

-  **Current Issue**
-  **Browse Issues**
-  **Search**
-  **About this Journal**
-  **Instruction to Authors**
-  **Online Submission**
-  **Subscription**
-  **Contact Us**
-  **RSS Feed**

Acta Medica Iranica

2009;47(4) : 33-40

Original Article

Errors in Medication Orders and the Nursing Staff's Reports in Medical Notes of Children

Fatemeh Valizadeh¹, Instructor of Pediatric Nursing; Syedeh-Fatemeh Ghasemi¹, Instructor of Pediatric Nursing; Seyed-Saeid Nagafi¹, Instructor of Surgery Nursing; Bahram Delfan², PhD of Pharmacology; Azam Mohsenzadeh³, MD, Pediatrician

1. Nursing and Midwifery Faculty, Lorestan University of Medical Sciences, IR Iran
2. Faculty of Medicine, Lorestan University of Medical Sciences, IR Iran

Corresponding Author:

Fatemeh Valizadeh, Instructor of Pediatric Nursing; Nursing and Midwifery Faculty, Lorestan University of Medical Sciences, IR Iran

E-mail: valizadeh1352@yahoo.com

Received: November 7, 2007
 Accept : May 18, 2008
 Available online: December 31, 2008

Abstract:

Objective:

Medication errors are the most common type of medical error and the avoidable cause of iatrogenic injury in pediatric patients. These errors can occur at any point in the process: ordering, transcribing, dispensing, administering, or monitoring medications. This study was done to verify medication errors by analyzing medication orders and the nursing staff's reports in medical charts of children admitted in Madany pediatric hospital of Khoramabad in the first 6 months of 2004.

Methods: This is a descriptive cross-sectional and hospital information based study. Samples included 898 medical charts of children admitted in Madany pediatric hospital of Khoramabad in the first 6 months of 2004 that were selected by random sampling. The data collection instrument was a demographic questionnaire for patients, physicians and nurses, a scale for analyzing medication orders and a scale for analyzing the nursing staff's reports. Data analyzed by SPSS Ver.11.5 software.



Findings: Analysis of the medication orders indicated that in 74.1%, drug administration precautions were not written, in 47.8%, drug administration time or intervals were not written exactly on hours, in 45.5%, drug unit was not written or was written incompletely or ambiguously and in 20.5%, orders had at least one drug interaction. Analysis of nursing staff's reports indicated that in 77.5% drug, administration precautions were not written, in 14.9%, drug interactions were not noted, in 14.8%, drug administration time or intervals were not according to medication orders and in 6.3% medication, orders were not administered by nurses.

Conclusion: In the busy and complex environment of pediatrics' units, medication errors can be frequent. However, most of these errors are trivial and do not harm patients. The types of errors indicate the need of continuous education and the implementation of management tools that allow the development of the practice and monitoring results, because medication errors are indicators of the quality of the healthcare provided. Therefore, their detection and systematic analysis of their causes can contribute to their systematic prevention, thus improving the healthcare delivery process.

Keywords:

[Medication error](#) . [Medication order](#) . [Nursing staff's report](#) . [Drug order](#) . [Drug interaction](#)

TUMS ID: 12356

Full Text HTML  Full Text PDF  140 KB

[Home](#) - [About](#) - [Contact Us](#)

TUMS E. Journals 2004-2009
[Central Library & Documents Center](#)
[Tehran University of Medical Sciences](#)

Best view with Internet Explorer 6 or Later at 1024*768 Resolutions