

# ABSTRACT

## ANALYSIS OF DRUG ADMINISTRATION BY NURSES IN HEALTH FACILITY XII

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### BACKGROUND

Drug related problems are occurred at various levels: drug choice, dosage, administration, interactions, adverse reactions etc. Drug administration errors include for example wrong drug administration (wrong dosage, wrong timing, wrong dosage form etc.), forgotten drug administration, non-use of drug and wrong drug use.

### AIMS

Aim of this work was to describe drug related problems occurred during drug administration in health care facility.

### METHODS

The data was collected at three different departments (follow-up care, surgery and neurology) in one hospital in Olomouc region. The method of direct observation was chosen. The morning, midday and evening drug administration was observed. The observation was taken time 3 days in every department. Identification of a patient, hand hygiene and check of use were observed. Manipulation of oral tablets and capsules, oral liquids and eye drops and ointments were observed. Also, severe drug related problems were observed for example wrong drug, wrong dosage, wrong timing, wrong patient, wrong dosage form etc. All data was filled in the paper forms and after that rewritten into electronic database (Pharma Portal®).

### RESULTS

53 patients were observed (17 in follow-up care, 18 in surgery and 18 in neurology), whereby were administered 499 drugs – 447 oral tablets and oral capsules, 39 oral liquids and 13 eye drops and eye ointments. We wrote down overall 1021 medication errors. Most frequent was administration without identification of a patient (333), insufficient hand hygiene of a nurse during administration (297), administration without check of use (89) and unclear prescription of a drug (71). The occurrence of severe drug related problems was 0,9 %. Most frequent was wrong dosage form (5) and dose omission (2).

**CONCLUSION**

Out of 1021 medication errors was occurred 25,5 % in follow-up care, 17,1 % in surgery and 57,4 % in neurology. Occurrence of medication errors was frequent at every department. It's necessary to solve these medication errors and receive precautions to prevent them.

**KEY WORDS**

Drug administration, nurse, health care facility