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INTERVENTION THROUGH MONITORING PRESCRIPTION PATTERN OF HIGH END USER OF ANTIBIOTICS

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ABSTRACT

This study has highlighted the prescription practice of antibiotics of inpatient department and outpatient department, uses of generic drugs and injection and usage of the drug prescribed from essential drug list. **Methodology:** Irrational prescribing practice of antibiotics results in serious emergence of resistance of drugs as well as leads to malfunctioning of the quality indicators of the treatment; ultimately causing misuse of drug resources, increasing costs and adverse drug reactions. The study may be defined as Prescription pattern monitoring practice which serves as a tool for assessing the prescribing, dispensing and distribution practices of antibiotics which facilitates rational use of antibiotics and assess the effectiveness in promoting rational use of antibiotics. **Result:** Both department follow good prescribing practices and 100% diagnostic practices within prescription. In OPD 91% prescription contain more than three antibiotic drugs which is 262 drugs and 68 of a total case 75. In IPD it is 97% which is 290 drugs and 72 of a total case 75. In OPD 93% prescription contain double/multi combination of antibiotics drugs on the other hand in IPD it is 100%. A prescription in OPD with antibiotics cost for 250 INR per prescription. But the expenditure in IPD is 700 INR which is much higher than OPD.

KEYWORDS: good prescribing practices, antibiotics, drug therapies, Irrational prescribing practice.

INTRODUCTION

Polypharmacy

The word polypharmacy applies to the bunch of medicines a person may take. It derives from two Greek terms of root: poly, which means numerous, and medicinal which means drugs or medications. This is often used where one person takes multiple narcotics as well or where many doctors have approved the prescriptions and might not be well-favored. There is also a controversial concept of the polypharmacy.

Although the word polypharmacy has evolved over time and is sometimes employed in a variety of cruel ways, the basic meaning is very clear, it embraces or includes more drugs than are scientifically necessary. The amount of medications taken is not indicative of the polypharmacy itself, because the amount of medicines approved decreases, and the likelihood of polypharmacy will be scientifically essential and appropriate for persistently.

A 2002 US survey found that five or more approaches a week was taken by 25 a cent of the general population. This prevalence levels rises to about 50%, with 44% of men and 57% of women taking five or more drugs a week and 12% of both sexes taking 10 or more medicines per week, especially given that the population is 65 a long and more experienced population. The most alarming consequence in polypharmacy is antagonistic sedate reactions (ADR), but higher rates in drugs and peaceful quality of living are all too serious problems.

The population of the elderly is growing, often suffering from many inveterate diseases which require many solutions. The polypharmacy and negative outcomes, especially ADRs, are more likely to occur in these patients. The usage of ADRs among elderly people is one of the more troubling concerns because this recurrent group has worse outcomes than others. ADRs impact approximately 10 to 20% and approximately 7% of the general population of patients hospitalized; these rise as the fascinated demographic becomes limited to the elderly.

Razons on Polypharmacy in consideration of the tremendous number of polypharmacy definitions, the estimation of its recurrence, regulation of its occurrence and the identification of the probability of adverse responses relevant to polypharmacy are needed in

conjunction with the description. The polypharmacy is based on many factors.

- A polypharmacy grows as the population ages. Senior citizens often required numerous medications to address specific aspects of safety.
- Furthermore separate medications were required for the treatment of each disorder in a patient with multiple comorbid restorative conditions. It is not unusual to use 6-9 drugs to minimize your or the risk of such disorders, that is, of diabetes and coronary occassions, for specific comorbid therapeutic disorders.
- A patient's subsequent hospitalization often places polypharmaceutical patients in risk. Medicinal goods are initiated and halted very much in the pharmacy center.
- Various authorities share the same interpretation of medicines. When a medication continues to sit still, it never ceases.
- The principal popular explanation is Lack of knowing teaching. Specialists should not educate nurses or pose questions to nurses. Polypharmacy can arise if additional medicine is used to address certain medications' antagonistic impacts. Currently alluded to as the cascade endorser. Many incomplete polypharmacy promoting combines more than one sedate medication in the same course or medication in sedates interatomic of, or contraindicated of, one of the medications of the individual.

On its own way, polypharmacy is not harmful. Polypharmacy can, however, be dangerous if adverse effects occur. The outcome has become polypharmacy

- Drug unwanted and/or unacceptable.
- Increased potential for drug and ADR reactions.
- Non-compatibility.
- CHERE Absolute changes in the prices of medications.

Rational and Irrational Use of Drugs

Rational Use of Drugs

Throughout the workshop the words "design" and "levelheaded" in the usage in medications are included. The Conference of Spezialists on the Sound Usage of Medications, which was conducted in Nairobi in 1985, characterizes the use of sound as follows: Levelheaded medicinal use demands that patients obtained medicines that match the health requirements of their persons in a dosage that fulfills the prerequisites of their possession for a fair period and at the lowest possible cost.

AIM

Find out the irrational promoting use of anti-microbial compounds and build a medication system that tracks honey as a method for surveying the helping, separating and distributing hones in anti-microbial medicines to facilitate the wise usage of anti-microbial goods.

OBJECTIVES

Prescription use in antibiotics in the pharmacy and ambulatory units will be illustrated. Data from patients are obtained based on organized questionnaires.

Our concentrations are

- patients' age,
- medication numbers by prescription,
- product numbers by generic name and medications by diagnosis;
- EDL by Diagnosis;
- consulting time per patient,
- The number of patients who have provided the right dosage,
- the number of patients receiving a nutritional instruction, the cumulative number of patients receiving a nutritional lesson, ie the number of patients having obtained a wellness assessment,
- the number of patients requesting for more prescription, ie the number of patients requesting for more care, ie the number of patients asking for the length of their disease, previous experience or medicament

  The number of patients under clinical review, the number of patients pleased or not, the amount of dosage advice finding patients, the number of patients approved for evaluation and clear or fair vision. The number of patients under clinical review.

METHODOLOGY

For data collection, seven separate types of antibiotic antibiotics have been selected. Many antimicrobials have two names: a pharmacy corporation that manufactures the drug trade, or brand identity depending on the chemical composition or chemical path of the antibiotic and a non-specified label. Exchange terms are capitalized, as are Keflex and Zithromax. Generics including cephalexin and azithromycin are not supported. Patients of misuse or heavy inference usage of anti-microbials are shown to be free from these drugs, and our work on all people aged from 90 to long has been puzzled. We have chosen seven classes of anti-microbial drugs to be specific as.

The majority come from only a few types of drugs. These are the main classes of antibiotics.

1. Penicillins such as penicillin and amoxicillin
2. Cephalosporins such as cephalexin (Keflex)
3. Macrolides such as erythromycin (EMycin), clarithr omycin, and azithromycin
4. Fluoroquinolones such as ciprofolxacin (Cipro), levo floxacin
5. Sulfonamides such as co-trimoxazole (Bactrim)
6. Tetracyclines such as tetracycline and doxycycline
7. Aminoglycosides such as gentamicin (Garamycin) and tobramycin (Tobrex)

The teaching hospital is an institution that associates in the healthcare sector by learning and study with medical and nursing schools, training services and testing centers.

Teaching hospitals provide a broad variety of benefits, including advanced modern medicines and treatments, cut-set equipment, faster clinics, higher tests and recovery rates, specialist and groundbreaking techniques for major diseases and techniques. Very trained physicians and surgeons are required in these clinics 24 hours a day.

We agreed on the basis of a planned format (Annex.-1: Medication indicator form), to take each of 150 prescriber-patient meeting (retrospective) data from the 7 groups of antifungal drugs. This document includes a date of delivery, age range of the infant, dosage number, number of medications, amount of antibiotics experience, amount of injection experiences, number of medical items on the important medicine list as well as documentation of treatment, etc. The details are accessible in this document.

In addition, we took 150 prescriber patients and 150 pharma / health care professional patient-hospital dates (forward) each of the seven forms of antibiotic drugs on the basis of the various questionnaires (Annex 2: Patient Satisfaction Survey, in the Patient Satisfaction Survey).

