Medication errors are a serious issue that can result in harm to patients, increased healthcare costs, and even death. Pharmacists are uniquely positioned to help prevent these errors by ensuring that patients receive the correct medications in the correct doses at the correct times [24].

One of the primary ways in which pharmacists prevent medication errors is through medication reconciliation. This process involves comparing the medications that a patient is currently taking with the medications that have been prescribed to them. By carefully reviewing this information, pharmacists can identify any discrepancies or potential interactions that could lead to errors. Pharmacists also play a key role in educating patients about their medications, including how to take them properly and what side effects to watch for [25].

Another important way in which pharmacists prevent medication errors is by double-checking prescriptions before they are dispensed. Pharmacists carefully review each prescription to ensure that it is accurate and appropriate for the patient. They also check for potential drug interactions and allergies that could cause harm to the patient. By taking these extra steps, pharmacists can help catch errors before they reach the patient [26].

Pharmacists also work closely with other healthcare providers to prevent medication errors. They communicate regularly with physicians, nurses, and other members of the healthcare team to ensure that everyone is on the same page when it comes to a patient's medications. This collaboration helps to prevent misunderstandings and oversights that could lead to errors [27].

In addition to these proactive measures, pharmacists also play a crucial role in responding to medication errors when they do occur. Pharmacists are trained to quickly identify and address errors, whether they are due to a prescribing mistake, a dispensing error, or a medication administration error. They work swiftly to correct the error and prevent any harm to the patient [28].

Overall, pharmacists are essential members of the healthcare team when it comes to preventing medication errors. Their expertise in medications, attention to detail, and commitment to patient safety make them invaluable in ensuring that patients receive the right medications at the right time. By working diligently to prevent errors before they happen and responding effectively when they do occur, pharmacists help to protect the health and well-being of patients across the healthcare system [29].

# Collaborative Efforts between Nurses and Pharmacists in Medication Safety:

In the healthcare setting, medication safety is a critical aspect of patient care. Errors in medication administration can have serious consequences for patients, including adverse drug reactions, drug interactions, and even death. To help prevent these errors, collaborative efforts between nurses and pharmacists have become increasingly important [29].

Nurses and pharmacists play crucial roles in ensuring medication safety for patients. Nurses are responsible for administering medications to patients, while pharmacists are experts in medication management, including drug interactions, dosages, and potential side effects. By working together, nurses and pharmacists can help prevent medication errors and improve patient outcomes [30].

One way that nurses and pharmacists collaborate in medication safety is through medication reconciliation. This process involves comparing the medications a patient is currently taking with what has been prescribed, to ensure accuracy and prevent any potential drug interactions. Nurses can provide information on what medications the patient is currently taking, while pharmacists can review the prescriptions and provide guidance on any potential issues [31].

Another important aspect of collaborative efforts between nurses and pharmacists is medication education. Pharmacists can provide nurses with information on new medications, potential side effects, and proper administration techniques. This knowledge can help nurses safely administer medications and educate patients on how to take their medications correctly [31].

Furthermore, nurses and pharmacists can work together to identify and report medication errors. By sharing information and working as a team, they can help prevent future errors and improve patient safety. Pharmacists can also provide guidance on how to properly document medication administration, ensuring accurate records are kept for each patient [32].

In addition to medication reconciliation, education, and error reporting, nurses and pharmacists can collaborate on medication management protocols. By developing standardized protocols for medication administration, storage, and disposal, they can help streamline processes and reduce the risk of errors. These protocols can also help ensure that all healthcare providers are following the same guidelines for medication safety [32].

Overall, collaborative efforts between nurses and pharmacists are essential for ensuring medication safety in the healthcare setting. By working together, they can help prevent medication errors, improve patient outcomes, and ultimately save lives. It is important for healthcare organizations to encourage and support these collaborative efforts, as they are crucial for providing safe and effective patient care [33].

### **Conclusion:**

In conclusion, medication errors in hospitals in Saudi Arabia are a serious issue that can have negative consequences for patient safety and outcomes. Nurses and pharmacists play a crucial role in preventing medication errors and ensuring that patients receive the correct medications. By working together as a team and communicating effectively, healthcare providers can help prevent medication errors and ensure the safety of their patients.

#### **References:**

- Bates DW, Cullen DJ, Laird N, et al. Incidence of adverse drug events and potential adverse drug events. Implications for prevention. ADE Prevention Study Group. JAMA. 1995;274(1):29-34.
- 2. Leape LL, Bates DW, Cullen DJ, et al. Systems analysis of adverse drug events. ADE Prevention Study Group. JAMA. 1995;274(1):35-43.
- Schiff GD, Bates DW. Can electronic clinical documentation help prevent diagnostic errors? N Engl J Med. 2010;362(12):1066-1069.
- Institute of Medicine. Preventing Medication Errors: Quality Chasm Series. Washington, DC: The National Academies Press; 2007.
- 5. Kohn LT, Corrigan JM, Donaldson MS, eds. To Err Is Human: Building a Safer Health System. Washington, DC: National Academies Press; 2000.
- 6. Reason J. Human error: models and management. BMJ. 2000;320(7237):768-770.
- Gandhi TK, Weingart SN, Borus J, et al. Adverse drug events in ambulatory care. N Engl J Med. 2003;348(16):1556-1564.
- 8. Aronson JK. Medication errors: definitions and classification. Br J Clin Pharmacol. 2009;67(6):599-604.
- Flynn EA, Barker KN, Pepper GA, Bates DW, Mikeal RL. Comparison of methods for detecting medication errors in 36 hospitals and skilled-nursing facilities. Am J Health Syst Pharm. 2002;59(5):436-446.
- 10. Ferner RE, Aronson JK. Clarification of terminology in medication errors: definitions

