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Knowledge, Attitude And Practice On Medication Errors Reporting Among Healthcare Practitioners In A Tertiary Care Teaching Hospital.

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ABSTRACT

Background

Medication errors are one of the preventable causes of factors upsetting the quality and safety of patients in hospitals. These errors can occur throughout the medication use process, from prescription, and dispensing to administration. Medication errors remain a critical challenge often leading to adverse patient outcomes. Despite advancements in healthcare, medication errors pose a important threat to patient safety worldwide, impacting morbidity and mortality rates in healthcare settings. Disparities in reporting systems across different regions, such as the absence of national medical error reporting in countries like India, can complicate error reporting and their assessment. Understanding healthcare providers' knowledge, attitude, practice, and perspectives toward error reporting is important for improving patient safety outcomes globally. The study aims to identify barriers and opportunities for implementing targeted interventions, developing efficient strategies, and exploring factors to decrease medication errors.

Methodology

This study used a descriptive cross-sectional design and relied on questionnaires to gather data. All subjects gave their informed consent after the study received ethics approval from the Gannavaram-based Dr. Pinnamaneni Institute of Health Sciences and Research Foundation's committee on 12/10/2023. This study included physicians, postgraduates, nurses, and pharmacists excluding patients and non-medical staff. The purpose of this study was to evaluate the KAP (knowledge, attitude, and practices) of 300 practitioners with respect to reporting medication errors. The link between demographic characteristics was investigated by collecting data via Google forms for one month and then analysing it using descriptive statistics and a Chi-Square test (P value < 0.05).

Results

Medication errors remain prevalent due to handwritten prescriptions and inadequate reporting systems. In our study, out of the 500 questionnaires distributed 323(64.6%) healthcare professionals responded. The study revealed a high baseline knowledge level of 90% among healthcare professionals regarding medication error reporting. Barriers to knowledge include absence of reporting systems, fear of reporting errors. approximately 63% of the respondents exhibited a favorable attitude towards MER with the remaining 37% unfavorable. Factors contributing to unfavorable attitudes include concerns about negative consequences, Healthcare organization

culture, perceptions of reporting in efficacy. Actual practice of MER was limited among respondents with reasons for under- reporting include thinking of it as a minimal harm, fear of consequences and concerns over documentation burden, blaming and confidentiality. The results highlight substantial disparities between knowledge, attitudes and the implementation of medication error reporting (MER) among healthcare providers. This underscores the necessity for targeted strategies to improve reporting behavior and patient safety outcomes.

Conclusion

Despite having good knowledge levels, healthcare professionals exhibit limited positive attitudes and practices in medication error reporting (MER). Enhancing education, implementing baseline awareness safety programmes, pharmacovigilance programmes and mentorship during undergraduate and house Surgeon training promotes awareness and increases active reporting. There is a need for comprehensive strategies to bridge the gap between knowledge and practice in MER among healthcare providers.

Keywords: KAP study, medication errors, healthcare professionals reporting, medication error reporting, reporting system

INTRODUCTION

Background

The term "medication error" refers to any avoidable occurrence that can cause patients to receive the wrong medication [1]. Alternatively, defined as failure within the treatment process. Medication mistakes are the second most recurrent cause of patient safety incidents in hospitals after patient accidents, contributing to approximately 11% of all incidents, affecting 1,34,684 patients. [4]

These errors can occur at various stages in a multidisciplinary paradigm with varying severities during 1) prescribing medication by a physician, 2) dispensing medication at pharmacy by a pharmacist, 3) administering and monitoring medication by a nurse and 4)lack of patient awareness on its usage [2]

Globally, medication errors are emerging as a significant patient safety concern with experts estimating over one million serious errors happening in hospitals every year, contributing to cumulative rates of morbidity and mortality. [2][3].

Medication error complaint frequencies vary across provinces and specialties with surgical specialities and obstetrics/gynecology exhibiting higher reportage rates than those in other countries. [5].

