

Safety in Medication Use

Dear Editor,

Using medicines is the most common treatment in health care and they significantly improve health when used appropriately. However, medicine use can also be associated with harm and may be associated with more errors and adverse events than any other aspect of health care. Medication safety has long been recognized to be important in the provision of patient care. Medication errors are one of the leading causes of avoidable complications and deaths, emphasizing the need for a better understanding of the nature and scope of medication errors. The present book provides an excellent overview of this difficult but fascinating subject.

The book is divided into three main sections. Section I deals with the extent of the problem which occurs during various stages of the medicine use process ranging from prescribing, dispensing to administering medicines. Section II examines medicine safety from a variety of perspectives ranging from measurement, education, psychology to quality improvement, and system-based factors. Section III of the book considers approaches and interventions to improve medicine safety.

This multi-author book has contributors from a number of nations though we did notice that most authors were from industrialized nations. The chapters in the book have been well structured with each beginning with key points, introduction, various sections and subsections, and ending with the conclusion.

Section I examines the medication use process in a chronological patient-centered sequence starting with prescribing and continuing to dispensing and administering the medicine and communicating issues of medication safety. Section II provides a detailed perspective on medication errors. Measuring medication errors may not always be easy due to a variety of reasons including reluctance to report the same on the part of health-care personnel (HCP) and institutions. Retrospective review of records, incident reporting, and reporting by a clinical pharmacist are the three main methods used to report medication errors. Patient safety research is an important area of research which widely uses psychological theories. The aviation industry was one of the pioneers in reducing errors and improving safety and error prevention in health care borrows heavily from aviation. Educational theories are important to guide learning and practice of health-care workers and ultimately promote safe medication use. The process of prescribing and various factors influencing the same have been described in detail. Electronic or e-prescribing is becoming increasingly common even in developing nations. Increasing availability of various resources electronically can support and promote rational use of medicines and reduce medication errors.

Improvement in science and continuous quality improvement attract an increasing attention, and the Institute of Healthcare

Improvement based in the United States offers online modules for health science students and practitioners in the discipline. This multi-author book adopts a system-based approach to medication errors and emphasizes solution/redressal operating at a system level rather than blaming a particular individual. Different medication error reporting systems in selected regions/countries have been described with lessons for other countries. Problems in communication between HCPs, especially occurring in hospitals, could be an important reason for medication errors. An entire chapter has been devoted to communication between HCPs. The book concludes by describing various interventions and approaches to create a safer work system and reduce errors. This book is a wonderful addition to scientific libraries and the drug safety literature and will be of interest to all health professionals, academics, students, and managers interested in reducing medication errors and creating a safer health system.

About the book

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Conflicts of interest

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