



CODEN [USA]: IAJPBB

ISSN: 2349-7750

**INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES**<http://doi.org/10.5281/zenodo.1161341>Available online at: <http://www.iajps.com>

Research Article

**ANALYSIS OF THE PATIENTS TREATMENT OUTCOME
ADMITTED IN THE PROVINCIAL TERTIARY CARE HOSPITAL
WITH RESPECT TO ANTIBIOTICS OMISSION ERRORS IN
QUETTA CITY, PAKISTAN****Tanzeel Ahmed^{1*}, Noman ul Haq¹, Syed Azhar Hussain Zaidi², Muhammad Waqas²,
Muhammad Ammar³, Muhammad Minhas⁴**

1. Faculty of Pharmacy and Health Sciences, University of Baluchistan Quetta, Pakistan.

2. Departments of Pharmacology and Therapeutics, Bolan Medical College Quetta, Pakistan.

3. Surgical-III, Jinnah Hospital, Lahore, Pakistan.

4. Centre of Excellence in Mineralogy, University of Baluchistan Quetta, Pakistan.

Abstract:

Objective: The investigation of patient's treatment outcome, death rate and errors of omission in antibiotics agents utilized in pediatric inpatients.

Material and Methods: This was a retrospective analysis of admissions. The examination utilized information collected tentatively inside a 50-bed pediatric ward of Bolan Medical Complex Hospital, Quetta, Pakistan. The information was collected by the examination of patient admission /discharge register by ward Pharmacist from October 2016 to March 2017. The total 735 patient were conceded trough out the investigation span. Information was recorded in a data collection form and analyzed. The recurrence and rate were investigated by utilizing SPSS 22.

Result: The total 735 patients were conceded all through the investigation, out of which 448 (60.95 %) were male and 287 (39.05%) were female and total medication administrations were 20095. Discharged/ improved were 531 (72.24%), Expired were 35 (4.74%), LAMA (left against medicinal advice) were 76 (10.34%), intravenous medication was stopped in 4 patients which was (0.54%), discharged on request 16 (2.17%), referred to other hospital 3 (0.40%) and still present in ward were 66 (8.79%). The omission errors in the antibiotic agents as follows; in ceftriaxone sodium was 4062 (20.21%), ampicillin+clavulanic acid 3179 (15.81%), streptomycin 29 (14.43%), vancomycin 1277 (6.35%) and cefepime 222 (1.10).

Conclusion: The patient's treatment outcome in pediatric ward of tertiary care was higher. One of the real reasons for mortality and morbidity might be omission errors.

Keywords: Patients, treatment outcome, omission errors, antibiotics, Pharmacist, Quetta, Pakistan.

Corresponding Author:**Tanzeel Ahmed,**

Faculty of Pharmacy and Health Sciences,

University of Baluchistan,

Quetta, Pakistan.

Email: tanzeel_ahmed27@yahoo.com**Contact Number:** +923148126949

QR code



Please cite this article in press as Tanzeel Ahmed et al., Analysis of the Patients Treatment Outcomes Admitted In the Provincial Tertiary Care Hospital With Respect To Antibiotics Omission Errors in Quetta City, Pakistan, *Indo Am. J. P. Sci.*, 2018; 05(01).

INTRODUCTION:

A patient is admitted to a healthcare facility where all relevant evidence is noted. A physician and additional facility resources are allocated to the patient. Subsequent treatment, the patient is discharged. This pattern designates only some of the features of patient treatment, which comprise the making and keep of the patient record and the task of the resources for usage by the patient. This pattern defines an over-all non-emergency treatment condition and does not reflect the details of patient analysis and treatment [1]. During admission, the patient record is shaped or information is reorganized from earlier appointment. Inpatients are allocated a place, nurse team, and referring doctors [1]. Even with the restorative work induce, there are varied on screen characters mandatory in handling this data. The association and get the chance to switch of the private uplifting information of everyone is mind confusing and separated [2]. To offer standards to the affirmation of these records various countries, including the US, are approving laws that deal with the use of electronic patient records. The British Medical Association in 1996 put strong controls on UK diligent records. In the US, the starting late asserted Health Insurance Portability and Accountability Act (HIPAA) tries to do similarly [3]. France, Germany and Iceland are diverse countries that have realized this kind of control. An illustration is a fair way to deal with enhance the methods anticipated that would execute systems that consent to a couple of areas of this control. Moreover, this case could be used as a starting stage to make security models for restorative information as in [4].