Errors can occur during drug instruction, dispensing or administering of medication, regardless of them causing harm to the patient or not. In India, the lack of a national medication error reportage system hinders the assessment of clinical and economic influence of medication errors. Establishing a strong and efficient reporting system is essential for evaluating, managing and addressing medication errors. A robust reporting system in healthcare can minimize the harm and adverse effects to patients. Improvements in healthcare transparency, quality, and safety can be achieved by integrating health care practitioners' understanding of medical errors with a reporting system that serves as a tool for quality improvement and an instructional exercise. Enhancing the safety of healthcare also decreases the incidence of medical errors, events, and harm to the patients. [4]

Healthcare providers must acknowledge that Error reporting is a vital means/ prospect to improve patient care and establish a reliable environment. Even though medical errors are said to be Often attributed to systemic issues in healthcare rather than individual misapprehension, healthcare providers may observe discrepancies between the principal and its application in practice. Healthcare providers may not witness this implementation in clinical practice. [5]. reporting medication errors contributes to active learning and promotes safer healthcare practices which reduces the incidence of adverse events and prevents repetition of similar errors. [6].

practice of no blame and non-inflictive culture, educating and updating with medication safety courses, and application of digital programmes can improve the reporting of medication errors[6][7]

Worldwide, many hospitals have accepted safety reporting system, (SRS) to document incidents that compromise patient safety. [7] Due to the global impact of medication errors, In October 2011, the world health organization (WHO) introduced a curriculum guide to educate and train healthcare professionals in priority patient safety practices to mitigate them .[8].

Examining and comparing healthcare workers' KAP (knowledge, attitude, practice) about reporting medication errors at a tertiary care teaching hospital was the major objective of this study. Furthermore, we checked for potential confounding factors including gender, age, years of experience, employment, surroundings, and medication error history. in the end, to establish or improve upon existing rules that put patient safety firs.[10]

Using a cross-sectional self-administered questionnaire, our study sought to assess the knowledge, attitude, and practices (KAP) of healthcare practitioners (physicians and nurses) at Dr. Pinnamaneni Institute of Health Sciences and Research Foundation, Gannavaram about medication error reporting. We want to assess the level of understanding, perspective, and behaviour of healthcare professionals (including postgraduates, physicians, nurses, and pharmacists) about pharmaceutical errors and how they report them. Furthermore, we strive to determine if there is a requirement to establish or enhance current mechanisms for reporting medication errors.

AIM & OBJECTIVES

AIM:

1. To evaluate the KAP of medical professionals working at Gannavaram's Dr. Pinnamaneni Institute of Health Sciences & Research Foundation.
2. To examine the reporting of medication errors through the use of a self-administered, cross-sectional questionnaire

OBJECTIVES:

1. To assess the knowledge of health care professionals (postgraduates, clinicians, nurses and pharmacists) on medication errors.
2. To assess the attitude of health care professionals towards medication error reporting.
3. To assess the health care professional’s reporting practices on medication errors.
4. To identify any need for creation or improvement of existing methods on reporting medication errors.

REVIEW OF LITERATURE

1. Ahmad E Aboshaiqah etal(2013) [6], collected data from 350 participants in a cross-sectional questionnaire study to determine if hospital nurses report prescription delivery errors the questionnaire containing situations explaining the different barriers of medication administration errors like fear, administrative response, disagree with definition, reporting effort and found that 1) If a patient suffers harm as a consequence of a medication error, the nurses may be held responsible. 1) The study's two most important findings are that 1) when medication errors occur, nursing administration focuses on the individual rather than looking at the system as a possible source of the error. A secure and supportive environment free of blame and punishment is essential for the improvement of patient care and the development of effective techniques.
2. Alsulami etal(2014) [7] surveyed 365 people—62 doctors and 303 nurses—using a cross-sectional questionnaire to gauge their level of understanding, attitudes, and behaviours regarding the reporting of prescription errors. The following statistics are derived from a questionnaire that measures participants'

knowledge, attitude, and practice regarding medication error reporting (MER): 90% have good attitude towards MER, 21.6% would rather educate the individuals responsible for medication errors than report them, and 44.8% have never reported a medication error. There is a lack of reporting of drug errors in practice, despite the positive outcomes. To reduce the occurrence of drug errors, we suggest taking a course on medication safety and using digital software.

