



Reasons of Medication Administration Errors' Occurrence and Remaining Unreported in Pakistan: Nurses' Perspective

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Abstract

Objective: The study is aimed at evaluating the reasons of medication administration errors occurrence and not reporting in Pakistan in the light of nurses' regular drug administration process.

Methodology: Cross Sectional review based investigation was done in Bolan Medical Complex Hospital Quetta, Pakistan. The pre-consent was taken from all the nurses who agreed to participate in research. The total number of 200 questioners were distributed to the nursing staff of the Bolan Medical Complex Hospital Quetta, Pakistan. The 180 questioners were returned out of which 7 questioners were excluded from the examination because of the inadequacy. The remaining 168 questioners were considered in the examination. All data were gathered, coded, classified and factual examination is performed by SPSS 20.

Result: For the reasons, why medication administration errors occur, most of the nurses (133=79.2%) consented to the statement, "There is no relaxed method to look up evidence on medicines". For the reasons, why medication administration not reporting, most of the nurses (154=91.7%) agreed to the statement, "The patients believe that medicines are given accurately as per instruction".

Conclusion: The reasons why medication administration errors occur, include: hard to pick up data taking drugs blunders, messy medicine request, and Pharmacist not being accessible for 24 hours. The factors clarifying why staff nurses may not report medicine mistakes, include: uplifting desire from nurses, blunder definition reasons, and fear from the patient family, doctor and nursing administration.

Keywords: Nurses, Perception, Medication Administration Error, Quetta, Pakistan

INTRODUCTION

The administration of medication process is a regular piece of nursing practice (Park S.A, et al., 2011), what's more, is far beyond a basic psychomotor undertaking (Wakefield B, et al., 2000). Harmless medicine administration is important to doctors, nurses, instructors, patients, administrators, the community at great and the whole healthcare structure. In spirit, each investor is possibly wedged after mistakes arise

(Bellebaum K.L, 2008). Administration of medicines is frequently seen as a standard and essential nursing undertaking (Myhre T.A, 2007; Demehin A, et al., 2008). In actuality, it mirrors a mind boggling association of an expansive number of particular choice and activities (Ahmed N.G, et al., 2011). Though medication administration errors are much of the time related by activities of nurses, the situation is critical toward perceiving that real organization of a medication is the keep going stride in a extensive and entangled method including various diverse doctors, drug specialists, attendants, administrative and specialized staff (Juarez A, et al., 2009).

Ceasing of medicine administration blunders speaks to a focal concentration of healing center's quality change and hazard administration activities, in light of the fact that the ID and revealing of medication administration errors is a non-mechanized and deliberate practice, the situation is basic to comprehend the degree to which mistakes might not stay accounted for (Myhre T.A, 2007). Different meanings of what creates a medication administration errors are in distributed investigation and writing. Single description every now and again utilized by restorative specialists of medication administration errors is a few deviance from the doctor's prescription request by way of composed on the patient's outline (LKM S.A.A.-Y, et al., 2013). In any case, the definition regularly referred to in writing that is composed by medical caretakers characterizes MAE as "botches related with drugs and intravenous arrangements that are made amid the solution, interpretation, administering, and organization periods of medication readiness and dispersion" (Wakefield B.J, et al., 1998; Peris-Lopez P, et al., 2011).

In the intense care setting of a healing center, the drug procedure is unpredictable and tedious, involving up to 33% of the medical attendants time (ABA, A.B.A., 2007). Administration of medicines is frequently done under turbulent and unpleasant conditions and is presumably the most noteworthy hazard action an attendant performs. A mistake in the pharmaceutical procedure can be minor or prompt destroying impacts for the patient and furthermore for the medical caretakers'/birthing assistants' vocation (LKM S.A.A.-Y, et al., 2013; Wakefield B.J, et al., 1998). Medical surroundings, nurses role in fast walked, compound, random locations by great pale patient attention circumstances (Ahmed S.E, et al., Flynn E.A., 2010). Adding to the many-sided quality are factors, for example, institutionalized solution organization calendars and diversions (Demehin A., 2008; Shane R., 2009). Thusly, attendants should be mindful of their legitimate and expert responsibility with respect to pharmaceutical administration (Ahmed S.E, et al., 2010).