We also reviewed a sample (prospects) for 150 patients to assess the trends of encounters they had with their prescriptors (annex.-3: Clinical Experience Checklist).

The prescription expense of 150 patients is also estimated to assess the quality history they had with prescribers (Annex.-4: Medication Expense per Experience during the hospitalization).

Pre-intervention

Data Collection

On the basis of prepared questionnaires, we have collected data from the outdoor patients. Our points of interest were:

- age of the patients,
- number of drugs per prescription,
- number of drugs prescribed by generic name,
- presence of antibiotics,
- presence of injections,
- number of drugs from EDL (Essential Drug List)
- diagnosis,
- consulting time per patient,
- dispensing time per patient,
- number of drugs dispensed per prescription,
- number of labeled drugs per dispensed drugs,
- number of patients having correct knowledge of dose,
- number of patients having diet education,
- number of patients having health education,
- number of patients asking for follow-up
- number of patients asked for duration of illness, past history or drugs history,
- number of patients undergoing physical examination,
- number of patients satisfied or dissatisfied with the health facility,
- number of patients getting dosing instruction,
- number of patients advised for investigation,
- about patient hearing, was it adequate or fair or little.

Data Entry and data analyzing

After entering the data into the computer and then by using MS OFFICE 16 which is recent version including MS Word and Excel, all the data were analyzed.

Data Presentation

Results are presented in different approaches using pie chart, bar diagram, line diagram, area diagram, cylinder chart, columns and different tables.

Decision Making

We obtained 150 medications for operation. The details gathered are two sections of these 150 prescriptions. Both are before and during the operation. Thus, before intervention we received 75 medications and 75 hospital medications following intervention.

For potential treatments, candidates were selected from the outside geriatric units of the ten hospitals. Taking the benefits and demerits of action approaches for research, administration and regulation into consideration, a synthesis of all three was envisaged according to the concept of previous foreign scientists. Standard antibiotic prescribing recommendations for all prescriber classes were valid. They have studied and qualified sufficiently to tackle the issues with antibiotics.

The goal category was thus homogeneous. Both were urban from the same area. After weighing all the variables, the therapy software was selected for an Informal Community Debate (IGD). The prescribers and pharmacists (as two focus classes separately) were supposed to do so in the same manner as before. After recognizing the objects, it was rendered simpler to fix these experiences. Furthermore, the informal conversation of the party (IGD) is swift, cheap and enjoyed by prescriber and pharmacists. The Informal Discusión Network was formed to communicate with their respective peers and discuss thoughts on research methods, emotions and opinions. A community of senior doctors and pharmaceuticals who are teaching.

Intervention Methodology

Physician-Physician IGD

Senior medical professors organized a moderated informal dialogue on the high end usage of antibiotics and presented updated knowledge on the topic. This is followed by 6-8 geriatric prescriber in 2 different classes of 10 hospitals. It took nearly two hours for the mid-day break.

The meeting did not take place and no other workers were permitted to participate other than chosen teachers and hires. Discussion points among teachers have been pre-distributed. Measures were taken to insure that one moderator was present among the students, so everyone took part in a concentrated and in-depth discussion. The

place was one of the office spaces for the senior doctor of both the hospitals. This initiative was followed by a hybrid training, management and regulatory approach.

Pharmacist-Pharmacist IGD

The pharmacist responsible for hospital pharmacies was often invited to the other Informal Working Group sessions after working hours at the same venue. Leading pharmacy teachers attended moderate session and 4-5 certificate medicinal pharmacists who visited clinics visited each session. The 4-5 course was a 2-hour certification. The conditions of product supply and supplies were addressed in the informal sessions. The need for different labels and clear labeling, Keep a proper dosage, pacing, and healthy household care for the individual. The talks were not registered and no other workers were required. The casual conversation was discussed by all parties, the teachers often spread topic points beforehand. It led to a hybrid pedagogical, administrative and legislative approach for the Informal Community Pharmacist-Pharmacist. All engaged in the IGD form and the moderators handled the sessions skilfully. Nobody skewed or inflated the participants' emotions and nobody overshadowed the debates. It represents and accommodates the strengths and shortcomings of the intervention approach. The intervention technique

Post-Intervention Study

Preparation Two weeks later, a second study was performed using an informal protocol of prescriber and pharmacist. After interference utilizing the same methods and surveys, another collection of data was gathered from the same amount of samples.

Post-intervention Methodology

The methodology used for post-intervention study was the same as used for the pre-intervention study as stated in the section. The factors considered and the sample sizes were also the same.

Data Collection

Data were collected using the same framework and questionnaires on the same points.

Data Entry and Data Analyzing

Data were entered in computer and analyzed the data using the same MS OFFICE 16 Programme.

Data Presentation

Different types of charts (pie, line, column, bar, area etc) and tables were used to present the post post-intervention findings.

Duration of Data Collection

Data has been collected over a period of 8 months. Three months for collection of data before interventions and remaining Three months is for after intervention data collection.

RESULTS

Various major finding and parameters regarding prescription patterns are demonstrated in tables and respective graphs below.

Age Distribution of Patients

Both patients, regardless of age, have been seen as the frequent victims of overdose of antibiotics. Both age classes, though, are in risk. Yet 16 percent and 33 percent of the overall patients under 4 years of age in all hospital and ambulatory departments and the number of patients with the greatest antibiotic misuse was younger than age 35 years. In all hospital and ambulatory wards, age 4 to 18 years is comparatively small, which is 23% and 22%, respectively. Similarly, the prevalence of 18 to 30 years in the ambulatory unit that is vulnerable to overuse antibiotics is 31% greater than that of the hospital unit 22%.

Table 1: Age distribution of patient.

Department	Less than 4 years	4-18 years	18-35 years	35 years above
Outpatient department	16%	23%	31%	30%
Inpatient department	33%	22%	22%	25%

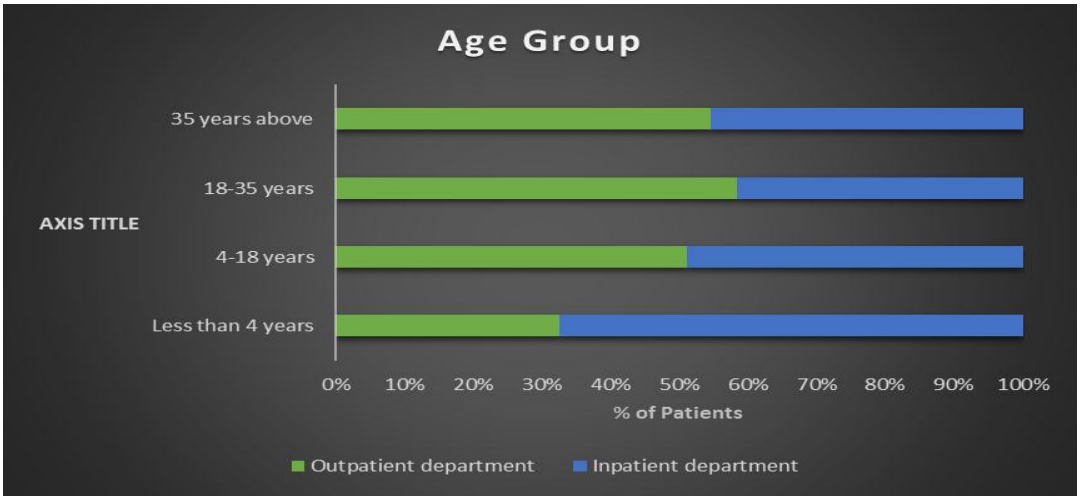

Figure 1: % Age distribution of patient.

Prescription Pattern of Antibiotics by Age Group

Patients are recommended with different classes of antibiotics. Medicines that kill or delay bacterial growth are antibiotics, often referred to be antibacterials. They include a number of powerful medicines and are used for the diagnosis of bacterial diseases. Unable to handle drugs are illnesses triggered by diseases such as colds, measles, the bulk of coughing and sore throat.

