Int.J.Curr.Res.Aca.Rev.2026; 14(2): 25-35

International Journal of Current Research and Academic Review

ISSN: 2347-3215 (Online) Volume 14 Number 2 (February-2026)

Journal homepage: http://www.ijcrar.com

doi: https://doi.org/10.20546/ijcrar.2026.1402.004

Study of Prescription Pattern in Intensive Care Unit of a Tertiary Care Hospital

Sweety Ramesh Deikar*

Department of Pharmacology, Goa Medical College, Bambolim, Goa India

**Corresponding author*

Abstract

The Medical Intensive Care Unit represent an important platform for conducting drug prescription studies. The pharmacological management of these patients typically involves the administration of several classes of drugs. Periodic evaluation of drug prescription in ICUs is essential for making prescription policies to make it more rational. A prospective observational study was conducted in Intensive Care Unit (Ward 123) of Goa Medical College and Hospital, Bambolim after obtaining approval from Institutional Ethics Committee. The study participants consisted of 300 patients admitted in Intensive care unit. Data relevant to the study was collected from the patient case records and the prescribing pattern was studied using WHO prescribing indicators. The most common illness which accounted for ICU admission was Road Traffic Accidents which accounted for 16.67%. A total of 714 potential drug-drug interactions were noted, among which majority that is 46.64% were moderate. Cases with acute liver failure had maximum treatment adherence which was 89% to national guidelines. From our study we conclude that most common cause for admission in ICU was Road Traffic Accidents followed by vascular pathology. Such type of studies helps in judicious selection of drug therapy based on clinical assessment of individual patients.

Article Info

Received: 26 December 2025
Accepted:28 January 2026
Available Online: 20 February 2026

Keywords

Intensive Care Unit, polypharmacy, Rational prescribing patterns, Drug-drug interactions and drug adverse effects.

Introduction

Patients admitted in intensive care unit are often seriously ill, suffering from chronic critical illnesses, and present with diverse demographic profiles, complex admission criteria, and co-existing medical conditions. [1]

Chronic disease and life-threatening disorders among ICU patients have resulted in medicating them with drugs from different pharmacological classes, which is further complicated by the altered physiology and multi-organ system failure.[2] Incidence of poor treatment response and adverse reactions increase due to critical conditions of patients and use of multiple medications with altered pharmacokinetic and pharmacodynamic conditions. [3]

There is a growing importance of prescription pattern studies due to surge in marketing of new drugs, different patterns of prescribing and consumption of drugs leading to increasing concerns for the provision of best healthcare.[4] The most of the drugs are empirically prescribed and mainly based on physician previous experience, resulting in the lack of quantitative precision of drugs usage.[5]

Critically ill-patients receiving multiple drug regimens with the target of providing adequate pharmacotherapeutic support are at risk for drug interactions (DIs) because of the complexity of this polypharmacy, as well as the frequent presence of altered organ function. Furthermore, elderly, critically ill patients are particularly vulnerable to AEs from DIs

because of the additional presence of multiple co morbid disease states. [28,34,35] Increasing number of patients, various diseases, and therapeutic drug regimens, renders polypharmacy unavoidable. Polypharmacy increases the risks of drug AEs, especially the DDIs, and that leads to elevated healthcare costs, morbidity and mortality. [6,14]

Adverse drug reactions (ADRs) are one of the main causes of injury and death. In recent years, the number of medications prescribed to patients has increased dramatically and so that percentage of ADRs have also increased. Adverse drug effects (ADEs) are one of the serious public health problems and also leading cause of injury and death which need to be focused with effective solutions. The ICUs are also the epicentre of antimicrobial resistance which play an important problem influencing patient outcomes.(18,19) ICUs' patients are at risk of developing nosocomial infections. Antimicrobials are heavily prescribed in the (ICUs), especially those broad-spectrum ones. (20, 21)

The WHO defined the inappropriate usage of antimicrobial as; any prescribing antimicrobial agents without need or any improper dosage form, or short or long duration of treatment which usually leads to increase in the risk of resistance and increases the side effects of such drugs. Therefore, there is an urgent need of implementing an evidence-based stewardship program depending on the use of antimicrobials in the health-care setting. [7,17]

Hence, institution of a rational pharmacotherapy is of utmost importance for saving the lives of critically-ill patients and to avoid life threatening complications arising out of irrational drug use.[8] Repeated timely evaluation of Prescription pattern in hospital ICUs is necessary for making suitable alterations in prescribing patterns, escalation of health care system, cautious use of resources and for generating and implementing prescription policies.[9]

In this study we intended to estimate the prescribing pattern in the ICU of a Tertiary care Hospital as per the National Guidelines and also to assess the potential drug interactions.