Guaranteeing MAE announcing is of incredible centrality aimed at the patient, the clinic and the nurse (LKM S.A.A.-Y, 2013). For the clinic, the final product of the under reporting of prescription blunders is debilitated inner excellence change and hazard administration openings because of insufficient information. Coming about for non-resemblance of medication administration mistakes information utilized for intra and among official examinations or bench-marking (Wakefield B., 2005; Al-Jeraisy M.I, et al., 2011). The final product for patients of under reporting of MAEs incorporates an expanded capability of unfriendly results, because of the disappointment of the doctor's facility to distinguish and adjust frameworks related issues agreeable to amendment (Rachidi S, et al., 2012). Under revealing of MAEs permits the medical caretaker, nonetheless, to abstain from being faulted, directed, or named by others as inept. The medical caretaker may likewise not report blunders by different attendants, either in view of compassion for the attendant submitting the mistake or the want to abstain from being segregated via additional workforce (Wakefield B, et al., 2000; Manias E, et al., 2002). Measures of clinical attendants in pharmaceutical administration are perplexing and complex. These parts incorporate controlling drug securely and productively, surveying and checking for alluring and undesirable impacts, release arranging, and giving patient instruction (Coombes I.D, et al., 2005). For nurses to do these parts viably, they should have exhaustive pharmacology learning, which includes a comprehension of the logical standards supporting pharmaceuticals and additionally the capacity to contextualize prescription administration to the mind boggling and altering necessities of patients (Pape T.M, 2001). Administration of drug requires broad learning and ability to make accurately (Demehin A, et al., 2008; Balas M.C, et al., 2004).

Regardless of the basic part of the nurses in distinguishing and revealing medicine administration errors once they occur, there has stayed slight study endeavoring to evaluate their discernment. Actually, all progression in persistent administer to a nursing proficient includes a possibility for mistakes and some level of hazard to tolerant security. Truly, legitimate comprehension of the causative purposes behind why medication administration errors occur, why medication administration errors remain unreported and the degree to which blunders are really revealed are the initial moves to avoid mistakes. Besides, a comprehension of their perceptions about MA is essential since it causes associations to discover the variables that undermine understanding security. Along these lines, this paper investigates the reactions of nurses to gauge their perceptions and also request data about their own encounters with pharmaceutical blunders.

Methodology

Study Design

Cross sectional survey based examination was taken.

Study Setting

The study was taken in Bolan Medical Complex Hospital Quetta, Pakistan.

Study Population

Nursing staff of Bolan Medical Complex Hospital Quetta, Pakistan were taken part in the study.

Study Sampling

Convenient Sampling technique was used.

Study Instrument

In the present review, one instrument was used that is called [Medicine Administration Errors Reporting Questionnaire], which was presented by Wakefield in 1996 and a similar questionnaire was used which was presented by Suliman Ali Al-Youssif in 2013 (LKM S.A.A.-Y, et al., 2013; Wakefield D.S, et al., 1995) as follows.

1. Demographic Characteristics

The following characteristics were taken into account: the age group, the highest qualification, the current position, the department and job experience.

2. Reasons of Medication Administration Errors Occurrence and not Reporting Questionnaire

This portion limited to 41 questions. It contained two segments; the first segment comprised 25 questions about detailed reasons of medicine administration errors occurrence and second segment comprised 16 questions about details why these medicine administration errors are remained unreported. The questionnaire was revised (some of questions were excluded from study) and the questionnaire was translated into Urdu language. Nurses were requested to point out their arrangement level by five opinions of (5 = Strongly Agree to 1 = Strongly Disagree) with regard to Likert scale.

Questionnaire's Validity and Reliability

Questionnaire was verified on behalf of its contented rationality and significance by a panel contained of 5 specialists in different nursing fields at Nursing School Bolan Medical Complex Hospital Quetta, Pakistan. The specialists' replies were characterized in four categories of 4 = Strongly Relevant, 3 = Relevant, 2 = Little Relevant, and 1 = Not Relevant.