For OPD patients that have been treated for fewer than 4 years a total of 15 antibiotics smaller than the IPD prescription total 17 regardless of the large volume of antibiotics administered for IPD before treatment.

The antibiotics administered are lower during the operation than during the treatment. In Table 3, Table 4, Table 5, Table 7 and Table 4, Table 5, Table 6, Table 6 and Table 4, Table 4, Table 6, Table 6 and Overall product counts are shown. Overall prescription levels have declined significantly both in the OPD and IPD since the operation.

Table 2: Multiple prescription pattern by age group.

		%Antibiotic courses					
Age of Patients	**No. of prescriptions**	**1**	**2**	**3**	**4**	**5**	**Total**
Less than 4 years	2	20	28	-	-	-	48
4-18 years	3	10	21	39	-	-	70
18-35 years	4	4	24	26	38	-	92
35 years above	5	2	25	23	15	25	90
							N=300

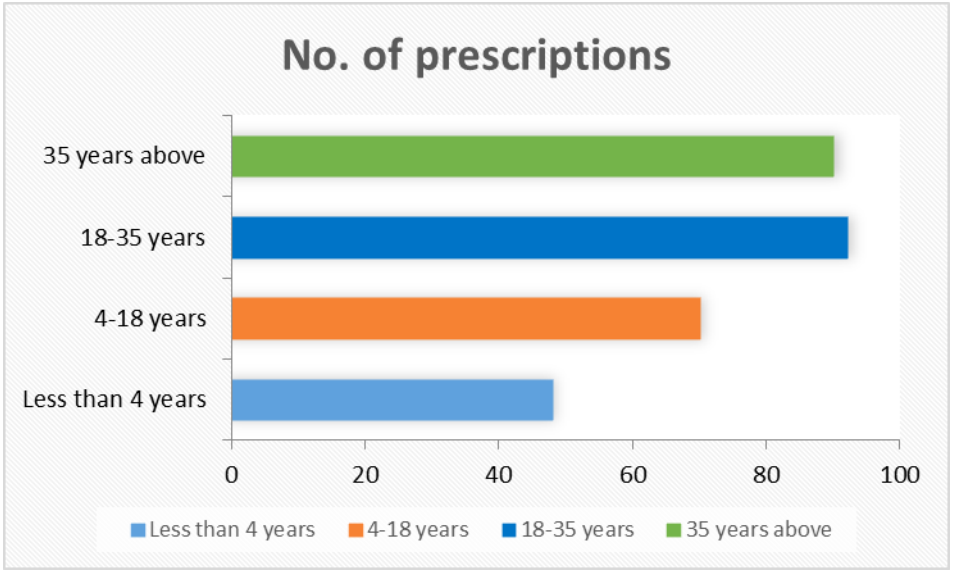

Figure 2: % Prescription pattern by age group.

Table 3: Prescription pattern for rational use of antibiotics in OPD (Before Intervention) (n=75).

		Repeat prescription within 1–2 days		Repeat prescription within 3–10 days	
Antibiotic Drugs	**Prescriptions**	**(%)**	**Adj.**	**(%)**	**Adj.**
Amoxicillin	7	28.57	2	71.42	5
Cefdinir	5	79.42	4	20.15	1
Clavulanate	23	34.78	8	65.21	15
Amoxicillin	12	41.61	5	58.33	7
Cephalexin	8	62.52	5	37.45	3
Clarithromycin	7	57.14	4	42.85	3
Azithromycin	8	74.43	6	25.22	2
Phenoxymethylpenicillin potassium	5	60.58	3	39.45	2

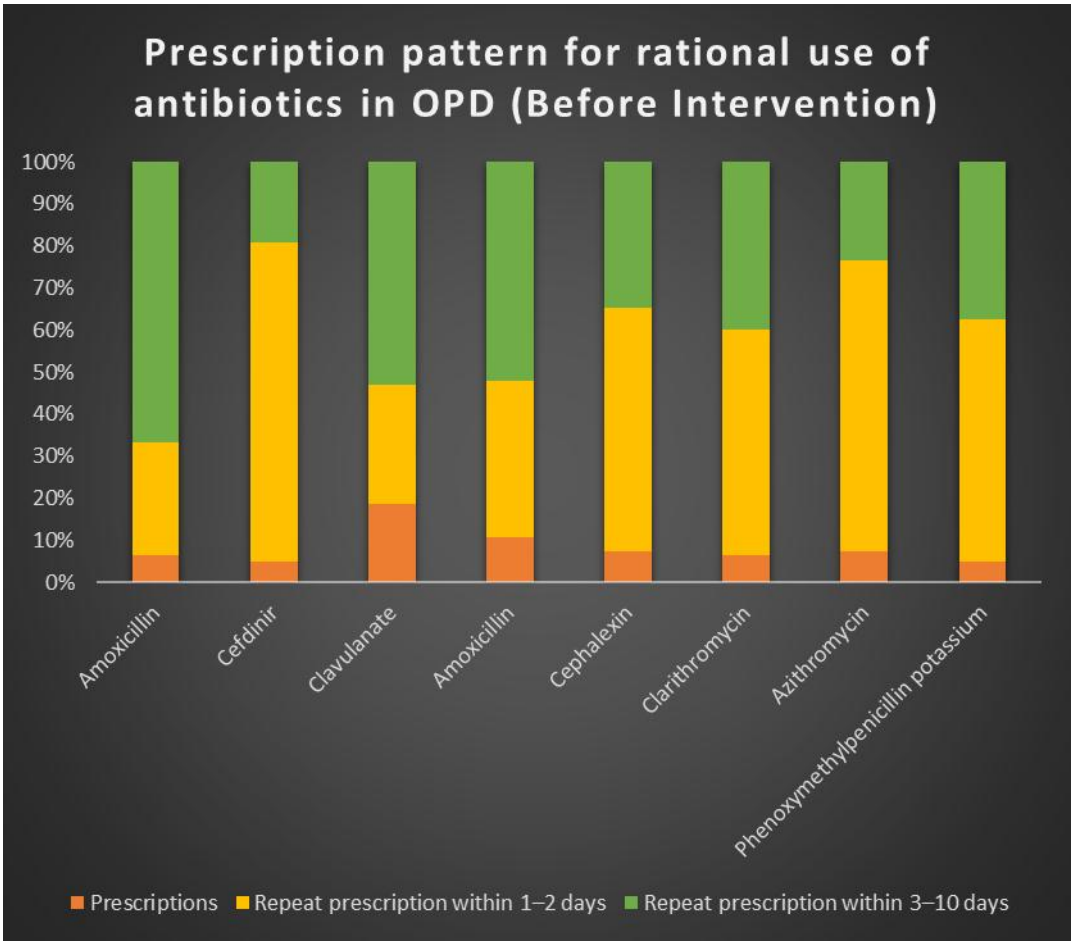

Figure 3: % Prescription pattern for rational use of antibiotics in OPD (Before Intervention).

Table 4; Prescription pattern for rational use of antibiotics in OPD (After Intervention) (n=75).