Seriousness of ailment is an essential clinical develop utilized by doctors to arrange their patients. The evaluation of sickness seriousness considers both illness and patient traits and degree and force of appearances of the malady are essential contemplation [5]. What's more, the doctor considers the patient's general condition, weight of co-morbid sickness and capacity to withstand the physiologic, psychological and social bothers of an intense ailment [5]. The greater part of the healing facilities in Pakistan take after the OPD (Out Patient Department) frameworks, where patients visit doctor's facility OPD, s for standard checkup or intense ailments. These OPD, s keeps running by the Physician's and PG, s (Post Graduate Medical Students). If the state of patient discovered basic then patient will be admitted to the ward for encourage examination and malady administration.

This is a first study in which understanding treatment result saw from admission to the released of the patient as for the omission errors.

MATERIAL AND METHODS:

Study Design

This was a retrospective analysis of admissions / discharge register.

Setting and Study Population

The examination utilized information collected tentatively inside a 50-bed pediatric ward of Bolan Medical Complex Hospital, Quetta, Pakistan. All patients' admission /discharged register during the examination time were watched.

Study Instruments

The parameters of data collection form were as follows; (1). Demographic Characteristics; drug administration comparison in different months, shift wise drug administration comparison, nurse wise drug administration comparison, medication route of administration comparison, age group and drug administration comparison. (2). Inpatient Admission Analysis; admission, discharged/improved, expired, LAMA (Left Against Medical Advice), intravenous medications stopped, discharged on request, referred to other hospital, patient present in ward. (3). Comparison of Omission Errors in Intravenous Antibiotics with Drug Administration; the admitted patients were treated with different kind of intravenous antibiotics as, ceftriaxone sodium, vancomycin, ampicillin+clavulanic acid, cefotaxime, tobramycin, cefepime, gentamycin, ciprofloxacin, amikacin, ceftazidime, streptomycin and levofloxacin.

Study Procedure

The information was collected by the investigation of patient admission /discharge register by ward Pharmacist from October 2016 to March 2017. The total numbers of 735 patients were conceded throughout the investigation span. Information was recorded in data collection form and analyzed. The reappearance and rate was investigated and One-Sample Kolmogorov-Smirnov test performed by utilizing SPSS22.

RESULT:

The total 735 patients were considered, out of which 448 (60.95 %) were male and 287 (39.05%) were female. The total medication administration was 20095 out of which in October 2016, the medication administration was 3612 (18.0%), in November 2016 (22.7%) drug administration was 4567, in December

2016 the medication administration was 1780 (8.9%), in January 2017, medication administration was 4596 (22.9%), in February 2017 drug administration were 3399 (16.9%) and in the month of March 2017 drug administration were 2141 (10.7%).

The total medication administrations in morning shift were 9312 (46.3%), in night shift were 2980 (14.8%) and in night shift were 7803 (38.8%). The medication administrations by nurse N1 were 3176 (15.8%), N2 4021 (20.0%), N3 1403 (7.0%), N4 2976 (14.8%), N5 2976 (14.8%) and N6 were 5543 (27.6%). The total intravenous (I/V) route drug administrations were 19571 (97.4%), intramuscular (I/M) route of medication administrations were 512 (2.5%) and subcutaneous (S/C) route of medication administrations were 12 (0.1%). The total drug administrations in the different age group were as follows; in the age group between 1- 11 months was 6060 (30.2%), 1-3 years 6256 (31.1%), 3-5 years 1903 (9.5%), 5-7 years 824 (4.1%), 7-9 years 2285 (11.4%) , 9-11 years 1559 (7.8%), 11-13 years 937

(4.7), 13-15 years 243 (1.2%) , 15-17 years 2 (0.0%), and in the age group N/A (Age was not specified) 26 (0.1%) as appeared in table-1. Inpatient admission analysis; the total 735 patients were admitted throughout the study out of which discharged / improved were 531 (72.24%), expired were 35 (4.74%), LAMA (left against medical advice) were 76 (10.34%), intravenous medications were stopped in 4 patients which was (0.54%), discharged on request 16 (2.17%), referred to other hospitals 3 (0.40%) and patients present in ward were 66 (8.79%) as shown in table - 2 and figure-1.