Material and Methods

The pilot study was taken on twenty nurses (excluded from the sample) aimed at two times isolated through two weeks to guarantee the unwavering quality of the device and survey the attendants' acknowledgment to be engaged with the examination. The pre consent was taken from all the nurses (included in the questionnaire) who consented to take part. The total number of 200 questionnaires were distributed to the nursing staff of the different ward in the Bolan Medical Complex Hospital Quetta, Pakistan. The 180

questioners were returned back out of which 7 questionnaires were excluded from the examination because of the inadequacy. The remaining 168 questioners were considered in the examination.

Statistical Analysis:

All the data were gathered, classified and exposed to measurable examination. Measurable examination is performed by SPSS 22, additionally Microsoft office Excel was utilized for information dealing with and graphical introduction. Downright factors are portrayed by extents and Percentages. Independent sample Kruskal Wallis test was utilized and $P < 0.05$ was considered as significant level for age, highest qualification, current position, department and job experience.

Result

Demographic Characteristics

All nurses were female and most of the nurses were at the age range of 18-27 years and 28-37 years (77=45.8%). Most of the nurses hold the general nursing degree (139=82.7%) and most of the nurses were on the position of staff nurse (141=83.9%). 29 (17.29%) nurses worked in CCU (Coronary Care Unit), trailed by 15 (8.9%) nurses worked in the pediatric medicine department, 13 (7.7%) of nurses worked in Gynecology/Obstetrics and NICU (Neonatal Intensive Care Unit). Most of the nurses were under 5 years of work experience i.e. 98 (58.3%) and 42 (25.0%) of nurses were 5-10 years of work experience as displayed in Table-1.

Questionnaire I. Reasons of Medication Administration Errors Occurrence

As shown in Table 2, most of the nurses (133=79.2%) agreed with the statement, "There is no relaxed method to look up evidence on medicines", followed by 119 (70.8%) of nurses agreed with the statement, "Physician's medication order is not legible". 56 (33.3%) of nurses strongly agreed with the statements, "Nurses are unaware of a known allergy", "Many patients are on the same or similar medicines" and "Nurses on this unit do not adhere to the approved medication administration procedure", 49 (29.2%) of nurses strongly agreed with the statements, "Different medicines are look-alike", "Pharmacist are not available 24 hours a day" and "Frequent substitution of drugs".

119 (70.8%) of nurses disagreed with the statement, "Pharmacy does not make the medicine appropriately", 112 (66.7%) disagreed with the statement, "Pharmacy sends improper doses to this unit" and 105 (62.5%) of nurses disagreed with the statement, "Pharmacy does not label the medication correctly". 21 (12.5%) of nurses strongly disagreed the statement, "The name of many medicines are similar", most of the nurses (14=8.3%) strongly disagreed with the statements, "Pharmacy does not make the medicine appropriately", "Acronyms are used instead of writing the complete instruction" and Pharmacist are not available for 24 hours a day".

Questionnaire II. Reasons of Medication Administration remaining unreported

Table 2 shows, most of the nurses (154=91.7%) agreed with the statement, "The patient believe that medicines are given accurately as per instruction", 119 (70.8%) agreed with the statement, "The patient or patient's family might establish a bad attitude towards the nurse or can take legal action against the nurse if a medicine error is stated". Most of the nurses (56=33.3%) strongly agreed with the statement, "Nurses do not come to an understanding by the hospital description of medicine mistake", most of the nurses (49=29.2%) strongly agreed with the statements, "Nurses may not think the error is important enough to be reported", "Nurses are scared the physician will notify them for medicine mistake", "Nurses distress opposing penalties from reporting medicine mistake", "The nurses' reaction by administration does not equal the sternness of mistake" and "Not any helpful feedback are given for passing medicines appropriately".

84 (50.0%) of nurses disagreed with the statement, "Nurses do not recognize occurrence of the errors", most of the nurses (56=33.3%) disagreed with the statements, "Filling out an incident report for a medication error takes too much time", "Communicating the Physician about a medicine mistake proceeds too much time", "Medicine mistake is not visibly distinct" and "Nurses may not think the error is important enough to be reported". Some of the nurses (14=8.3%) strongly disagreed with the statement, "Nurses do not recognize

errors' occurrence", "Communicating the Physician about a medicine mistake proceeds too much time", "Nurses may not think the error is important enough to be reported", "Nurses believe that other nurse will consider them as incompetent if they mark medicine errors".