3. Alzaagi etal(2015) [8] conducted a study with the goal of describing the medical safety unit (MSU) programmes at KSMC in Saudi Arabia, along with their aims, and drawing on qualitative research conducted worldwide to enhance medication error reporting. The study used a mixed-methods approach. Performing campaigns and offering training courses are part of MSU's yearly objectives and operations. In order to improve patient safety, healthcare quality, and medication safety, the MSU established 14 programmes and an annual medication safety plan of actions, along with related policies, procedures, and guidelines. These initiatives were backed by qualitative evidence-based research data and aimed at reducing medication errors and increasing safe medication management and use. MER incorporates MSU as a safety tool to improve drug management and patient safety.
4. Rogie Royce etal [9] did a study on medication error reporting amongst health care practitioners in manalia. By doing a cross sectional questionnaire study on a sample of 180 medical practitioners . Questionnaire consists of four sections focusing on situations to assess knowledge, attitude and practice on MER and found that 28% health care practitioners are knowledgeable and 72% are non-knowledgeable and more than 58% have unfavourable attitude on MER and 52% are practicing MER. On analysis and comparison with other demographic details there is a native improvement on health practitioners basic knowledge on MER and make them practicing of MER by doing certain MSU programmes on personal approaches etc.
5. Afsaneh and Saadat etal(2012) [10] conducted an observational study in an 11-bed internal intensive care unit (ICU) ward supervised by a trained pharmacist to determine the frequency, types, and consequences of medication errors. The study found that out of 5,785 opportunities, 442 (or 7.6% of the total) errors were identified. Daily, each patient received an average of eleven medications. Mistakes in administration (9.8%), prescription (6.8%), transcribing (3.3%), and dispensing (2.3%). To improve the quality of care in the intensive care unit (ICU), it is necessary to enhance the prescription system, write and implement standard treatment guidelines, and allocate a full-time pharmacist. Rule violations, slips and memory upsets, and a lack of drug knowledge are predisposing factors.
6. Johnson and Thomas etal (2013) [11] used a cross-sectional questionnaire to evaluate the knowledge, attitude, and practice of 120 hospital nurses on medicine administration and medication errors; of these, 67% hold a GNM degree, while the rest hold a B.Sc. According to the results, the average knowledge score among B.Sc. grads was 15.1+2.6%, while among GNM graduates it was 14.2+2.8%. When broken down by age group, participants with less than two years of experience had a 13.9% score, while those with more than two years had a 14.8% score. Participants' levels of familiarity with drug errors are consistent across demographics defined by clinical experience and education. To prevent prescription errors, more than 75% of nurses believe that ongoing education and current knowledge of pharmacology are crucial.
7. Sabina Sahzadi etal(2017) conducted a study to determine the factors preventing nurses from reporting medication administration errors (MAEs) at Service Hospital Lahore. The study used a quantitative description cross-sectional questionnaire with 222 participants selected using a solving formula sampling

method. The questionnaire assessed various barriers, such as disagreements over definitions, reporting effort, fear, and the response from administration. The majority of participants reported feeling frightened and unconvinced by the administration's approach to managing MAEs. To fix this, all hospitals should have a mechanism in place for reporting the administration of medications. When a staff nurse reports an error, the hospital administration shouldn't hold that person responsible. Before beginning their tasks, staff nurses should receive proper orientation and guidance.

8. Alshaikh etal(2013) [12] conducted research to determine how often medication errors were reported and what variables were connected with the underlying causes of these errors in a Saudi Arabian hospital. Based on data collected from hospital web-based medication error reports, which were reviewed and reported quarterly for a year, we know that the medication error rate over that time was 0.4%. Of these errors, 89% occurred during the prescribing stage, and we know that various factors, such as a lack of specific performance (43%), knowledge (28%), and unclear handwriting (17%), contributed to these errors. This means that a tertiary teaching hospital in Saudi Arabia's capital city of Riyadh does not adequately record medication mishaps. To encourage healthcare practitioners to disclose drug errors, future research should assess the efficacy of interventions in this area.
9. Abdel-latif etal [13] conducted a study to gauge healthcare workers' understanding of drug errors in a hospital setting. 322 healthcare workers were given a self-administered questionnaire with questions designed to measure this understanding. The vast majority of them are well-versed in the ideas of drug errors and the risks they pose to patients. Their familiarity with the reporting system is low at 68.7 percent. According to their findings, the majority of hospitals do not have any transparent systems in place for patients to report mistakes. The most common causes of mistakes are formulation (46.5%) and delivery (24%). Healthcare providers' levels of knowledge about the dangers of drug errors in hospitals varied, according to this research. There has to be an immediate effort to educate Saudi hospital staff about the seriousness of pharmaceutical errors due to the widespread lack of understanding in this area.
10. Alsafi etal [14] gave a self-administered survey questionnaire to licenced physicians in order to investigate their knowledge and practice regarding the reporting of prescription errors. Questions on demographics, as well as MER knowledge, attitude, and practice, are all part of the questionnaire. Medical professionals' familiarity with medical error reporting practices and their understanding of the prevalence, incidence, and root causes of medical errors are the subjects of this research. Medical errors frequently went unreported at this facility. There was still a blaming culture in place, and doctors did not like efforts to make the error reporting system better. It is the responsibility of doctors, hospitals, and other healthcare organisations to encourage patients to report medical mistakes. Healthcare facilities ought to implement a system that encourages and facilitates the reporting of errors. A culture free of blame, secrecy, and openness should characterise this.