Materials and Methods

Study Design

A prospective observational study was conducted in Intensive Care Unit (Ward 123) of Goa Medical College and Hospital from August 2022. The study participants consisted of 300 patients. Prior to the commencement of the study Institutional ethics committee approval was obtained with IEC number GMCIEC/2022/134 on 26th July 2022.

Inclusion criteria

- Patients admitted in ICU
- Aged 18 years and above
- Patients of both genders

Exclusion criteria

- Patients having ICU stay less than 24 hours
- Post-operative patients
- Pregnant or lactating

Relevant data for the study were obtained from patient case records, including demographic information and details of prescribed medications. The Guidelines for the Management of Critical Care issued by the Ministry of Health and Family Welfare, Government of India, were used as the standard reference for treatment. Potential drug-drug interactions were evaluated using a drug interaction checker.

Statistical analysis

Data compilation was performed using Microsoft Excel. The prescribing pattern was evaluated using WHO prescribing indicators, while drug-drug interactions were assessed with a drug interaction checker. Data analysis involved the use of means and percentages, and the findings were illustrated through graphs and charts. Adherence to guidelines was assessed by directly comparing the diagnosis with the prescribed therapy on a case-by-case basis.

Results and Discussion

The study included a total of 300 participants. The age of patients in this study ranged from 18 to 87 years. Graph 1 shows that the majority of patients that is 120 (40 %) were in the age group ranging from 41- 60 years and 88 (29.33 %) patients were from the group 21- 40 years.

Graph 2 shows that out of 300 patients, total number of male patients were 210 (70%) and females were 90 (30%) with male: female ratio of 7:3.

Table 1 depicts that the most common cause for admission in ICU was Road Traffic Accidents (RTA) which was observed in 50 patients which accounted for

16.67 % of the total number of cases. Second most common diagnosis was vascular pathology which was seen in 49 patients accounting for 16.33 % followed by Gastrointestinal disorders which accounted for 16%.

Table 2 indicates that among patients with comorbidities, hypertension was the most encountered comorbidity which accounted for 42.65 % of the cases. Diabetes Mellitus was the second most common comorbidity affecting 24 patients (35.29 %) followed by coronary artery disease (10.29 %).

Graph 3 indicates number of drugs prescribed per patient which was in the range of 6-10 in maximum number of prescriptions i.e., 210 which accounted for 70 % of the total prescriptions. 46 prescriptions (15.33 %) had 11-15 drugs prescribed per prescription.

Graph 4 shows that the most frequently employed route to administer drugs in ICU was intravenous accounting for 66.73%. Oral route was the second most common route used to deliver drugs which accounted for 19.66%.

Table 3 shows that the most frequently prescribed class of drugs was GI drugs which were included in 282 prescriptions accounting for 26.4 % of the total prescriptions. Antibiotics were prescribed 152 times (14.2 %) followed by analgesics, anti-inflammatory and muscle relaxants which accounted for 133 of the total prescriptions (12.4 %).

Table 4 indicates number of antibiotics prescribed per patient. Majority of patients i.e., 38 % received 2 antibiotics followed by 33.67 % of patients receiving 3 antibiotics.

Table 5 shows that among antibiotics, the majority of patients (152 individuals, 50.67%) received metronidazole, followed by meropenem, which was prescribed to 34.33% of patients.

Graph 5 indicates that majority of the drugs were prescribed in their branded or proprietary names (1885) whereas only 702 drugs were prescribed as generic medicines.

Graph 6 depicts that out of the total number of drugs prescribed, 1940 drugs i.e., 75.04% were from national list of essential medicine 2022 whereas it was observed that 1566 drugs which accounted for 60.58% was prescribed from WHO list of essential medicines 2023.

Table 6 depicts a total of 714 drug interactions, out of which 333 were moderate drug interactions (46.64 %), 321 were minor drug interactions (44.96 %). Severe interactions were encountered 58 number of times (8.12 %) and 2 patients (0.28 %) were prescribed drugs which were contraindicated together.

Table7 depicts adherence of treatment to national guidelines. Maximum adherence to treatment was seen in cases with acute liver failure constituting 89% followed by neurotoxic snake bite cases i.e., 80%.