Table 1. Demographic Characteristics

Description	Frequency	Percentage
Age Group		
18-27	77	45.8
28-37	77	45.8
38 & >	14	8.3
Highest Qualification		
BSN	8	4.8
General Nursing	139	82.7
Diploma Holder	20	12.5
Current Position		
Matron	1	0.6
Head Nurse	6	3.6
Staff Nurse	141	83.9
Trainee	20	11.9
Department		
Medicine Units	8	4.8
CCU	29	17.26
Pediatric Medicine	15	8.9
Neurology	1	0.6
ICU	10	6
Pediatric Surgery	13	7.7
Gastroenterology	8	4.8
NICU	13	7.7
Skin Ward	7	4.2
Oncology	3	1.8
Gynecology/Obstetrics	13	7.7
Diabetes	7	4.2
ENT	14	8.3
Burn ICU / Ward	8	4.8
Surgical Ward	8	4.8
Emergency OT	4	2.4
General OT	1	0.6
Cardiac Ward	6	3.6
Job Experience		
Less than 5 years	98	58.3
5-10 years	42	25
10-15 years	21	12.5
15 years & Above	7	4.2

CCU= Coronary Care Unit, ICU= Intensive Care Unit, NICU= Neonatal Intensive Care Unit, ENT= EAR Nose Throat, EOT= Emergency Operation Theater, GOT= General Operation Theater

Table 2. Questionnaire I. Reasons of Medication Administration Errors' Occurrence

Statements	Agree	Strongly Agree	Disagree	Strongly Disagree
The name of many medicines are similar.	49 (29.2%)	42 (25.0%)	56 (33.3%)	21(12.5%)
Different medicines are look alike.	84 (50.0%)	49 (29.2%)	33 (16.6%)	2 (1.1%)
The packing of many medication are similar.	98 (58.3%)	42 (25.0%)	21 (12.5%)	7 (4.2%)
Physicians' medication order are not legible.	119 (70.8%)	14 (8.3%)	33 (16.6%)	2 (1.1%)
Physicians change medication order frequently.	98 (58.3%)	28 (16.7%)	35 (20.8%)	7 (4.2%)
Acronyms are used instead of writing the complete instruction.	98 (58.3%)	28 (16.7%)	28 (16.7%)	14 (8.3%)
Oral instructions are used instead of written instructions.	70 (41.7%)	42 (25.0%)	49 (29.2%)	7 (4.2%)
Pharmacy sends improper doses to this unit.	42 (25.0%)	7 (4.2%)	112 (66.7%)	7 (4.2%)
Pharmacy does not make the medicine appropriately.	35 (20.78%)	--	119 (70.8%)	14 (8.3%)
Pharmacy does not label the medication correctly.	49 (29.2%)	7 (4.2%)	105 (62.5%)	7 (4.2%)
The pharmacist is not available 24 hours a day.	84 (50.0%)	49 (29.2%)	21 (12.5%)	14 (8.3%)
Frequent substitution of drugs	63 (37.5%)	49 (29.2%)	49 (29.2%)	7 (4.2%)
Poor communication between nurses and physicians	70 (41.3%)	63 (37.5%)	33 (16.6%)	2 (1.1%)
Nurses have restricted information about medicines.	77 (45.8%)	63 (37.5%)	25 (14.8%)	3 (1.7%)
Nurses do not abide by accepted medicine administration practice.	28 (16.7%)	56 (33.3%)	77 (45.8%)	7 (4.2%)
Once planned medications are stuck, nurses do not talk about the period of next dose.	98 (58.3%)	21 (12.5%)	48 (28.5%)	1 (0.5%)
While administration of medication, nurses are disturbed to do other duties.	63 (37.5%)	70 (41.7%)	33 (19.64%)	2 (1.1%)
Unit staffing levels are inadequate.	112 (66.7%)	28 (16.7%)	25 (14.8%)	3 (1.7%)
Medication orders are not transcribed to the treatment chart correctly.	70 (41.7%)	49 (29.2%)	42 (25.0%)	7 (4.2%)
Errors are made in medication chart.	77 (45.8%)	42 (25.0%)	42 (25.0%)	7 (4.2%)
Equipment malfunctions are not set correctly.	105 (62.5%)	7 (4.2%)	56 (33.3%)	7 (4.2%)
There is no relaxed method to look up evidence on medicines.	133 (79.2%)	21 (12.5%)	14 (8.3%)	7 (4.2%)
Nurses are unaware of a known allergy.	42 (25.0%)	56 (33.3%)	63 (37.5%)	7 (4.2%)
Many patients are prescribed to the same or similar medicines.	84 (50.0%)	56 (33.3%)	25 (14.8%)	3 (1.7%)

