International Journal of Biotechnology and Allied Fields (IJBAF)

www.ijbaf.com

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FRAMEWORK FOR PATIENT SAFETY

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Article Synopsis

Appropriate medication use is a complex process involving multiple organizations and professions from various disciplines combined with a working knowledge of medications, access to accurate and complete patient information and integration of interrelated decisions over a period of time. The growing complexity of science and technology requires health care providers to know more, manage more, monitor more, and involve more care providers than ever before. Current methods of organizing and delivering care are not able to meet the new expectations of patients and families because the knowledge, skills, care options, devices, and medications have advanced more rapidly than the health care system's ability to deliver them safety, effectively, and efficiently. The potential for errors of omission or commission to creep into the process is extraordinary. No one clinician can retain all the information necessary for overseeing sound, safe, best practice. This is especially true in the case of pharmaceutical delivery and development. safety crosses professional boundaries and the curriculum is presented in a multi-disciplinary and multi-professional way. (team oriented).

Outline: Abstract; Introduction; Important Definitions; Scope of Safety Problems; Understanding Error; Identifying Risk; Targeting Medication Safety at The Microsystem Level; Collaboration Across the Medication Use Process; System Failures in the Medication Use Process; Classification of Medication Errors; Medication error-prevention strategies; Recommendations for Prescribing Improvements; Error Potential in the Dispensing Phase; Error Potential in the Administration Phase; Changing Systems Within Organizations; Steps for Conducting a Root Cause Analysis; Role of Patients in Medication Errors; Developing a medication communication framework

Abbreviations: After Action Reviewers (AARs); Adverse Drug Event (ADE); Potential Adverse Drug Event (PADE); Adverse Drug Reaction (ADR); Medical Error (ME); National Institute for Health and Care Excellence (NICE); People's Dispensary for Sick Animals (PDSA); Sound Alike Look Alike Drugs (SALAD); Computerized Provider-Order Entry (CPOE); Drug-drug interactions (DDIs); Hospital Survey on Patient Safety Culture (HSOPS); Safety Attitudes Questionnaire (SAQ); Agency for Healthcare Research and Quality (AHRQ); Situation, Background, Assessment, Recommendation (SBAR); Institute for Health Care Improvement (IHI); Australian Pharmaceutical Advisory Council's (APAC); Medical Office Assistant (MOA); Electronic Medical Record (EMR); Institute of Medicine (IOM); High-Reliability Organizations (HROs)