		Repeat prescription within 1–2 days		Repeat prescription within 3–10 days	
Antibiotic Drugs	**Prescriptions**	**(%)**	**Adj.**	**(%)**	**Adj.**
Amoxicillin	7	57.14	4	42.83	3
Cefdinir	5	100	5	-	-
Clavulanate	21	52.19	10	56.58	12
Amoxicillin	14	66.66	10	33.33	4
Cephalexin	8	87.58	7	12.36	1
Clarithromycin	7	71.42	5	28.57	2
Azithromycin	8	100	8	-	-

Phenoxymethylpenicillin potassium	5	100	5	-	-

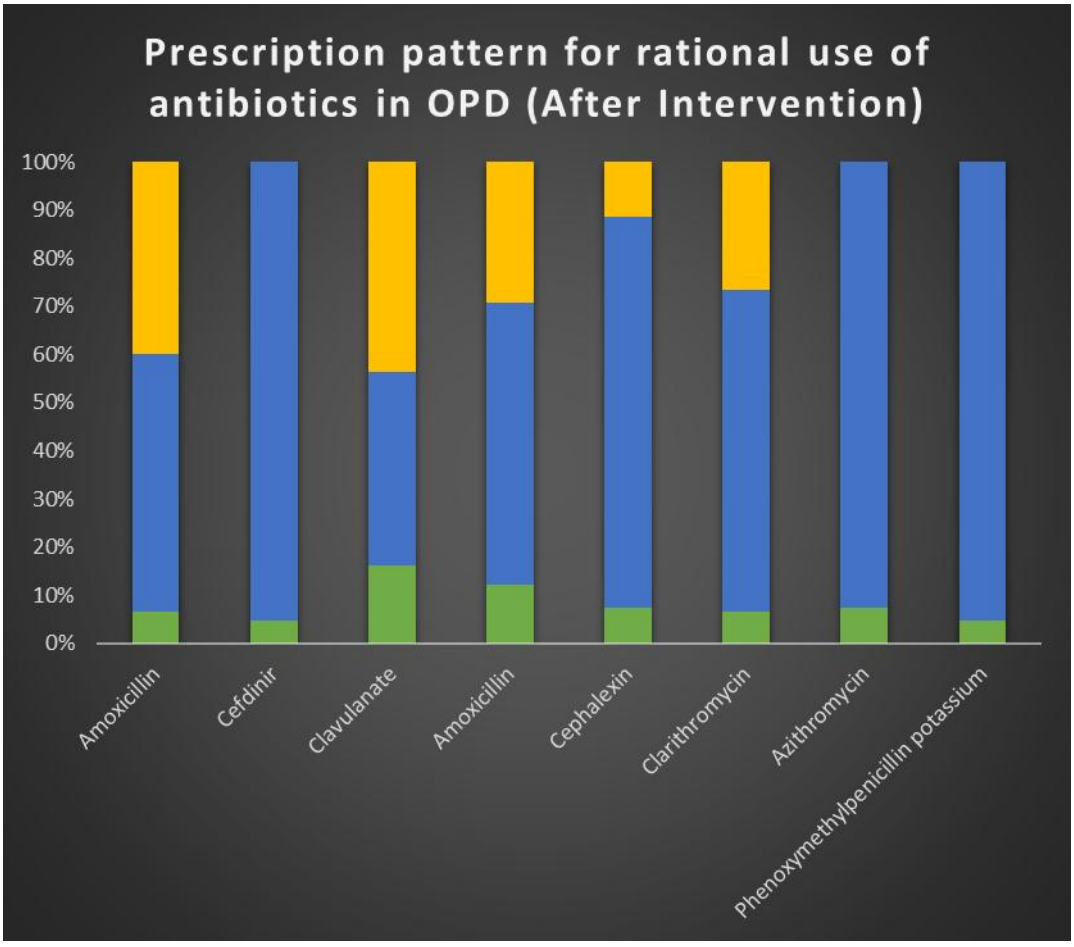

Figure 4: % Prescription pattern for rational use of antibiotics in OPD (After Intervention).

Table 5: Prescription pattern for rational use of antibiotics in IPD (Before Intervention) (n=75)

		Repeat prescription within 1–2 days		Repeat prescription within 3–10 days	
Antibiotic Drugs	**Prescriptions**	**(%)**	**Adj.**	**(%)**	**Adj.**
Amoxicillin	6	33.33	2	66.66	4
Cefdinir	5	78.34	4	22.18	1
Clavulanate	20	45.21	9	55.11	11
Amoxicillin	15	13.33	2	86.66	13
Cephalexin	5	40.65	2	59.21	3
Clarithromycin	4	25.12	1	74.56	3
Azithromycin	17	34.34	6	65.64	12
Phenoxymethylpenicillin potassium	3	34.33	1	65.66	2

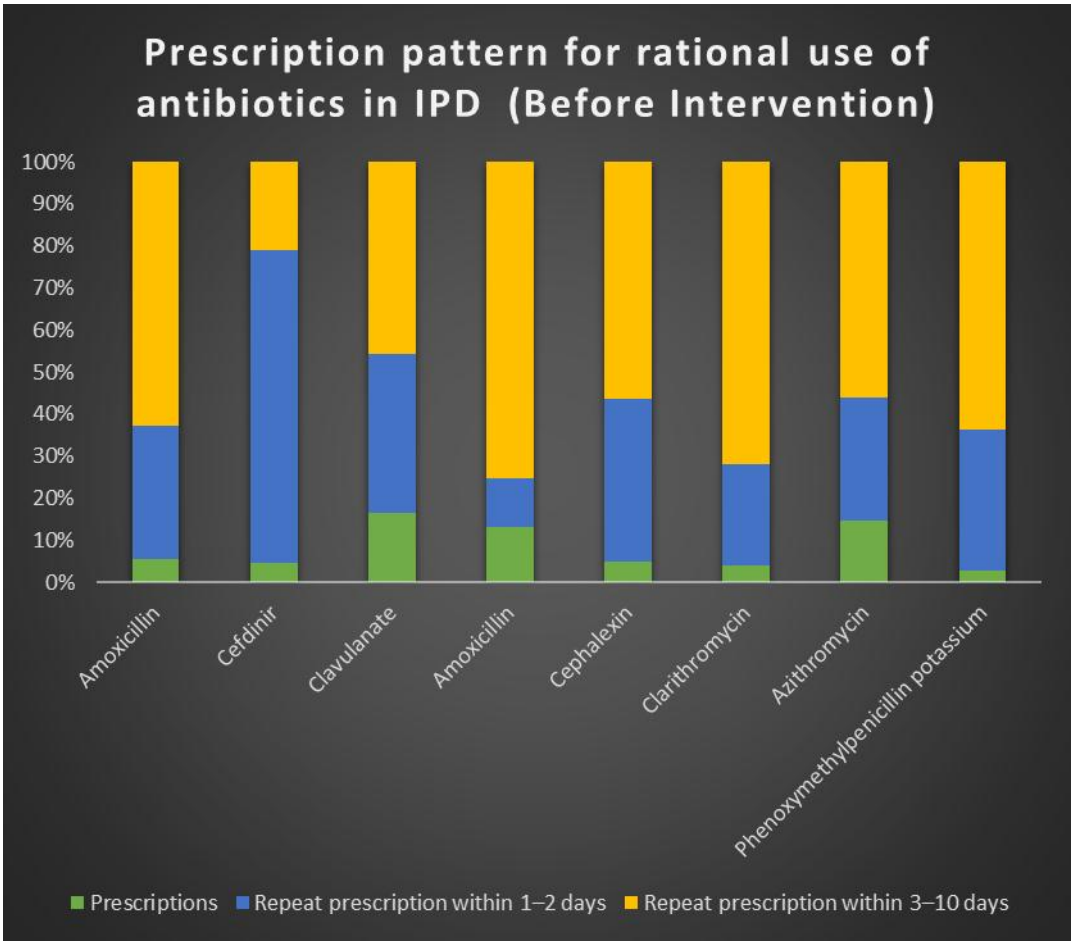

Figure 5: % Prescription pattern for rational use of antibiotics in IPD (Before Intervention).

Table 6: Prescription pattern for rational use of antibiotics in IPD (After Intervention) (n=75).