The omission errors in the antibiotics as takes after; ceftriaxone sodium was 4062 (20.21%), vancomycin 1277 (6.35%), ampicilline+clavulanic corrosive 3179 (15.81%), cefotaxime 93 (0.46%), tobramycin 458 (2.79%), cefepime 222 (1.10), gentamycin 99 (0.44%), ciprofloxacin 8 (0.03%), amikacin 90 (0.49%), ceftazidime 124 (0.61%), streptomycin 29 (14.43%) and levofloxacin 40 (0.19%) as appeared in table-3.

Table.1: Demographic Characteristics, Months, Shift Wise, Nurse Wise, Route of Administration and Age Group Comparison.

Demographic Characteristics (N=735)		
Description	Frequency	Percent
Gender		
Male	448	60.95
Female	287	39.05
Drug Administration Comparison in Different Months (N= 20095)		
Months		
October 2016	3612	18.0
November 2016	4567	22.7
December 2016	1780	8.9
January 2017	4596	22.9
February 2017	3399	16.9
March 2017	2141	10.7
Shift Wise Drug Administration Comparison (N= 20095)		
Shifts		
Morning	9312	46.3
Evening	2980	14.8
Night	7803	38.8
Nurse Wise Drug Administration Comparison (N= 20095)		
Nurse		
N1	3176	15.8
N2	4021	20.0
N3	1403	7.0
N4	2976	14.8
N5	2976	14.8
N6	5543	27.6
Medication Route of Administration Comparison (N= 20095)		
Route		
I/V	19571	97.4
I/M	512	2.5
S/C	12	0.1
Age Group and Drug Administration Comparison (N= 20095)		
Age Group		
1Month - 11Months	6060	30.2
1Year - 3Years	6256	31.1
3Years - 5Years	1903	9.5
5Years - 7Years	824	4.1
7Years - 9Years	2285	11.4
9Years - 11Years	1559	7.8
11Years - 13Years	937	4.7
13Years - 15Years	243	1.2
15Years - 17Years	2	0.0
N/A (Age was not mentioned)	26	0.1

Table. 2: Inpatient Admission Analysis

Inpatient Admission Analysis (N=735)		
Description	Frequency	Percent
Patient Status		
Admission	735	100.00
Discharged/Improved	531	72.24
Expired	35	4.76
LAMA (Left Against Medical Advice)	76	10.34
Intravenous Medications Stopped	4	0.54
Discharged on Request	16	2.17
Referred to Other Hospital	3	0.40
Patient Present in Ward	66	8.79