Table 3. Questionnaire II. Reasons of not reporting the Medication Administration’s errors

Statements	Agree	Strongly Agree	Disagree	Strongly Disagree
Nurses do not come to an understanding by the hospital description of medicine mistake.	63 (37.5%)	56 (33.3%)	45 (26.7%)	4 (2.3%)
Nurses do not identify mistakes’ occurrence.	49 (29.2%)	21 (12.5%)	84 (50.0%)	14 (8.3%)
Filling out an incident report for a medication error takes too much time.	98 (58.3%)	7 (4.2%)	56 (33.3%)	7 (4.2%)
Communicating a physician about a medicine mistake proceeds too much time.	84 (50.0%)	14 (8.3%)	56 (33.3%)	14 (8.3%)
Medicine mistake is not visibly distinct.	77 (45.8%)	35 (20.8%)	56 (33.3%)	---
Nurses may not think the error is important enough to be reported.	49 (29.2%)	49 (29.2%)	56 (33.3%)	14 (8.3%)
Nurses believe that other nurse will consider them incompetent if they mark medicine errors.	70 (41.7%)	42 (25.0%)	42 (25.0%)	14 (8.3%)
The patient or patient’s family might establish a bad attitude towards the nurse or can take legal actions against the nurse if a medicine’s error is stated.	119 (70.8%)	7 (4.2%)	35 (20.8%)	7 (4.2%)
The patient believe that medicines are given accurately as per instruction .	154 (91.7%)	7 (4.2%)	4 (2.3%)	3 (1.7%)
Nurses are scared the physician will notify them for medicine mistake.	91 (54.2%)	49 (29.2%)	25 (14.8%)	3 (1.7%)
Nurses distress opposing penalties from reporting medicine mistake.	70 (41.7%)	49 (29.2%)	42 (25.0%)	7 (4.2%)
The nurses reaction by administration does not equal the sternness of mistake.	70 (41.7%)	49 (29.2%)	42 (25.0%)	7 (4.2%)
Nurses are responsible in case of a problem with a patient including the medicinal mistake.	77 (45.8%)	42 (25.0%)	49 (29.2%)	---
Not any helpful feedback are given for passing medicines appropriately.	56 (33.3%)	49 (29.2%)	56 (33.3%)	7 (4.2%)
Excessively stress is sited on medicinal mistakes.	105 (62.5%)	42 (25.0%)	15 (8.9%)	6 (3.5%)
When medicinal mistakes take place, nurses’ administration focus on the single rather than the observing the system as potential reason of the mistakes.	105 (62.5%)	42 (25.0%)	19 (11.3%)	2 (1.1%)

Table 4. Kruskal Wallis Test Vs. Demographics Characteristics

Statements	Age*	Current* Position	The Highest* Qualification	Department*	Job* Experience
The name of many medicines are similar.	0.000	0.077	0.001	0.001	0.002
Different medicines are look alike.	0.291	0.364	0.004	0.000	0.000
The packing of many medication are similar.	0.996	0.167	0.013	0.000	0.080
Physician's medication order are not legible.	0.006	0.029	0.043	0.000	0.012
Physicians change medication order frequently.	0.000	0.001	0.000	0.000	0.000
Acronyms are used instead of writing the complete instruction.	0.679	0.011	0.010	0.001	0.003
Oral instructions are used instead of written instructions.	0.012	0.042	0.008	0.000	0.000
Pharmacy conveys improper doses to this unit.	0.000	0.292	0.005	0.000	0.000
Pharmacy does not make the medicine appropriately.	0.02	0.115	0.000	0.005	0.000
Pharmacy does not label the medication correctly.	0.000	0.408	0.120	0.002	0.001
The pharmacist’s unavailability for 24 hours a day	0.000	0.008	0.000	0.001	0.000
Frequent substitution of drugs	0.080	0.000	0.000	0.002	0.000
Poor communication between nurses and physician	0.24	0.000	0.000	0.000	0.000