METHODOLOGY

The research methodology used in this study is a descriptive cross-sectional survey. All subjects provided written agreement in the local language, and the study was authorised by the ethics committee on 12/10/2023 at Dr. Pinnamaneni Institute of Health Sciences & Research Foundation, Gannavaram.

Inclusion Criteria:

- All health care professionals in a tertiary care teaching hospital.
    i. Clinicians,

ii. Post-Graduates
iii. Nurses and
iv. pharmacists

Exclusion Criteria:

- Patients, and
- Non-Medical Staff

Sampling Design and Sample Size:

To assess their present knowledge, attitudes, and practices (KAPs) regarding medication error reporting, 300 healthcare professionals from Dr. Pinnamaneni Institute of Health Sciences & Research Foundation in Gannavaram were chosen at random to participate in the survey.

Research Instrument and Measurement

Concerned doctors, nurses, and pharmacists filled out a survey to provide data. This medication mistake questionnaire was derived from previous surveys published in peer-reviewed journals. To make sure the questionnaire was reliable and to be able to compare the results with other studies, we used these instead of making our own. A few adjustments were made to make the study more applicable to the local context and to reduce the number of categories to three. Each category now contains five questions that examine knowledge, attitude, and practices. Seeking advice from competent experts guaranteed the content's legitimacy. The questionnaire was further revised in response to the comments. For knowledge, we looked at the medication error reporting system's procedures and aims. For attitude, we asked people why they report medication errors and what could make them not report. Additionally, the various methods employed by the medical professionals were covered.

The survey consisted of four parts. In the corresponding areas, we collected data on the health practitioners' demographics, as well as their knowledge, attitudes, and behaviours regarding reporting medication errors, as well as their attitudes towards reporting.

Section A

Socio-Demographic Profile

Demographic characteristics included in the study are:

- Name:
- Age:
- Sex:
- Department:

- Qualification:
- Years of experience:

Section B

Knowledge on Medication Error Reporting

Medical professionals' A 5-point Likert's scale, from "strongly agree" to "strongly disagree," was used to assess knowledge on the reporting of medication errors. After adding up all of the replies, doctors and other medical professionals were deemed educated if their scores were between 20 and 25, and uninformed if their scores were below 20.

Section C

Attitude on Medication Error Reporting

We used a 5-point Likert scale, from "strongly agree" to "strongly disagree," to measure the attitudes of health practitioners towards reporting prescription errors. After adding together all of the replies, we found that health practitioners with a score between 20 and 25 had a positive attitude towards reporting drug errors, whereas those with a score between 5 and 19 had a negative attitude.

Section D

Practices on Medication Error Reporting

The last part of the survey used a 5-point Likert scale, with "always" being the highest and "never" the lowest, to enquire about how often medical professionals notice and report pharmaceutical errors. The results were added up, and doctors and nurses who received a score between 20 and 25 were deemed to be reporting drug errors, while those with scores between 5 and 19 were deemed not to be.

Data Collection

Within one month of receiving the Ethics Committee's green light, 300 randomly selected health practitioners were contacted via email or other means of electronic communication with a link to a Google form that contained all of the survey questionnaires. They were kindly requested to complete the form and submit it without delay. The health practitioners were able to easily accommodate the completion of the questionnaire into their schedules.

Data Analysis

With a significance level of $P < 0.05$, the variables were cross-tabulated using the Chi-square test distribution. Included in this were assessments of the impact of KAPs on the reporting of drug errors by healthcare professionals, including doctors, nurses, and pharmacists. The demographic data of the health practitioners, including their age, gender, years of practice, work environment, and history of medication errors seen, were analysed using frequency and percentage. The demographics of the participants were correlated with their KAPs on reporting medication errors using a Pearson chi-square test.