This prospective study was conducted in the Intensive Care Unit of Goa Medical College and included a total of 300 patients. The primary objective was to assess prescribing patterns in accordance with the National Guidelines, with a secondary focus on identifying potential drug interactions.

Age of patients ranged from 18 to 87 years. The majority of patients (40%) were in the age group ranging from 41 - 60 years followed by age group 21 – 40 years (29%). Mean age was 48 years in our study. In a study done by Venkat *et al.,*[1] mean age was found to be 53.81 ±14.63 years. Male patients (70%) outnumbered female patients (30%). As higher rates of underlying critical illness and cardiovascular disease are observed in men and women may exhibit lower inclination towards receiving the aggressive care typically offered in ICUs. [10]

In consistence with the study done by Mahmood *et al.,* it was noted that a higher readmission rate and extended duration of stay in the ICU was seen in men. [11]

The most common illness which accounted for ICU admission was RTA which accounted for 16.67%. This may be attributed to driving under the influence of alcohol, Speeding, failure to use motorcycle helmets and seat-belts and unsafe vehicles. [12,26,27]

Systemic hypertension (42.65%) and diabetes mellitus (35.29%) were the commonest underlying co-morbid conditions in our study which supports the existing evidence that these conditions are achieving epidemic proportions. This is similar to a study conducted by Rajathilagam *et al.,* [9] in a medical ICU of a tertiary care teaching hospital of south India wherein diabetes mellitus was seen in 26.98% and systemic hypertension was seen in 26.45% of patients.

Table.1 Diagnosis Distribution

Diagnosis	Number of cases (n)	Percentage (%)
Respiratory	10	3.33
Renal	1	0.33
Neurology	42	14.00
Infections	12	4.00
Cellulitis	5	1.67
Sepsis	25	8.33
Others	22	7.33
Gastrointestinal	48	16.00
Liver	3	1.00
Road Traffic Accidents	50	16.67
Poisoning	2	0.67
Malignancy	29	9.67
Haematology	2	0.67
Vascular	49	16.33
Total	**300**	**100**

Table.2 Associated Comorbidities

Comorbidity	Number of patients (n)	Percentage (%)
Diabetes Mellitus	24	35.29
Hypertension	29	42.65
Coronary Artery Disease	7	10.29
Chronic Kidney Disease	4	5.882
Alcoholic Liver Disease	4	5.882
Total	**68**	**100**

Table.3 Different classes of drugs prescribed

Class of drug	Number of prescriptions (n)	Percentage (%)
Antibiotics	152	14.2
Gastrointestinal	282	26.4
Haematology	46	4.3
Antihistamines	3	0.3
Analgesic, Anti-inflammatory and Muscle relaxants	133	12.4
Vitamin and minerals	75	7.0
Hormones	59	5.5
Central nervous system	119	11.1
Cardiovascular system	38	3.6
Respiratory system	87	8.1
Renal	59	5.5
Electrolytes and acid base	17	1.6
Total	**1070**	**100**

Table.4 Number of antibiotics prescribed

Number of antibiotics per day	Number of patients (n)	Percentage (%)
0	6	2.00
1	57	19.00
2	114	38.00
3	101	33.67
4	20	6.67
≥5	2	0.67
Total	**300**	**100**

