Background: Older people are potentially at greater risk of medication error. Gaining insight into the physicians prescribing pattern in order to identify prescribing problem is the fundamental step in improving the quality of prescription and patient care.

Objectives: To analyze drug use pattern and study elderly inpatient file for prevalence and frequency of occurrence of some predetermined prescribing errors.

Method: A retrospective study of elderly (65 years and older) inpatient record was conducted from April to June, 2010. WHO core drug prescribing indicator was used to evaluate prescription pattern. Prescription errors were categorized as errors in prescription writing and errors of commission (ignoring drug interactions, use of potentially inappropriate medication).

Results: A total of 305 medical files were studied. 211 were male and 204 were younger elderly (65-74 years). 2985 drugs were prescribed (average exposure/patient: 9.8). 84% of drugs were prescribed by generic name. Percentages of drugs prescribed from National essential drug list and WHO list were 75% and 55% respectively. 1233 errors in prescription writing were identified. Route, ending date of therapy, and signature of prescribing doctor were most missed items (missing in 10.2%, 7%, and 12% of drug prescribed respectively). 5% of drugs names were written with unacceptable abbreviations while use of error prone abbreviations, symbols and dose designations was 0.27% per prescribed items. 145 patients were prescribed at least one potential inappropriate medication as determined by Beer's criteria. Medication prescribed to 88 elderly patients had at least one potential chance for drug-drug interaction.

Conclusion: Frequency of occurrence of prescription errors found during the study can be rated high. The prescription pattern and the prescription errors have indicated the need to establish proper system of recording and analyzing therapy before writing a prescription in order to promote rational drug therapy in elderly. Further comprehensive studies on medication error are necessary to anticipate the scale of problem and their economic impact.

Keywords: Elderly, Prescribing pattern, Prescription error, Beer's criteria.
Drug Occurrences interaction checker 14. Drug–Drug interactions were checked using Medscape drug While error in commission included: ignoring drug–drug interaction, medications were identified using Beers’ 1997 explicit criteria. The potentially inappropriate medication use. Inappropriate categorized as: • Errors of omission (when rate or dose, concentration, dosage form, duration, frequency, route omitted and when prescriber signature missing) • Abbreviated and non standard drug names • Error prone abbreviations, symbols and dose designations • Prescribing one tablet of drug when available in more than one strength of tablet • Writing milligram when microgram was intended

While error in commission included: ignoring drug–drug interaction, potentially inappropriate medication use. Inappropriate medications were identified using Beers’ 1997 explicit criteria. The Drug–Drug interactions were checked using Medscape drug interaction checker 14.

Data analysis and result
Results were analyzed using Microsoft Excel 2007 and SPSS version 15.0 for windows. The error rate was calculated by dividing the number of errors detected by the total number of prescribed items. The chi-squared test for categorical variables was used to compare the characteristics of patient receiving and not receiving inappropriate medications. A probability value of less than 0.05 was considered statistically significant.

RESULTS
A total of 305 inpatient files were studied. 211 (69%) patients were male and 204 (67%) patients were younger elderly (65-74 years). Most patients presented with acute medical problem on a background of chronic illness. BPH was the most common (17%) reason for hospitalization of elderly patients.

Prescription pattern
A total of 2985 (2155 during hospital stay and 830 on discharge) drugs were prescribed to 305 patients (average exposure of 9.8±3.23 drugs/ patient). 84% of drugs were prescribed by generic name. More than half (55%) of drugs belonged to tablet dosage form. One hundred and eighty-seven different types of drugs were prescribed to elderly patients. Ranitidine was the most frequently prescribed drug (19% of all drugs) followed by Diclofenac (12%) and Ciprofloxacin (5%). The table 1 shows drug use indicators found from study.

Prescription error
Errors in prescription writing
The study found a total of 1233 errors in prescription writing. Table 2 shows types of error detected and their frequency of occurrence.