RESULT

Patient safety and wellbeing are the main and most important concerns in healthcare. In order to make sure patients receive the right medication at the right time, reporting an insufficient dose is a proactive step. Inadequate dosages can result in therapy failure, less than ideal therapeutic outcomes, or even patient damage in certain situations. By reporting such mistakes, negative consequences can be avoided quickly by involvement and rectification. Healthcare professionals may be required by law or ethical standards to disclose pharmaceutical errors, particularly where those errors have the potential to cause patients damage. Ignoring such mistakes could have legal repercussions and jeopardize one's integrity as a professional.

Of the 150 individuals, 40 percent identified as male and 60 percent as female. Survey respondents were mostly in agreement with the statement, as seen by the 60.4% of female participants and the 59.3% of male participants who expressed concurrence or strong agreement. In contrast, a smaller proportion—4.2% of females and 9.3% of

males—disapproved or severely disapproved. Furthermore, 5.6% of respondents who were female and 7.4% of respondents who were male took a neutral position.

If healthcare providers disclose errors promptly, they can take timely action to correct the situation. To suit the patient's needs, this can entail rearranging the delivery of the drug, getting a replacement dose, or looking into alternate forms of treatment. In the healthcare industry, transparency is essential, and admitting mistakes shows a dedication to responsibility and transparency. It enables medical personnel to accept accountability for their deeds and cooperate to stop such occurrences from happening in the future. By reporting the inaccuracy, you provide yourself the chance to conduct a comprehensive investigation into the underlying reasons of the issue. Recurrence can be prevented by implementing corrective actions if underlying issues, such as communication breakdowns, system failures, or procedural faults, are identified.

Of the 150 participants, 36 percent identified as male and 64 percent as female. Upon analysis of the responses, it was found that a significant proportion of participants, both male and female, agreed with the statement. Specifically, 69.8% of male participants and 62.9% of female participants indicated strong agreement or concurrence. A tiny minority, 2.1% of women and 3.7% of men, on the other hand, disagreed. Six percent of females and seven percent of males took a neutral view.

By reporting the mistake, the treatment plan can be corrected in a timely manner. To preserve the effectiveness of the recommended regimen, this may entail giving the missing drug, modifying subsequent doses, or looking at alternate forms of treatment. Strict prescribing guidelines are followed by medical experts to guarantee that patients receive the right care. It is imperative to report drug administration errors in order to comply with established guidelines and preserve the caliber of care rendered. Error reporting is a crucial component of the healthcare industry's ongoing learning process. Through a comprehensive analysis of the contributing elements to the error, valuable insights can be obtained to improve processes, communication, and overall patient care.

Sixty-four percent of the respondents overall identified as female, and 36 percent as male. According to an analysis of the responses, 57.3% of the participants who were male and 59.3% of the participants who were female agreed with the statement. On the other hand, a lower proportion—5.2% of women and 7.4% of men—disapproved. 1.9% of men and 4.2% of women took a neutral position.

Sharing knowledge about drug mishaps with coworkers fosters a sense of collective accountability. It promotes candid communication among team members of the healthcare system, fostering an atmosphere in which they may discuss possible problems and work together to find solutions. Understanding the significance of reporting events is one aspect of being knowledgeable about drug errors. Teaching colleagues about the reporting process and its advantages fosters a culture that sees errors as chances for growth rather than places blame. Education on medication errors is a type of professional growth. It gives medical practitioners the information and abilities they need to handle complicated drug schedules, make efficient use of technology, and keep up with changing safety regulations.

Of the participants, 64% self-identified as female and 36% as male. After analyzing the responses, it was found that a sizable majority of the participants—57.3% of the females and 72.2% of the males—were in agreement with the statement. Remarkably, a significant percentage—41.7% of women and 27.8% of men—showed strong agreement. Just 1% of women selected the neutral position.

Acknowledging the significance of reporting medication errors requires knowledge of the potential effects these errors may have on patient outcomes. By reporting, possible harm can be reduced and the general standard of care can be raised in a timely manner. Your assurance might come from knowing exactly what the moral and legal

requirements are when it comes to reporting pharmaceutical errors. Understanding one's ethical and legal obligations strengthens one's commitment to openness and responsibility. Your assurance could be a sign that you recognize the importance of finding systemic problems in addition to personal accountability when reporting pharmaceutical errors. Error patterns can be identified and reported, which can result in systemic changes that enhance patient safety.