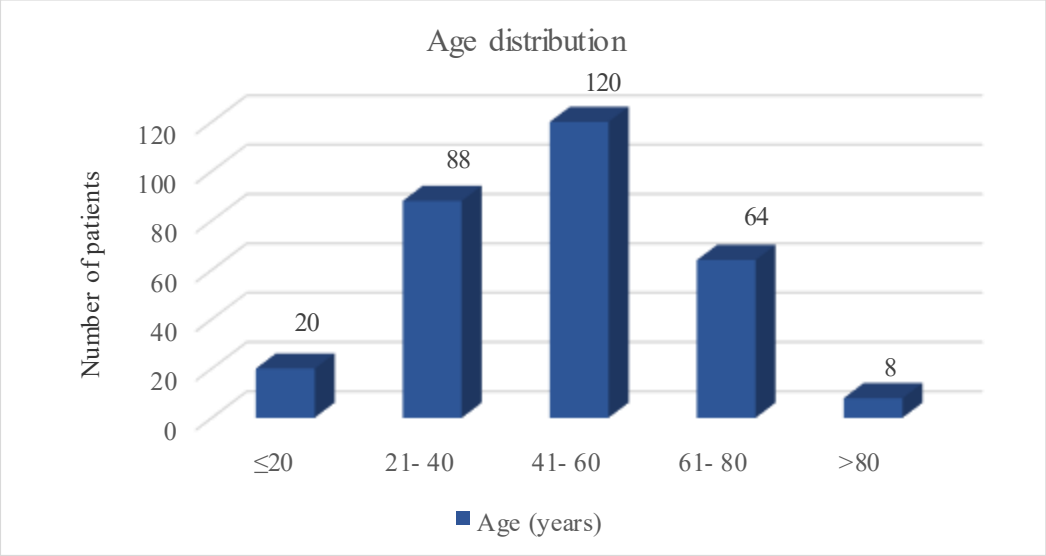
Table.5 Antibiotics prescribed

Antibiotic prescribed	Number of patients (n)	Percentage (%)
Meropenem	103	34.33
Teicoplanin	41	13.67
Ceftriaxone	12	4.00
Clindamycin	25	8.33
Linezolid	7	2.33
Metronidazole	152	50.67
Cefotaxime	1	0.33
Ciprofloxacin	7	2.33
Amikacin	24	8.00
Ofloxacin	3	1.00
HRZES(isoniazid, rifampicin, pyrazinamide, ethambutol, streptomycin)	2	0.67
Azithromycin	12	4.00
Ceftazidime + Sulbactam	1	0.33
Cefoperazone + Sulbactam	64	21.33
Gentamicin	6	2.00
Cefuroxime	36	12.00
Colistimethate	4	1.33
Co-amoxiclav	7	2.33
Cefoperazone	10	3.33
Aztreonam	54	18.00
Levofloxacin	5	1.67
Chloramphenicol	6	2.00
Ceftazidime	9	3.00
Amoxycillin + Cloxacillin	2	0.67
Vancomycin	3	1.00
Piperacillin-Tazobactam	43	14.33
Cilastatin + Imipenem	10	3.33
Doxycycline	7	2.33
Tigecycline	2	0.67
Cefuroxime + Sulbactam	1	0.33
Rifaximine	21	7.00

Table.6 Drug Interactions

Type of interactions	Number of DI (n)	Percentage (%)
Severe Interactions	58	8.12
Moderate Interactions	333	46.64
Minor Interactions	321	44.96
Contraindicated	2	0.28
Total	**714**	**100**

Graph.1 Age Distribution



Graph.2 Sex distribution

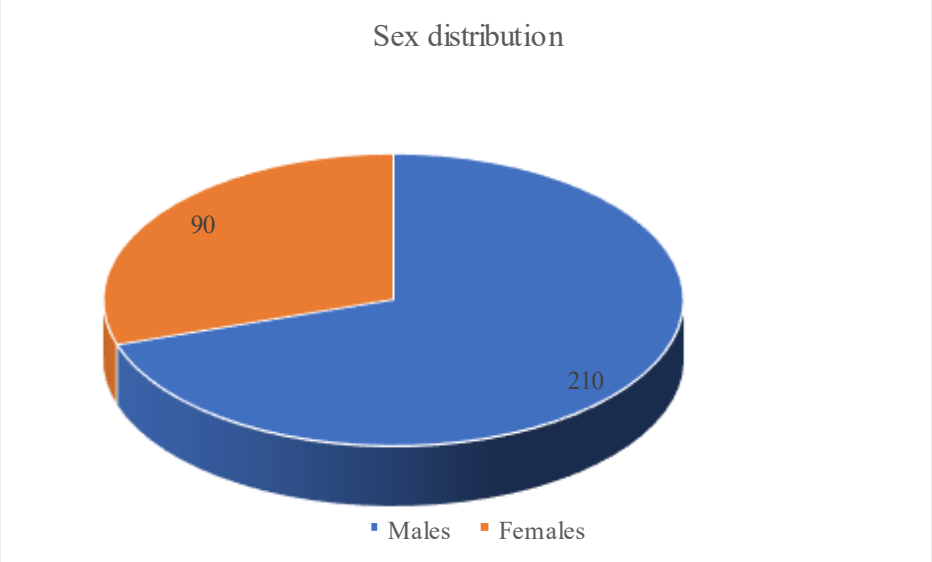
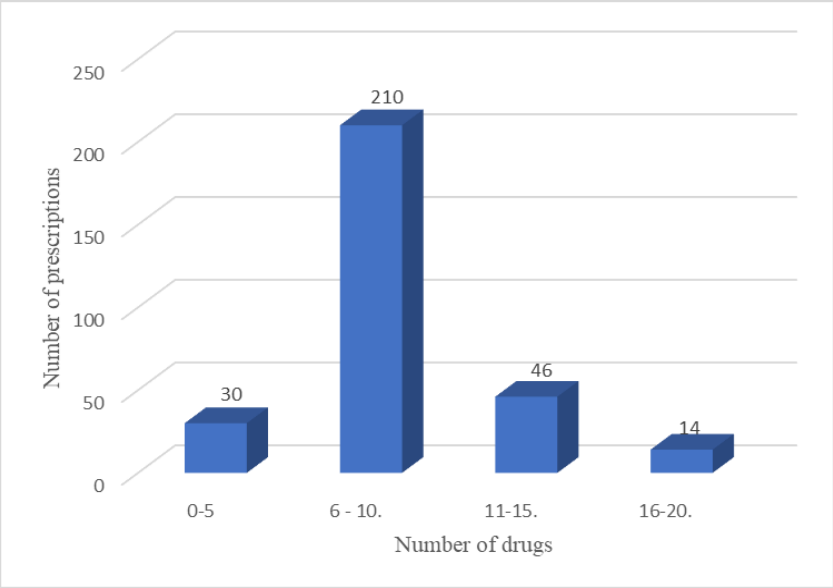