Nurses have restricted information about medicines.	0.000	0.012	0.010	0.000	0.000
Nurses do not abide by accepted medicine administration practice.	0.000	0.000	0.098	0.000	0.000
Once planned medications are stuck, nurses do not talk about the period of next dose.	0.000	0.005	0.025	0.000	0.000
While administration of medication, nurses are disturbed to do other duties.	0.003	0.021	0.017	0.000	0.005
Unit staffing levels are inadequate.	0.000	0.000	0.001	0.000	0.000
Medication orders are not transcribed to the treatment chart correctly.	0.232	0.001	0.000	0.000	0.000
Errors are made in medication chart.	0.000	0.019	0.006	0.001	0.007
Equipment malfunctions are not set correctly	0.074	0.000	0.085	0.000	0.000
There is no relaxed method to look up evidence on medicines.	0.002	0.040	0.011	0.000	0.004
Nurses are unaware of a known allergy.	0.025	0.007	0.338	0.000	0.000
Many patients are transcribed the same or similar medicines.	0.557	0.018	0.000	0.000	0.005
Nurses do not come to an understanding by the hospital description of medicine mistake.	0.108	0.011	0.004	0.000	0.002
Nurses do not identify mistakes' occurrence.	0.000	0.000	0.007	0.000	0.000
Filling out an incident report for a medication error takes too much time.	0.121	0.20	0.021	0.003	0.000
Communicating a physician about a medicine mistake proceeds too much time.	0.476	0.018	0.002	0.000	0.003
Medicine mistake is not visibly distinct.	0.000	0.006	0.001	0.000	0.000
Nurses may not think the error is important enough to be reported.	0.011	0.009	0.000	0.001	0.000
Nurses believe that other nurse will consider them incompetent if they mark medicinal errors.	0.154	0.056	0.000	0.000	0.003
The patient or patient's family might establish a bad attitude towards the nurse or can take legal actions against the nurse if a medicine error is stated.	0.000	0.000	0.060	0.000	0.000
Patients believe that medicines are given accurately as per instruction.	0.000	0.000	0.379	0.004	0.000
Nurses are scared the physician will notify them for medicinal mistake.	0.019	0.031	0.000	0.000	0.000
Nurses distress opposing penalties from reporting medicinal mistake.	0.104	0.003	0.000	0.000	0.000
The nurses' reaction by administration does not equal the sternness of mistake.	0.000	0.025	0.000	0.000	0.000
Nurses are responsible in case of any problems with patient as of the medicinal mistake.	0.000	0.094	0.004	0.000	0.000
Not any helpful feedback are given for passing medicines appropriately.	0.040	0.031	0.007	0.000	0.000
Excessively stress is sited on medicinal mistakes.	0.004	0.120	0.071	0.000	0.000
When medicine mistakes take place, nurses' administration focus on the single rather than observing the whole system as potential reason of the mistakes.	0.810	0.000	0.001	0.000	0.000

Kruskall Wallis Test

Discussion

Nurses are assumed as a noteworthy part in diminishing prescription mistakes and much of the time direct medications in patients' social insurance settings (Hsaio G.Y, et al., 2010). In the same vein, they are the last to defend against pharmaceutical mistakes (Despins L.A, et al., 2010). In this way, the point of the present investigation was to evaluate the contribution from members in light of their clinical encounters towards view

of event and announcing of drug administration mistakes, and additionally the degree to which blunders are accounted for on their units.

These reasons behind the errors' occurrence were reported as the following based on the present study: no easy look up information on medication errors, illegible medication order, similar medication for many patients, look-alike medicines, frequent substitution of drugs and the pharmacist's unavailability for 24 hours.