Sixty-four percent of the respondents overall identified as female, and 36 percent as male. Upon analysis of the responses, it was found that 61.5% of the female participants and 66.7% of the male participants agreed with the statement. Just 1% of the respondents, who were both male and female, disagreed. Remarkably, a sizable proportion of participants expressed a neutral position, with 12.5% of female respondents and 14.8% of male respondents selecting this choice.

All drug errors should be reported in order to promote systemic improvement. Even in cases when the patient is affected, reporting offers valuable insights into the processes that led to the error. This information can be used by the healthcare system to enhance training, communication, and procedures. Errors discovered before to reaching the patient, or near misses, are priceless teaching moments. By reporting these instances, medical practitioners can identify the underlying reasons and take preventative action. Adopting a mindset that values learning from close calls can result in ongoing improvements to patient safety. An essential part of efficient risk management in the healthcare industry is reporting near-misses. Organizations can lower the overall risk of pharmaceutical errors by implementing proactive measures aided by an understanding of the number and type of near-misses.

Of the participants, 64% self-identified as female and 36% as male. A complex distribution of opinions is shown by the statistics upon examination of the responses. The majority of participants—39.6% of females and 14.8% of males—both female and male, disagreed with the assertion. However, a lesser proportion—27.1% of women and 50% of men—agreed with the assertion. A significant proportion of participants opted for a neutral position, comprising 14.6% of females and 16.7% of males.

A non-punitive approach to error reporting is supported by confidentiality. If healthcare personnel are aware that reporting errors would be kept private and used for improvement rather than punishment, they may report errors. The reporting system must be trusted by healthcare practitioners. Ensuring anonymity fosters trust among employees by highlighting the fact that improving patient safety is the primary objective of reporting, not placing blame. The efficacy of the reporting procedure depends on this confidence. One major obstacle to reporting errors is fear of reprisals. By protecting healthcare workers from unfavorable outcomes, confidentiality encourages them to come forward with information that could improve patient safety. Of the participants, 64% self-identified as female and 36% as male. Upon analysis of the responses, it was found that 61.5% of the female participants and 62.9% of the male participants agreed with the statement. 7.4% of men and 8.3% of women disagreed, which is a lower proportion. A significant percentage of participants opted for a neutral position, comprising 11.5% of females and 16.7% of males.

Patient safety and wellbeing are the main priorities in healthcare. Reporting medication errors is an essential first step toward putting patient safety ahead of personal concerns, regardless of who is at fault. Healthcare providers work together to provide high-quality care, and they are all accountable for it. Reporting mistakes made by others strengthens the commitment to delivering the best possible care by fostering a culture of accountability and teamwork. Regardless of who is at fault, healthcare personnel frequently have moral and legal obligations to

report pharmaceutical errors. This guarantees adherence to legal requirements and contributes to preserving the integrity of the healthcare system.

Of the participants, 64% self-identified as female and 36% as male. Upon analysis of the responses, it was found that 51% of the female participants and 53.7% of the male participants disagreed with the statement. Of the male and female population, 10.4% and 14.8%, respectively, agreed at lower rates. A significant percentage of participants opted for a neutral position, comprising 10.4% of female respondents and 13% of male respondents. People live in complicated systems, and a culture that values a systems-based approach to errors acknowledges this. Error reporting sheds light on systemic problems by directing attention away from personal responsibility and onto areas where procedures and guidelines need to be improved. Reporting faults is considered an essential component of professional development. It shows a dedication to lifelong learning and development, which helps to shape the growth of a more capable and resilient healthcare practitioner. For the patient as well as the healthcare provider, failing to disclose an error may have more dire repercussions. The repercussions of failing to report an error that causes harm to patients may be worse than the initial cost of doing so.