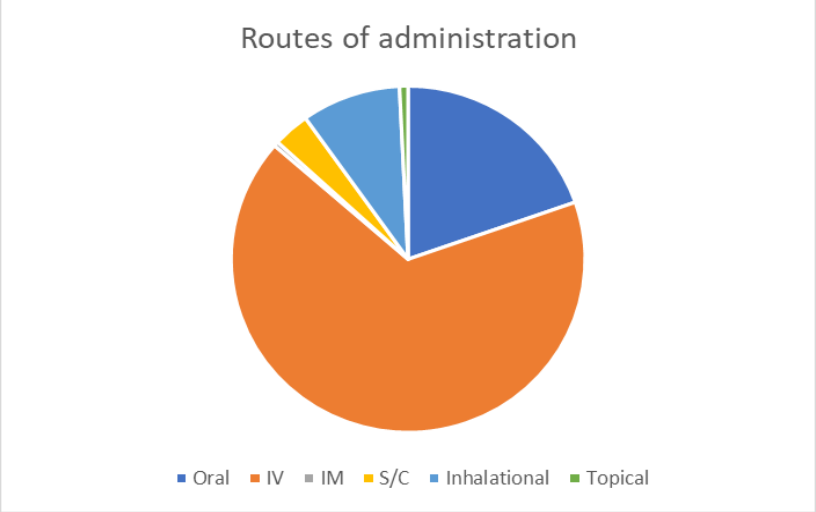
Table.7 Adherence to guidelines in percentage

Diagnosis	Percentage (%)
Severe sepsis and septic shock	60
Traumatic brain injury	75
ARDS	60
Acute liver failure	89
Pneumonia	60
Status epilepticus	71
Neurotoxic snake bite	80

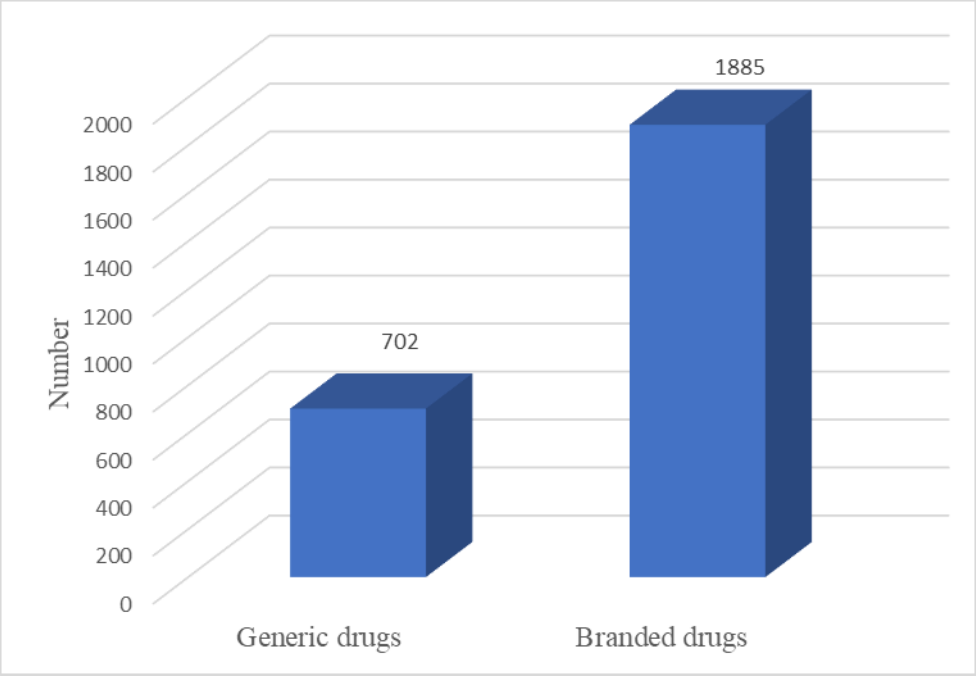
Graph.3 Number of drugs prescribed per patient