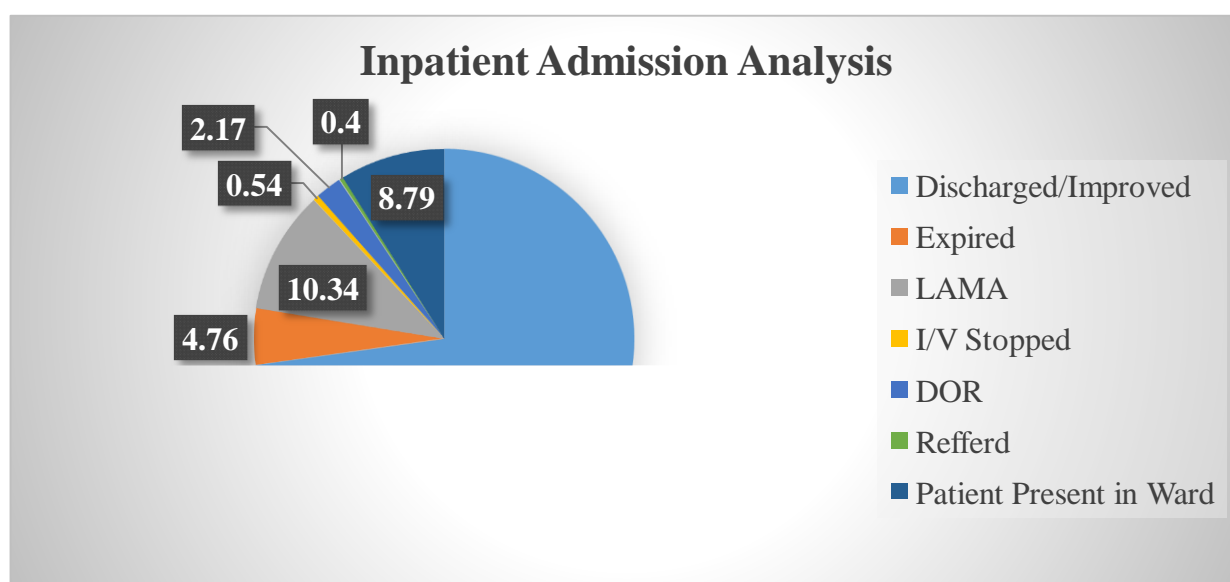


Fig.1: Inpatient Admission Analysis

Table- 3: Comparison of Omission Errors in Intravenous Antibiotics with Drug Administration

Comparison of Omission Errors in Intravenous Antibiotics with Drug Administration (N=20095)		
Description	Omission Errors	Percent
Antibiotics		
Ceftriaxone Sodium	4062	20.21
Vancomycin	1277	6.35
Ampicilline+clavulanic Acid	3179	15.81
Cefotaxime	93	0.46
Tobramycin	458	2.79
Cefepime	222	1.10
Gentamycin	8	0.03
Ciprofloxacin	90	0.44
Amikacin	99	0.49
Ceftazidime	124	0.61
Streptomycin	29	14.43
Levofloxacin	40	0.19

Table- 4: One-Sample Kolmogorov-Smirnov Test

Description	Month	Shift	Nurse	Age	Age Group	Weight	Gender	Drug Name	Route	Frequency	Time	OE	Status	
N	20095	20095	20095	20095	20095	38	735	20095	20095	83	20095	20095	1439	
Normal Parameters ^{a,b}	Mean	3.91	1.92	3.76	15.07	2.84	10.38	1.39	6.61	1.03	.15	2.65	1.41	1.95
	Std. Deviation	2.085	.920	1.867	9.189	1.950	5.212	.488	10.937	.165	.069	.887	.492	1.596
Most Extreme Differences	Absolute	.146	.306	.185	.109	.280	.352	.398	.359	.538	.331	.268	.386	.348
	Positive	.146	.306	.185	.109	.280	.352	.398	.359	.538	.331	.268	.386	.348
	Negative	-.110	-.267	-.171	-.063	-.172	-.325	-.285	-.304	-.436	-.257	-.201	-.297	-.276
Test Statistic	.146	.306	.185	.109	.280	.352	.398	.359	.538	.331	.268	.386	.348	
Asymp. Sig. (2-tailed)	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	.000 ^c	

a. Test distribution is Normal.

b. Calculated from data.

c. Lilliefors Significance Correction.

DISCUSSION:

There fundamental discoveries from this examination was that a huge number of men than ladies were admitted to pediatric ward. Most of the drug were administered in January 2017. The death rate was less (4.74%) which a decent sign for quiet wellbeing and the treatment achievement rate was high (72.24%). The utmost omission mistakes were found in Ceftriaxone sodium i.e. (20.21%).

The great quantity of male over female confirmations speaks to an inversion of the sexual orientation contrasts in psychiatric affirmation [6-8]. Consequence of existence study supported the result of past investigation.

To date there has been compelled uncovering of HES data for psychiatric affirmations. Smith et al (1996) used HES data for 1992 to develop a record of relative necessity for psychiatric administrations and uncovered an overall (all ages) in-understanding affirmation rate of 4.2 for each 1000 in England. In their examination, there was a wealth of female certifications, however this was a result of higher affirmation rates among those developed 45–79 years [9]. In any case, in the present understudy a bigger number of guys were conceded than females so contradict the consequence of past investigation.

PICU (Pediatric Intensive Care Unit) results shifted essentially by the wellspring of confirmation. Three hundred seventy-six (4.2%) youngsters kicked the bucket in examination with the ED (Emergency Department) affirmations (3.7%) [10]. However, in the present examination, the death rate was (4.76%) which was (0.56%) higher than PICU and if contrast and the ED (Emergency Department) the death rate of present investigation was (1.06%) higher.