		Repeat prescription within 1–2 days		Repeat prescription within 3–10 days	
Antibiotic Drugs	**Prescriptions**	**(%)**	**Adj.**	**(%)**	**Adj.**
Amoxicillin	6	83.33	5	16.66	1
Cefdinir	5	79.38	4	20.67	1
Clavulanate	20	70.15	14	29.46	6
Amoxicillin	14	71.42	10	28.57	4
Cephalexin	6	82.24	5	16.66	1
Clarithromycin	4	100	4	-	-
Azithromycin	18	72.22	13	27.77	5
Phenoxymethylpenicillin potassium	2	100	2	-	-

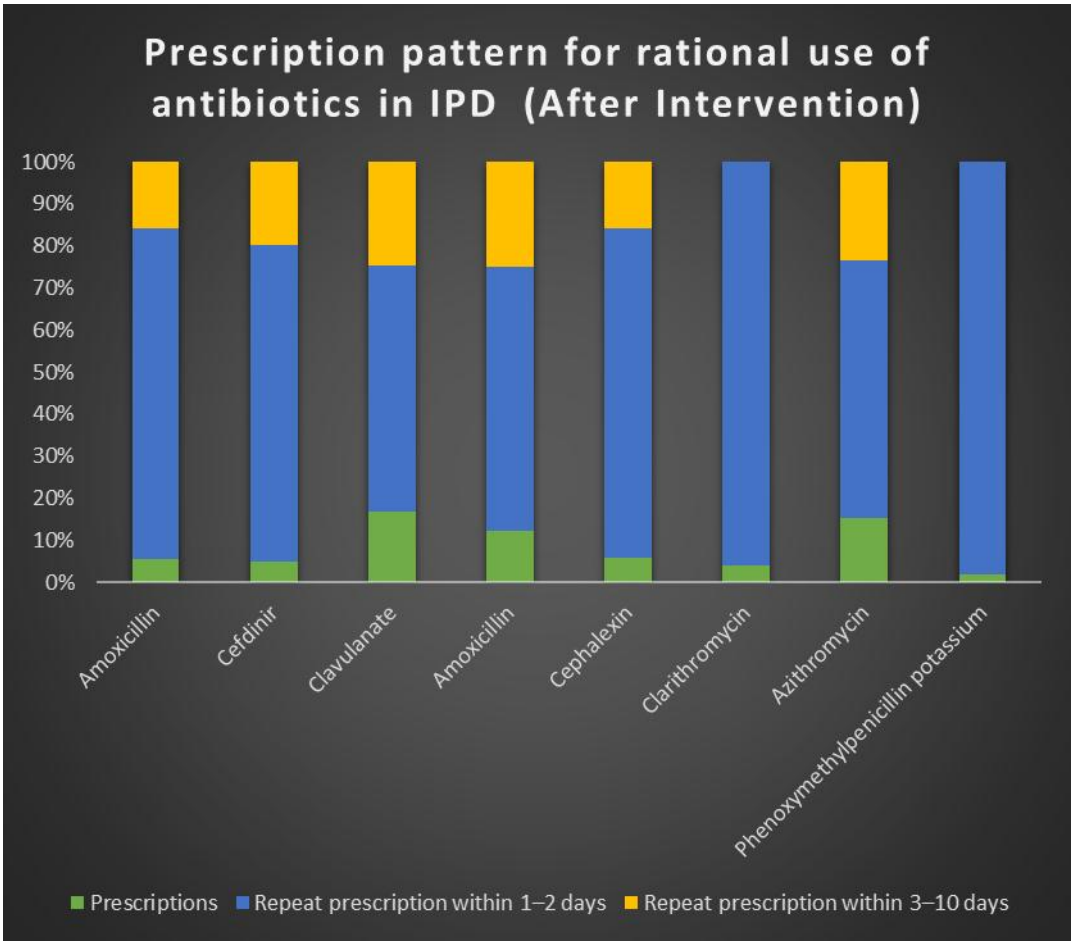

Figure 8: % Prescription pattern for rational use of antibiotics in IPD (After Intervention)

Average number of Antibiotics received by Age Group of patients in OPD and IPD

The total number of pediatric antibiotiques in OPD under 4 years of age and > 35, respectively, before action was 2,57 and 4,17. Similarly, patients 4- < 18 years of age and 18-35 years of age undergo almost the same medications and before operation it is 4.5 and 4.18. This amount has declined between less than 4 to more than 35 years to an average of 2.6 to 3.72 since the treatment. The total number of prescriptions per medication is strong for patients aged 4-18 years. Table 16 and Figure 6 display this.

Table 7: Average number of Antibiotics received by Age Group of patients in OPD.

	Less than 4 years		4-18 years		18-35 years		35 years above	
	Cases	**Antibiotics**	**Cases**	**Antibiotics**	**Cases**	**Antibiotics**	**Cases**	**Antibiotics**
Before Intervention	7	18	8	36	11	46	11	46
Average Number of antibiotic per prescription	2.57		4.5		4.18		4.17	
After Intervention	5	13	9	38	12	50	11	41
Average Number of antibiotic per prescription	2.6		4.22		4.16		3.72	

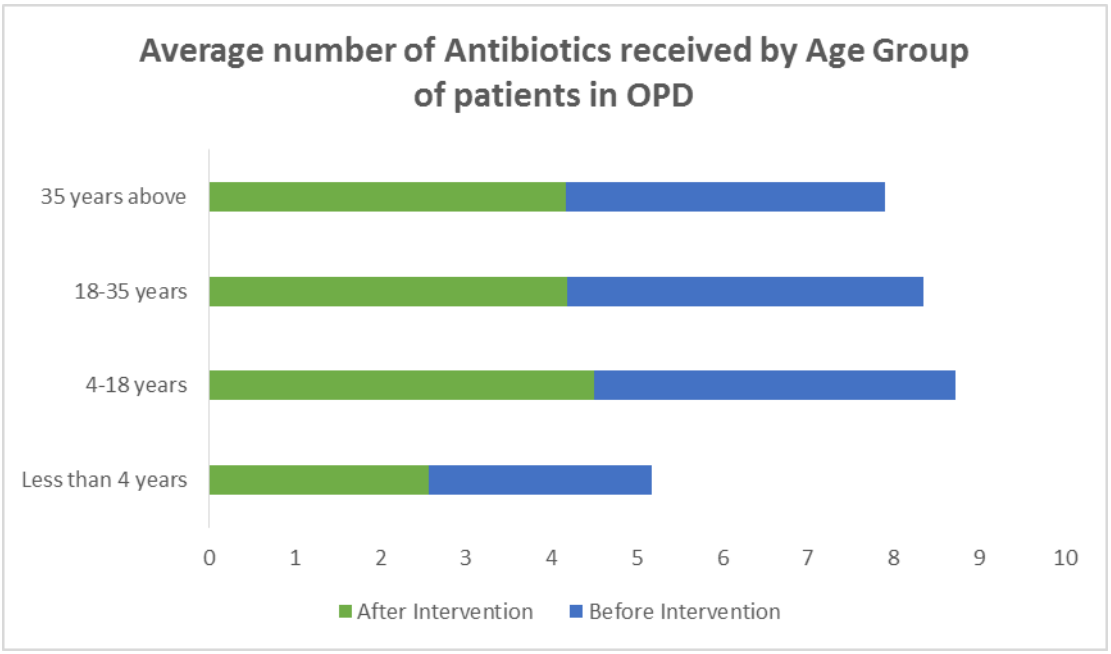

Figure 6: Average number of Antibiotics received by Age Group of patients in OPD.

Table 8: Average number of Antibiotics received by Age Group of patients in IPD.