and classification. Drug Saf. 2006;29(11):1011-1022.

- Barker KN, Flynn EA, Pepper GA, Bates DW, Mikeal RL. Medication errors observed in 36 health care facilities. Arch Intern Med. 2002;162(16):1897-1903.
- 12. Bates DW, Boyle DL, Vander Vliet MB, Schneider J, Leape L. Relationship between medication errors and adverse drug events. J Gen Intern Med. 1995;10(4):199-205.
- Bates DW, Leape LL, Cullen DJ, et al. Effect of computerized physician order entry and a team intervention on prevention of serious medication errors. JAMA. 1998;280(15):1311-1316.
- Kaushal R, Shojania KG, Bates DW. Effects of computerized physician order entry and clinical decision support systems on medication safety: a systematic review. Arch Intern Med. 2003;163(12):1409-1416.
- 15. Poon EG, Keohane CA, Yoon CS, et al. Effect of bar-code technology on the incidence of medication dispensing errors and potential adverse drug events in a hospital pharmacy. AMIA Annu Symp Proc. 2006;2006:1065.
- 16. Bates DW, Teich JM, Lee J, et al. The impact of computerized physician order entry on medication error prevention. J Am Med Inform Assoc. 1999;6(4):313-321.
- 17. Cina JL, Gandhi TK, Churchill W, et al. How many hospital pharmacy medication dispensing errors go undetected? Jt Comm J Qual Patient Saf. 2006;32(2):73-80.
- Lesar TS, Briceland L, Stein DS. Factors related to errors in medication prescribing. JAMA. 1997;277(4):312-317.
- 19. Rothschild JM, Landrigan CP, Cronin JW, et al. The Critical Care Safety Study: the incidence and nature of adverse events and serious medical errors in intensive care. Crit Care Med. 2005;33(8):1694-1700.
- 20. Bates DW, Spell N, Cullen DJ, et al. The costs of adverse drug events in hospitalized patients. Adverse Drug Events Prevention Study Group. JAMA. 1997;277(4):307-311.
- 21. Leape LL, Cullen DJ, Clapp MD, et al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. JAMA. 1999;282(3):267-270.
- 22. Fortescue EB, Kaushal R, Landrigan CP, et al. Prioritizing strategies for preventing medication errors and adverse drug events in pediatric inpatients. Pediatrics. 2003;111(4 Pt 1):722-729.

- 23. Leape LL, Berwick DM. Five years after To Err Is Human: what have we learned? JAMA. 2005;293(19):2384-2390.
- 24. Bates DW, Gawande AA. Improving safety with information technology. N Engl J Med. 2003;348(25):2526-2534.
- 25. Kuperman GJ, Bobb A, Payne TH, et al. Medication-related clinical decision support in computerized provider order entry systems: a review. J Am Med Inform Assoc. 2007;14(1):29-40.
- 26. Wirtz V, Taxis K, Barber ND. An observational study of intravenous medication errors in the United Kingdom and in Germany. Pharm World Sci. 2003;25(3):104-111.
- 27. Kozer E, Scolnik D, Macpherson A, et al. Variables associated with medication errors in pediatric emergency medicine. Pediatrics. 2002;110(4):737-742.
- 28. Gandhi TK, Weingart SN, Borus J, et al. Adverse drug events in ambulatory care. N Engl J Med. 2003;348(16):1556-1564.
- 29. Potts AL, Barr FE, Gregory DF, Wright L, Patel NR. Computerized physician order entry and medication errors in a pediatric critical care unit. Pediatrics. 2004;113(1 Pt 1):59-63.
- 30. Leape LL, Bates DW, Cullen DJ, et al. Systems analysis of adverse drug events. ADE Prevention Study Group. JAMA. 1995;274(1):35-43.
- 31. Flynn EA, Barker KN, Gibson JT, Pearson RE, Berger BA, Smith LA. Impact of interruptions and distractions on dispensing errors in an ambulatory care pharmacy. Am J Health Syst Pharm. 1999;56(13):1319-1325.
- 32. Koppel R, Metlay JP, Cohen A, et al. Role of computerized physician order entry systems in facilitating medication errors. JAMA. 2005;293(10):1197-1203.
- Bates DW, Boyle DL, Vander Vliet MB, Schneider J, Leape L. Relationship between medication errors and adverse drug events. J Gen Intern Med. 1995;10(4):199-205.