Of the participants, 64% self-identified as female and 36% as male. Based on the analysis of the responses, 42.7% of the female participants and 35.2% of the male participants, respectively, disagreed with the statement. A lower proportion

DISCUSSION

Knowledge:

Even in industrialised nations, where computerised systems and robotic dispensing facilities handle the pharmaceutical use process, mistakes can happen. This is true even when hospitals use formularies and specialised clinical pharmacists are on staff. Medication errors still have a ways to go before they are adequately addressed. For instance, doctors still use cliches and symbols when writing prescriptions, which increases the likelihood of mistakes. Additionally, there are inadequate reporting mechanisms and a severe lack of healthcare workers. In our study, of the 500 questionnaires distributed, the response was 323 (64.6%), comprising 42.72% for physicians, 10.53% for pharmacists, and 46.75% for nurses. The present study showed a basic knowledge among healthcare professionals. In our study, nearly 90% of individuals are knowledgeable about the medication error reporting may be due to the baseline awareness about MER from the education level or during clinical practises and exposed to different programmes regarding MER or any under good guidance and their experiences.

One probable explanation for the remaining people's lack of understanding of mistake reporting systems is that many healthcare providers may not have active pharmacovigilance reporting systems. Healthcare practitioners were hesitant to report prescription errors due to a lack of understanding about the reporting systems, as well as a general aversion to doing so.

Poor information on reporting procedures and availability and/or accessibility of reporting systems were the primary factors for under-reporting of medication errors in our investigation, when compared to other studies. Several research from various countries, such as the UK, France, the Netherlands, Italy, and Sweden, found that practitioners lacked an understanding of reporting systems and were unaware that hospitals had pharmacovigilance centres. These findings are in agreement with these findings. The proper way to report an adverse drug reaction was unclear to many EU healthcare workers. In addition, 71% of Chinese healthcare professionals were unfamiliar with the reporting process, and 40% of Malaysian respondents were unaware that a national reporting system existed.

Attitude:

According to this study, nearly 63% has favourable attitude towards MER and remaining 37% are not favourable towards MER. Even though 90% of them are knowledgeable only 63% of them are favourable reporting MER. Based upon this, the unfavourable attitude may be due to:

1. Fear of Reprisal:
   - Concerns about Negative Consequences
2. Blame Culture:
   - Impact of Blame Culture on Reporting
3. Lack of Trust in Reporting Systems:
   - Confidence in Reporting Mechanisms
4. Time Constraints:
   - Balancing Time Pressures with Reporting
5. Perceived Uselessness of Reporting:
   - Beliefs about the Efficacy of Reporting
   - Lack of Feedback: Importance of Feedback in Reporting
6. Professional Ego and Stigma:
   - Overcoming Stigma and Professional Ego
7. Organizational Culture:
   - Influence of Organizational Environment
8. Lack of Education and Training:
   - Importance of Education on Error Reporting
9. Fear of Legal Ramifications:
   - Legal Concerns Impacting Reporting
10. Ineffective Communication:
    - Role of Communication in Reporting Culture

Practise:

Only few individuals are practising medication error reporting and many are not practising MER at all. Some of them had not even experienced MER in their practise. The reasons for not reporting MER even though having knowledge and favourable attitude towards it are:

1. Minimal Perceived Harm:
   - Downplaying the Significance
2. Fear of Consequences:
   - Balancing Attitude with Fear
3. Documentation Burden:
   - Time and Reporting Constraints
4. Normalization of Errors:
   - Cultural Impact on Reporting
5. Lack of Clear Procedures:
   - Ambiguity in Reporting Steps
6. Concerns about Blame:
   - Balancing Accountability and Reporting

7. Confidentiality Issues:
   - Privacy Concerns in Reporting
8. Inadequate Feedback:
   - Impact on Motivation to Report
9. Cultural Factors:
   - Influence of Organizational Culture
10. Leadership and Organizational Support:
    - Importance of Organizational Backing
11. Incomplete Understanding:
    - Awareness of Reporting Impact
12. Perceived Ineffectiveness:- Assessing System Efficacy

CONCLUSION:

On this study I conclude that many individuals having good knowledge on the MER, even though having good knowledge only low individuals have favourable attitude and habit of practising MER. This is due to many barriers of MER like fear, administrative response, disagree with definition etc. So, in order to overcome this type of barriers and achieve proper MER practise by maintaining patient safety, we have to promote the base line awareness programmes on MER and pharmacovigilance programmes during UNDER GRADUATION and HOUSE SURGEON level and also implement safety programme(MSU) and proper guidance from the Teachers, seniors and other colleagues. By this, we can develop good knowledge, favourable attitude and habit of medication error reporting. Thus, by increasing the significance of MER and achieving patients' safety, we can reduce the medication errors.

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