	Less than 4 years		4-18 years		18-35 years		35 years above	
	Cases	**Antibiotics**	**Cases**	**Antibiotics**	**Cases**	**Antibiotics**	**Cases**	**Antibiotics**
Before Intervention	7	18	10	43	12	38	12	51
Average Number of antibiotic per prescription	2.57		4.3		3.16		4.25	
After Intervention	6	16	9	38	9	50	11	45
Average Number of antibiotic per prescription	2.66		4.22		5.55		4.09	

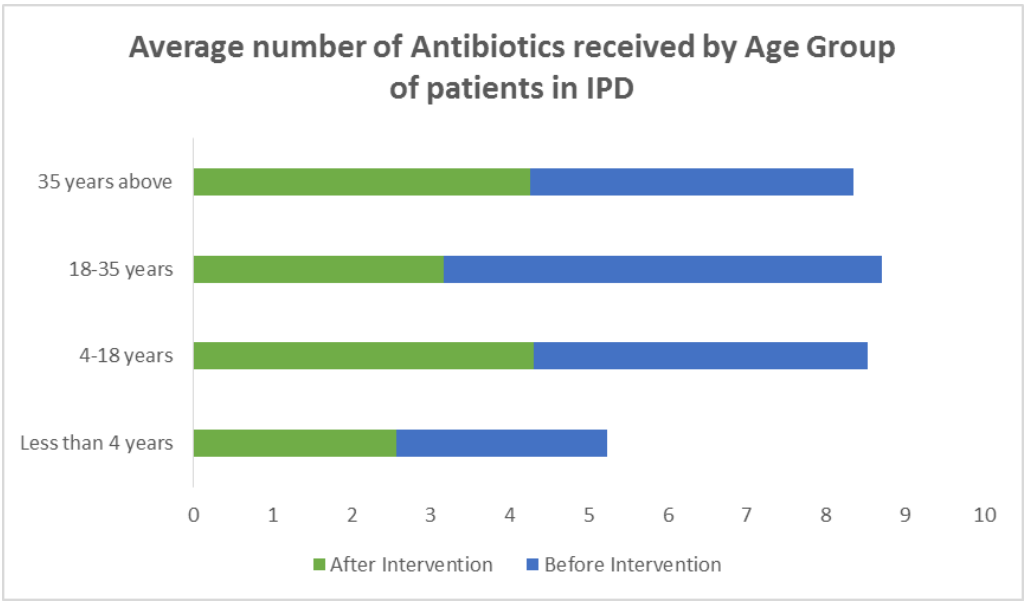

Figure 7: Average number of Antibiotics received by Age Group of patients in IPD.

Improvement of average number of prescription for antibiotic drugs both in OPD and IPD

For OPD, before and after action 146 medications are given and 142. In IPD, the cumulative amount of prescribed medications is 150 and 149 before the operation. It is seen here that more IPD prescriptions than OPD prescriptions are eligible. However, after the therapy, the amount of medications in OPD has declined by 2.73% and IPD by 0.66%.

Table 9: Improvement of average number of prescription for antibiotic drugs both in OPD and IPD.

OPD		IPD	
Total Number of Drugs Before Intervention	***Total Number of Drugs After Intervention***	***Total Number of Drugs Before Intervention***	***Total Number of Drugs After Intervention***
146	142	150	149
Total reduced	2.73 %	***Total reduced***	0.66%

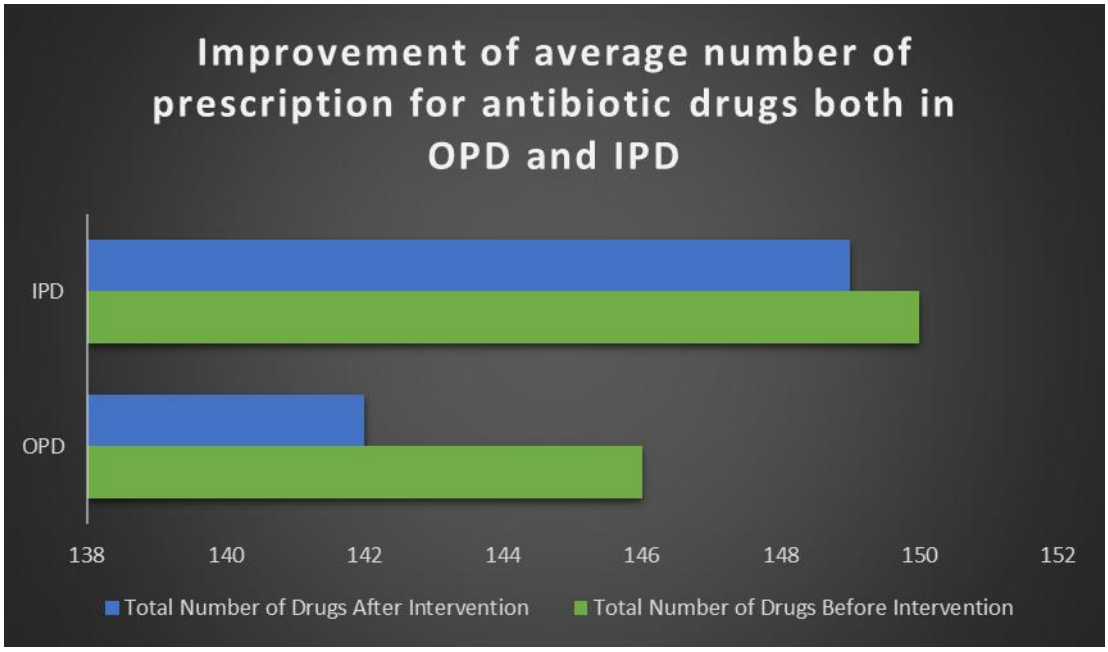

Figure 8: Improvement of average number of prescription for antibiotic drugs both in OPD and IPD.

Average number of antibiotic per prescription before and after intervention both in OPD and IPD

The table reveals that after operation, the amount of antibiotics used in OPD was smaller than in IPD. This is 15.42 for OPD, while 15.28 for IPD before the operation. On average, 14,72 antibiotic decreases were reported in OPD after the treatment, but they were increased by IPD 16,52. Table 19 and Figure 20 show this.

Average number of antibiotic per prescription before and after intervention both in OPD and IPD.

Table 10: Average number of antibiotic per prescription before and after intervention both in OPD and IPD.

OPD		IPD	
Antibiotic Before Intervention	15.42	***Antibiotic Before Intervention***	15.28
Antibiotic After Intervention	14.72	***Antibiotic After Intervention***	16.52

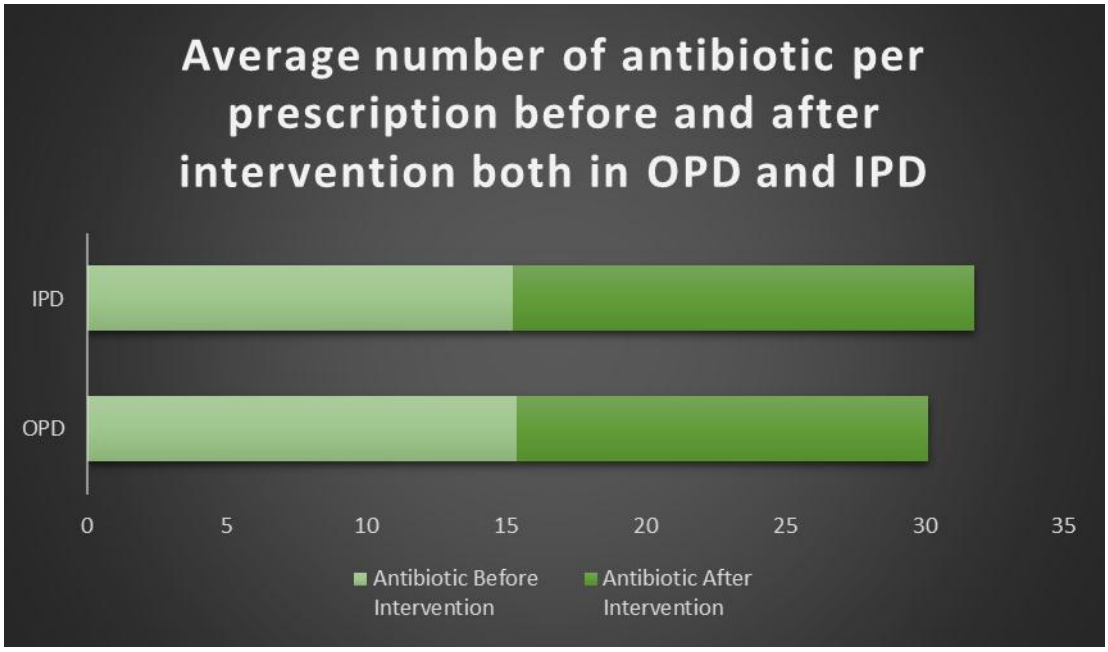

Figure 9: Average number of antibiotic per prescription before and after intervention both in OPD and IPD.