Table 1: Pattern of WHO core drug use indicator

<table>
<thead>
<tr>
<th>Prescribing indicators</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of drugs per encounter</td>
<td>9.8</td>
</tr>
<tr>
<td>Percentage of drugs prescribed by generic name</td>
<td>84%</td>
</tr>
<tr>
<td>Percentage of encounters with an antibiotic prescribed</td>
<td>18%</td>
</tr>
<tr>
<td>Percentage of encounters with an injection prescribed</td>
<td>30%</td>
</tr>
<tr>
<td>Percentage of drugs prescribed from national essential drugs list</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of drugs prescribed from WHO essential druglist</td>
<td>55%</td>
</tr>
</tbody>
</table>

Table 3: Inappropriate prescribing as determined by Beer’s criteria

<table>
<thead>
<tr>
<th>Drug</th>
<th>Hospital stay</th>
<th>Discharge</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LD*</td>
<td>C.D*</td>
<td>Total</td>
</tr>
<tr>
<td>Diazepam</td>
<td>57</td>
<td>2</td>
<td>59</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>54</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>Phenargan</td>
<td>41</td>
<td>0</td>
<td>41</td>
</tr>
<tr>
<td>Pentazocine</td>
<td>14</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>172</td>
<td>5</td>
<td>177</td>
</tr>
</tbody>
</table>

*ID: independent of diagnosis; CD: considering diagnosis

Patients who were prescribed more than 5 medications were 5.7 times more likely to receive a potentially inappropriate medication than those who were prescribed five or fewer medication. There was no association between gender and age in receiving potentially inappropriate medications (table 4).

Ignoring Drug–Drug Interaction
A total of 114 chances of potential drug–drug interactions were found, an average of 0.37 (95% CI: 0.29–0.45) drug interaction per patient. The drugs prescribed to 88 (29%) elderly patients had at least one chances of potential drug–drug interaction. The top 4 potential drug–drug interaction are shown in table 5.

Errors of commission
Potentially inappropriate medication use
At least one potential inappropriate medication was prescribed to 145 patients (53%) as determined by Beer’s criteria. Of the 2985 drugs prescribed, 182 (6%) were potentially inappropriate for elderly. Diazepam was most the frequent inappropriate medication prescribed (table 3).

Table 5: Top 4 drug–drug interactions

<table>
<thead>
<tr>
<th>No.</th>
<th>Drug combination</th>
<th>Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Meperidine Inj and Promethazine Inj</td>
<td>40</td>
</tr>
<tr>
<td>2</td>
<td>Ketorolac Inj and Diclofenac Inj</td>
<td>28</td>
</tr>
<tr>
<td>3</td>
<td>Gentamicin Inj and Cefotaxime Inj</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Isoniazid Oral and Rifampin Oral</td>
<td>4</td>
</tr>
</tbody>
</table>
DISCUSSION

Polypharmacy, defined as the use of five or more medications, occurs in 20-40% of older people. The prevalence of polypharmacy in 76% of patients in our study is very high. In a study carried out by Joshi et al. in one of the other teaching hospitals in Nepal the incidences of polypharmacy in elderly inpatients were found to be similar (73%). It is, however, essential to determine the potential benefits of polypharmacy in particular settings before dismissing it as entirely inappropriate. Though deprescribing is difficult, prescriber's feedback, pharmacist-led medication reviews, encouraging general practitioner to withdraw medication in older patients have been tried to reduce polypharmacy.

Percentage of drugs prescribed by generic names in our study is higher than that reported in study done in College of Medical Sciences, Bharatpur, Nepal by Ghosh et al. where it was about 23% and just over half (53.6%) of drugs were prescribed by generic names in the study by Joshi et al. It is important that drugs should be prescribed in their generic names to avoid confusion. Although there are both advantages and disadvantages of generic prescribing, there is more to gain than to lose by this practice, especially in a teaching hospital which has a dual responsibility of providing patient service as well as medical education.

In retrospective study by Shanker et al in Manipal hospital in western Nepal among hospitalised elderly, Ranitidine (30%), Multivitamins, Amlodipine, Ipratropium and DNS were the most commonly prescribed drugs. In a study by Ghosh et al percentage of drugs from essential drug lists of WHO and Nepal were 41.76% & 38.20% respectively, lower than in our study. Use of drugs from the essential drug list should be promoted for optimal use of limited financial resources, to have acceptable safety and to satisfy the health needs of the majority of the population.