The ward confirmations, non-PICU exchange affirmations, and between PICU affirmations had higher unadjusted death rates of 9.8%, 6.7%, and

12.7%, individually [10]. but in the present examination the correlation of death rate with the ward affirmations was (5.04%) less, in non-PICU exchange affirmations the death rate was (1.94%) less and in between PICU affirmations the death rate was (7.94%) lesser.

Additionally, enhanced results have been related with early distinguishing proof of fundamentally sick grown-up patients on the wards before physiologic crumbling and requirement for emergent revival and ICU affirmation [11-13]. The consequence of present investigation upheld the aftereffect of as of late performed examinations.

CONCLUSIONS:

The patient's treatment outcome of provincial tertiary care pediatric ward was fundamentally higher. This is great sign for the patient wellbeing. Methodologies went for lessening of mortality at the pediatric ward of tertiary care hospital should refers patients from the pediatric wards to NICUs and from NICUs to different therapeutic centers. A great percentage of the omission errors were found in the ceftriaxone sodium intravenous injection that was routinely used two times/day which is recognizable for authorities. One of the real reason for mortality and morbidity might be omission errors. Additionally, inquire about is expected to distinguish indicators of mortality and morbidity in patients. To overcome the omission mistakes more Pharmacist intervention studies required in such manner.

Conflict of Interest

Authors affirmed that they have no conflict of interest.

Source of Funding

None.

REFERENCES:

- 1.Sorgente, T., Fernandez, E. B., & Petrie, M. M. L. (2004). Analysis patterns for patient treatment records. In Procs. Of the Pattern Languages of Programs Conference.
- 2.Electronic Privacy Information Center, "Medical Privacy", July 6, 2002. <http://www.epic.org/privacy/medical>
- 3.Department of Health and Human Services, "Health Insurance Reform: Security Standards; Final Rule", Federal Register / Vol. 68, No. 34, February 20, 2003 <http://bmj.bmjournals.com/cgi/content/short/318/7194/1328>.
- 4.E. B. Fernandez, M. Petrie, and T. Sorgente, "Security models for medical and genetic information", Procs. of the IADIS International Conference (e-Society 2004), Avila, Spain, July 2004, 235-249. http://www.iadis.org/confman_es2004/accepted.asp
- 5.Pompei, P., Charlson, M. E., Ales, K., MacKenzie, C. R., & Norton, M. Relating patient characteristics at the time of admission to outcomes of hospitalization. *Journal of clinical epidemiology*, 1991; 44(10):1063-1069.
- 6.Prior, P. M., & Hayes, B. C. Changing Places: men replace women in mental health beds in Britain. *Social Policy & Administration*,2001; 35(4): 397-410.
- 7.Bartlett, John Holloway, Mark Evans, John Owen, Glynn Harrison, C. Alternatives to psychiatric in-patient care: a case-by-case survey of clinician judgements. *Journal of Mental Health*,2001; 10(5): 535-546.
- 8.Payne, S. The rationing of psychiatric beds: changing trends in sex-ratios in admission to psychiatric hospital. *Health & Social Care in the Community*, 1995;3(5): 289-300.
- 9.Smith, P., Sheldon, T. A., & Martin, S. An index of need for psychiatric services based on in-patient utilization. *The British Journal of Psychiatry*,1996; 169(3): 308-316.
- 10.Odetola, F. O., Rosenberg, A. L., Davis, M. M., Clark, S. J., Dechert, R. E., & Shanley, T. P. Do outcomes vary according to the source of admission to the pediatric intensive care unit? *Pediatric Critical Care Medicine*, 2008;9(1): 20-25.
- 11.Bellomo, R., Goldsmith, D., Uchino, S., Buckmaster, J., Hart, G. K., Opdam, H., & Gutteridge, G. A prospective before-and-after trial of a medical emergency team. *Medical Journal of Australia*,2003; 179(6): 283-288.
- 12.Goldhill, D. R., White, S. A., & Sumner, A. (1999). Physiological values and procedures in the 24 h before ICU admission from the ward. *Anaesthesia*1999; 54(6): 529-534.
- 13.Goldhill, D. R., Worthington, L., Mulcahy, A., Tarling, M., & Sumner, A. (1999). The patient-at-risk team: identifying and managing seriously ill ward patients. *Anaesthesia - London*, 1999;54: 853-860.