Check List for Clinical Encounter both in OPD and IPD

OPD requires more than 36 medications for the length of the present illness, as it is marginally smaller than IPD which has 21 medications. Physicians had no evidence of "true condition" with 44 patients treated, but that has not been changed so far in IPD since it has been 30 prescriptions. There were only 37 patients who requested a referral to record their prior drug background in OPD where 52 patients were able to supply details, as was the case in IPD. Just 29 patients have sought OPD study guidance, and this condition is comparatively strong for IPD, where 56 patients are recommended to be treated. 27 patients treated for the OPD will not provide guidance while 68 patients are advised in the recommended IPD. IPD is more alert and compassionate than OPD in contrast to patients.

Table 11: Check List for Clinical Encounter both in OPD and IPD.

Indication	OPD			IPD		
	Yes	No	N.A.	Yes	No	N.A.
Asking about duration of present illness	32	36	7	49	21	5
Taking history of past illness	27	44	4	42	30	3
Taking previous drug history	37	30	8	52	21	2
Investigation advised	29	42	4	56	17	2
Instruction about taking drugs	47	27	1	68	6	1
Instruction about diet	10	58	7	70	4	1

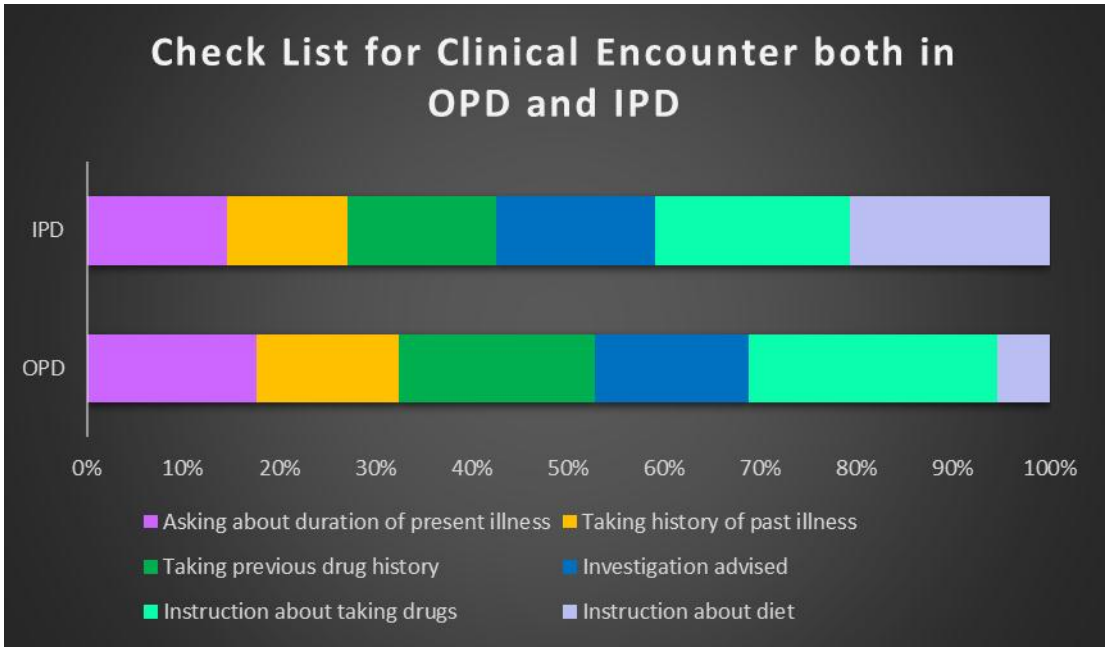

Figure 10: Check List for Clinical Encounter both in OPD and IPD.

Patient satisfaction percentage inquiry of antibiotic drugs

In IPD 38% of patients were pleased with the care plan, while in OPD just 12% were really happy. Unfulfillment (only 6%) in the IPD is still far smaller than the OPD where it is 13%. In OPD, on the other side, 70% of patients are little pleased with the same pattern. However, IPD is safer than OPD for the user.

Table 12: Patient satisfaction percentage.

	OPD					IPD			
Patient Satisfaction	***(a)***	***(b)***	***(c)***	***(d)***		***(a)***	***(b)***	***(c)***	***(d)***
Percentage	12	70	5	13		38	50	6	6

Note: *Very Satisfied - (a)*
Little Satisfied - (b)
Little Dissatisfied - (c)
Very Dissatisfied - (d)

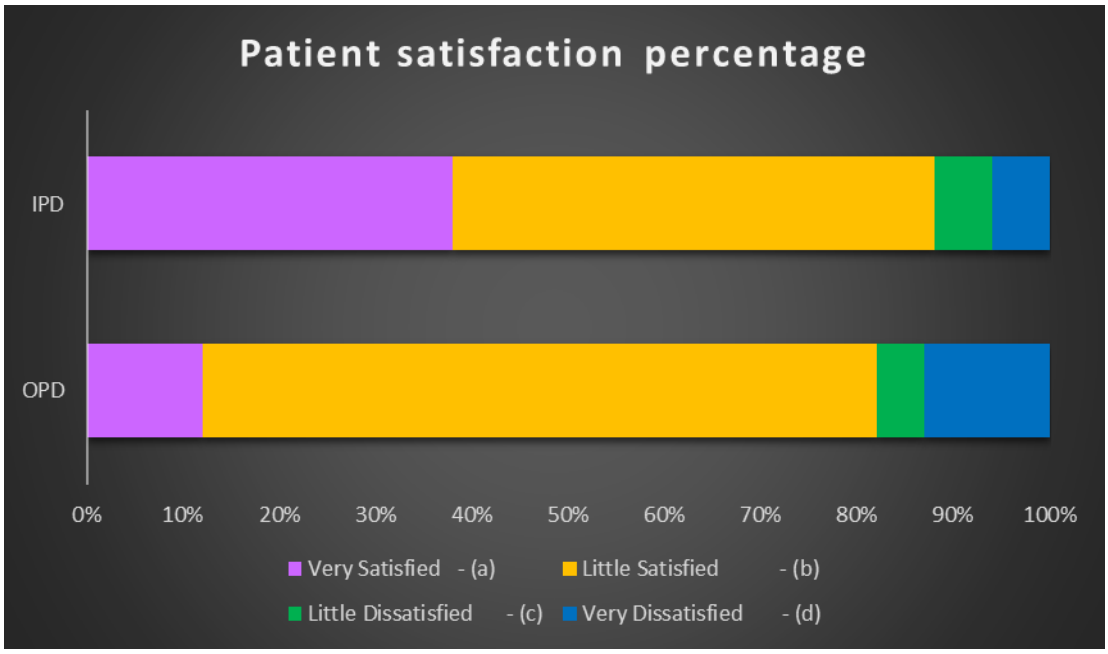

Figure 11: Patient satisfaction percentage.

Percentage of patients' hearing

OPD users are not so diligent with the drug listening of the psychiatrist. Around 60% of patients do not hear anything from doctors in OPD, but 37% hear in IPD. In IPD, 29% of IPD, adequate hearing exists, but, in OPD, the figure was just under one tenth of the amount.

Table 13: Patient hearing percentage.