Rational drug prescribing is defined as the use of the least number of drugs to obtain the best possible effect in the shortest period and at a reasonable cost. Since, WHO has recommended that average number of drug per prescription should be 2.0, result of our study reflects polypharmacy. The recommendation by WHO is not applicable to inpatient. Since majority of elderly patient in our study have undergone surgery, and average length of stay was also higher (about 6) which mean more medication prescribed and administered. In such cases polypharmacy can be justifiable.

The study has shown a high tendency to omit necessary information (viz. date of starting a drug, signature of prescribing doctor, date of stoppage of drug) in the medical wards. Though such incidences were recorded, such variables were less frequent in our study than those reported in study by Joshi et al. Ideally, no information should be missed. A medication order is valid only if the medical officer enters all the required items. Any information that might be missed may result into occurrence of more serious error.
Though the frequency of occurrence is low, one of the major causes of medication errors is the use of potentially dangerous abbreviations in prescribing. An abbreviation used by a prescriber may mean something quite different to the person interpreting the prescription. Although using abbreviations may seem to be a time-saving convenience, use of abbreviations does not promote patient safety. The study highlights the need to pay attention to prescription writing. Further important but simple directions that come out as priorities from this study are the necessity to print prescriptions and the need to record the route, frequency of administration, starting and stopping date of the drug should be rigorously enforced. The lack of frequency of administration and doctor’s signature were the most critical areas in terms of prescription completeness, both accounted for more than 25% of the total error of omission. A systematic use of feedback together with the adoption of formats where spaces for prescription date, signature of the physician and route of administration are more emphasized would simplify the prescriber’s task.

The inappropriate prescribing prevalence rate of 53% in this study is very high. The higher prevalence rate of inappropriate prescribing may be of concern because significant numbers of prescription come from junior medical doctors and medical intern, the most likely reason for such high prevalence of inappropriate prescribing may be the lack of awareness among prescriber of the list of inappropriate medication for elderly population. Unless the study is carried out in other hospitals where prescriber involved is more experienced, no such valid conclusions can be made at present. Nevertheless it is essential to make the prescriber, aware about appropriate/inappropriate medications to be prescribed and encourage them to follow it strictly for better health care to geriatric population at all the level of health care.

Ignoring drug-drug interaction can cause important injuries and clearly affect the process of treatment or even cause serious or fatal problems for the health of patient, thus evidencing the need of constant evaluation of these events in order to prevent them. The lack of hospital pharmacist in majority of hospitals of Nepal means many of drug interactions go unnoticed and might have led to innumerable harm and adverse reactions. Further research on the occurrence and consequences of drug interactions in both hospitalized and ambulatory patient shall shed a light on the dangerous implications of drug interactions.

Growth in the occurrences of prescribing error is expected to occur for two reasons. First, the number and potency of drug products being developed and used are increasing. Second, the elderly population, who consumes the greatest quantity of medications, continues to increase in number.

CONCLUSION

The drug prescription pattern suggests the need to establish rational drug therapy. Geriatric polypharmacy is prevalent. A high number of potential prescription errors were found. Whilst many of these were minor and unlikely to have had serious consequences, some were of potentially great significance and may represent only the tip of the iceberg. The study has highlighted the need to pay attention to prescription writing and reduce the practice of inappropriate prescribing through provision of appropriate unbiased information to healthcare professional. Further comprehensive studies on medication error are necessary to anticipate the scale of problem and their economic impact.

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REFERENCES

1. Silva, AMS. Inpatients’ medical prescription errors, Einstein, 2009; 7(3 Pt 1):290-4
2. Barber ND, Dean BS, The incidence of medication errors and ways to reduce them, Clinical Risk 1998; 4:103–6
4. Pote S, Tiwari P, & Drcur S, Medication prescribing errors in a public teaching hospital in India: A prospective study, Pharmacy Practice (Internet) v.5 n.1 Redondolene.- Mar. 2007