Be that as it may, in another overview directed via Cohen et al. (2003), five notable explanations behind what initiated or expanded the danger of pharmaceutical mistakes were stated; diversions and intrusions amid MA, lacking staffing and high nurse/patient proportions, unintelligible prescription requests, mistaken measurements count and comparative medication names and bundling (Cohen H, et al., 2003). But in the present study, the two major categories of the Cohen et al. study i.e. illegible medication orders and similar drug names and packaging are the same but the other three categories are different.

Truly, look-alike/sound-alike medication names can bring about pharmaceutical mistakes. Misreading medicine names that appear to be comparative is a typical slip-up. These twin pharmaceutical names can prompt blunders related with verbal solutions. Consequently, the Joint Commission distributed a list of {look-alike/sound-alike} medications that are viewed as the utmost dangerous pharmaceutical terms crosswise over locations. The investigation was led by Mrayyan et al. in 2007 upheld this discovery and recommended that the medicines' names and bundles might be incomprehensibly the social insurance work force due to putting essential data unmistakably and little text dimension of showing content, which may prompt poor comprehensibility (Mrayyan M.T, et al., 2007). The present study supports the findings of Mrayyan et al. because look-alike medicines were one of major reasons pointed out by the nurses.

An examination was directed by Roy et al in 2005 called attention to that miscommunication of medications instructions, which can include deprived penmanship, mistaking among medicines for comparable names, abuse of decimal and zeroes focuses. Besides, natural factors, for example, lighting, warmth, commotion and interference were reported that can occupy well-being proficient from their nursing task (Roy V, et al., 2005). But in the present study, most of the nurses pointed out the illegible medication order and similar medication to many patients, these two reasons support the study performed by the Roy et al.

The consequences of the factor examination uncovered distinctive classifications of reasons for why medication administration errors remain unreported that were distinguished in this study. These classes include, expectation that administration of medicine by nurses will be accurate, error definition reasons, fear from the patient, family, physician and nursing administration, errors is not important enough to be reported and no positive feedback is given by patients.

The examination factor investigation for not reporting medicine administration errors indicated classifications positioned as; fear reasons, and trailed by regulatory reasons. In this regard, a few examinations utilized a comparative instrument to explore attendants' impression of not revealing medicine mistakes and bolstered this discoveries but rather with various positioning (Wakefield B, et al., 2000; Wakefield B.J, et al., 2005; Mohamed S.R.D.L.K, 2012; Hashish E.A.A, et al., 2013) . The present study supported the result of recent studies performed by different researches as cited above.

Obviously, nurses must comprehend that the missteps are indicator of security issue existence. The mix-up ought to be seen as a chance to realize why the blunder happened and how to forestall comparative mistakes that others may focus later on.

Recommendations

The present examination recommended the essential to enhance the exactness of medication errors detailing through nurses complete. Outlining harmless workplace favorable for tolerant maintenance conveyance and lessen the event of medication administration errors. Upper administration should be to urge their workforce to prepare occurrence report far from any kind of fault or discipline philosophy and saw by nurses as intended to enhance quiet well-being instead of finding botches. Creating and scattering the patient security rules in all doctor's facility setting. The doctors prescribed for arrangement of progressing instruction and preparing on routine with regards to twofold checking medicine to safe drug administration for all nurses, and in

addition usage of medication data direct however creating self-report record book. The findings from this investigation indicated the necessity to advance examination on how the administration of hospital is speaking.

Conclusion

This study classifies the reasons of medication administration errors' occurrence as follow; difficult to gain information on medication errors, illegible medication order, similar medication, look-alike medicine, frequent substitution of drugs and Pharmacist not being available for 24 hours. The issue examination reveals factors clarifying why staff nurses may not report medicine errors which include: positive expectation from nurses, error definition reasons, and fear from the patient's family, physician and nursing administration, errors not being too important to report and no positive feedback by patients.

Essentially, decreasing these mistakes needs the commitment of each person considering the patients' care. The doctors who write the prescriptions, dispensed by Pharmacist and the nurses who administer medicines to the patients, are considered as essential elements in avoiding prescription blunders. These prescription rights are intended to guarantee patients' care.

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