	OPD					IPD			
Patient hearing	***(a)***	***(b)***	***(c)***	***(d)***		***(a)***	***(b)***	***(c)***	***(d)***
Percentage	58	10	20	12		37	29	24	10

Note: *Not hearing - (a)*
Adequate - (b)
Fair - (c)
Little Hearing - (d)

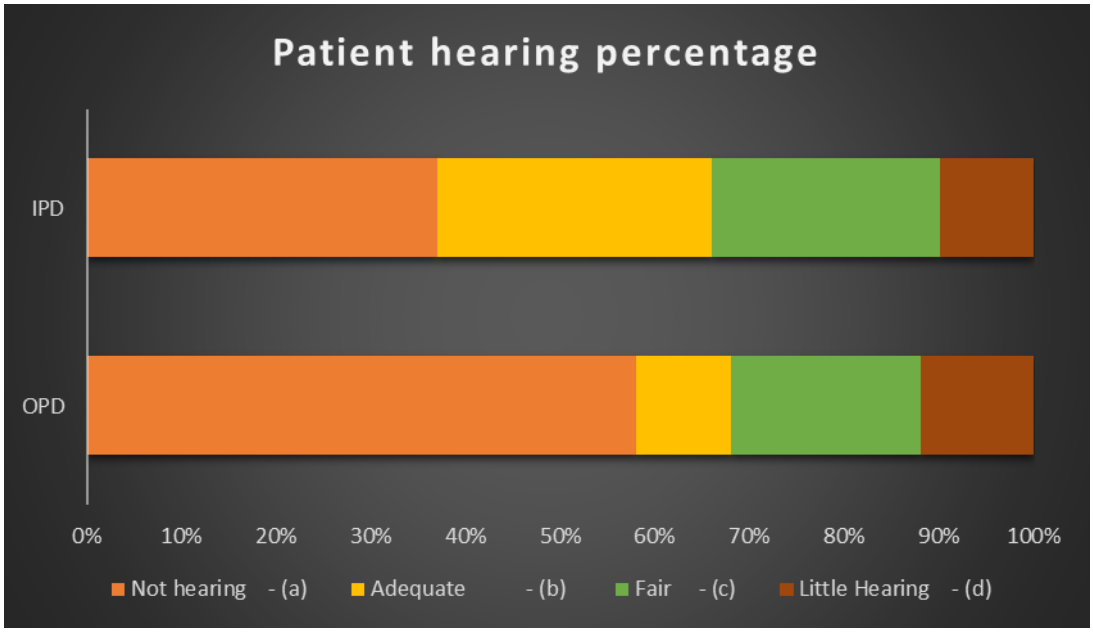

Figure 12: Patient hearing percentage.

Percentage of Drugs Dispensed from Hospital Pharmacy and Outside of Hospital Pharmacy

35% of prescription medications have been dispensed by Hospital Pharmacy in the network of OPD treatment facilities, whereas Hospital Pharmacy dispenses half of the approved narcotics in IPD. In fact, 100% had to purchase IPD hospital drugs that are just 35% of OPD.

Table 14: Percentage of Drugs Dispensed from Hospital Pharmacy.

	OPD			IPD	
Drugs Dispensed from Hospital Pharmacy	***Yes***	***No***		***Yes***	***No***
	35%	65%		100%	0%

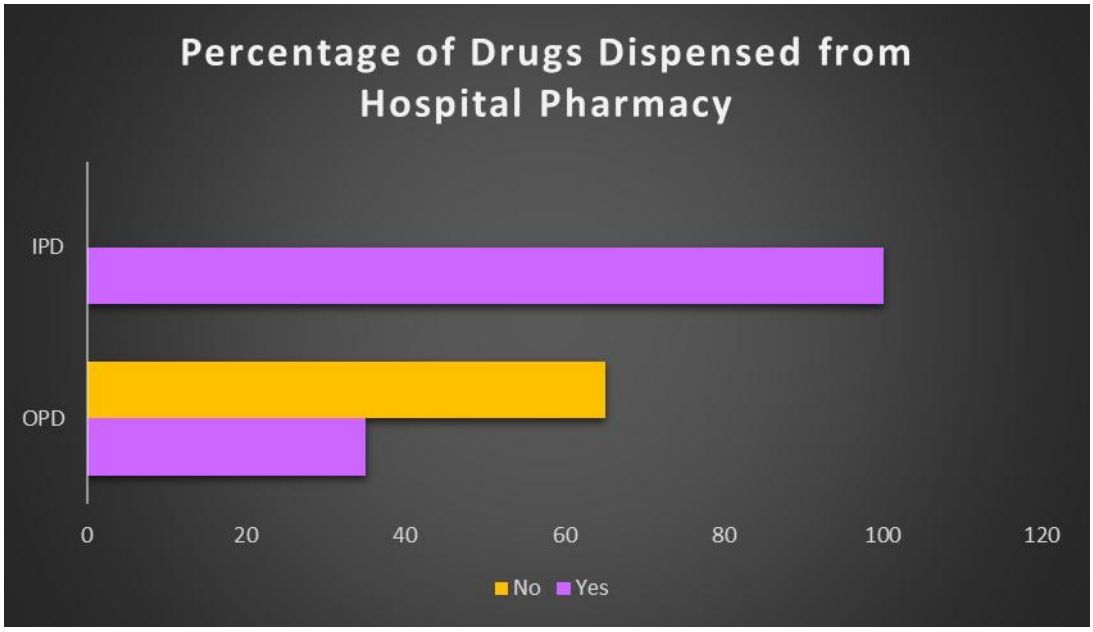

Figure 13: Percentage of Drugs Dispensed from Hospital Pharmacy.

CONCLUSION

Irrational habits are a condition that is disturbing to remedy. The patients suffer terribly over some sort of mistake by a doctor. While prescribing anti-biotic medicines is quite vulnerable in India, patients between 18 and 35 years of age are generally greatly influenced by this high usage. OPD will improve the resources, appointment period and any other programs requested by the general public. With comparison to IPD, more pharmaceutical medications, examinations, etc. will therefore be minimized. Antibiotics are comparatively cost-effective because their overall generic goods are inexpensive and so doctors prescribe a lot of antibiotics. In order to strengthen pharmacy practice, doctors need to be made more explicit in development on reasonable prescribing practices, professional pharmacology and opioid therapy. The triangular health-care group will be formed jointly with physicians, pharmacists and nurses to reduce the health crisis. While in our country this pattern is not yet active, it is highly anticipated. Governing institutions must be more familiar with the unjust phenomenon and take the required action for it. Within our health program, no disruption is ideal. Patients tend to be getting good care and to be safe.

REFERENCES

1. Yadav, P., Kanase, V., Lacchiramka, P., & Jain, S. (2010). Drug utilization trends in ENT outpatient department in a Teaching hospital. Int J Pharm Biol Sci, 1: 153-60.
2. Pallavi, I., Shrivastava, R., Sharma, A., & Singh, P. (2016). Prescribe Pattern of Drugs and Antimicrobials Preferences in the Department of ENT at Tertiary Care SGM Hospital, Rewa, MP, India. Journal of Pharmaceutical and Biomedical Sciences, 6(2): 89-93.
3. World Health Organization. Medicines: rational use of medicines [Internet], 2010.
4. Patel V, Vaidya R, Naik D, Borker P. Irrational drug use in India: A prescription survey from Goa. J Postgrad Med, 2005; 51(1): 9-12.
5. Dineshkumar B, Raghuram TC, Radhaiah G, Krishnaswamy K. Profile of drug use in urban and rural India. Pharmacoecon, 1995; 7: 332-346.
6. Irshaid YM, Al-Homrany M, Hamdi AA, Adjepon-Yamoah KK, Mahfouz AA. Compliance with good practice in prescription writing at outpatient clinics in Saudi Arabia. East Mediterr Health J, 2005; 11(5-6): 922-928.
7. Cohen MR. Medication Errors: Causes, Prevention, and Risk Management. Sudbury, MA: Jones and Bartlett Publishers, 2000; 8-22.
8. Institute of Medicine. Microbial threats to health: emergence, detection and response. Washington DC: National Academics Press, 1998.
9. Aminzadeh F, Dalziel WB. Older adults in the emergency department: A systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. Ann Emerg Med, 2002; 39: 238–47.
10. Carlson JE. Perils of polypharmacy: 10 steps to prudent prescribing. Geriatrics, 1996; 51: 26–35.
11. Hanlon JT. Drug-related problems update. Am J Geriatr Pharmacother, 2004; 2: 88-90.