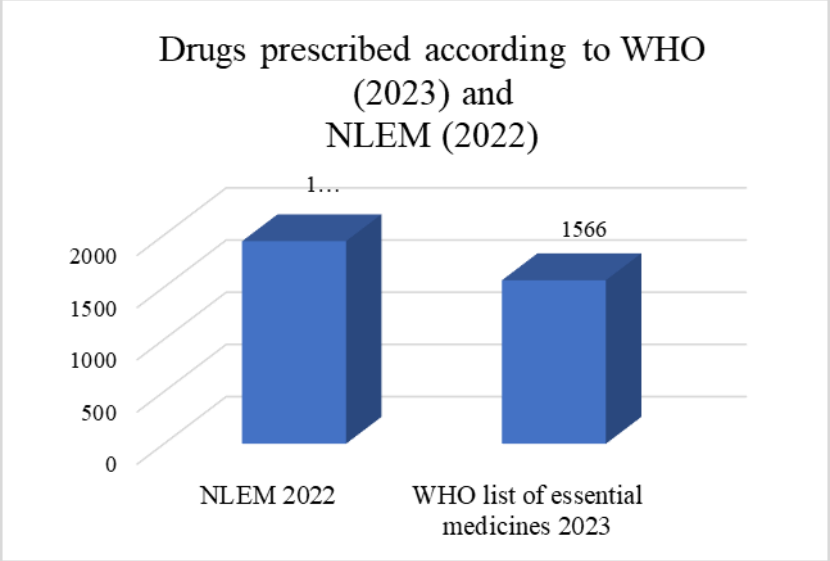
Graph.4 Routes of administration



Graph.5 Number of generic and branded drugs prescribed



Graph.6 Drugs prescription as per NLEM and WHO essential list**.**



300 patients were included in our study. The total number of drugs used was 2591. The average number of drugs per patient was 8.6 with a maximum number of 18 drugs and a minimum number of drugs 3. The average number of drugs per person is the utmost important indicator of trends in pattern of prescription. It is advisable to keep the mean number of drugs per prescription as minimum as possible since multiple drugs lead to increased chances of drug interactions and increased healthcare cost.

The total number of GI drugs were 642, of which pantoprazole (43.9%) and ondansetron (43.9%) were the most prescribed drugs which is in consistent with the study done by Venkat *et al.,* [1]

It was noted that the total number of antibiotics prescribed were 680 in 300 prescriptions; the maximum number of antibiotics prescribed per prescription was 5. The average number of antibiotics per prescription was 2.

The most common AMAs prescribed was metronidazole in 50.67% Since anaerobic infections are common nosocomial infections, metronidazole is used to treat these infections. [13]

The maximum number of prescriptions i.e. 70% had 6-10 drugs, followed by 11-15 in 15.33% and 0-5 drugs in 10%. As reported by various studies, polypharmacy is a common practice in recent times. Patients with multiple co-morbidities are often subjected to polypharmacy, which significantly increases the risk of drug-drug interactions. [22,23,24,25] The most frequently employed route of administration was parenteral route accounting for 70.49% of the total drugs prescribed followed by oral or nasogastric route 19.65%. This is comparable to the study done by Rinku Ghimire et.al [8] in which 81.39% of drugs were administered by parenteral route.

Percentage of drugs prescribed by generic name was 27.13% in our study, when compared to 100% advised by WHO [15] and branded drugs were prescribed in the remaining 72.86%. But when compared to other studies done by Shoba P *et al.,* in which generic drug prescriptions were only 17.9% [16], our study showed considerably higher percentage of generic drug prescriptions. Low use of generic names among practitioners reflects the fact that pharmaceutical companies and their representatives have influence on physician's mind in using brand names.

The importance of prescribing with generic name have been emphasised as it helps to rationalize the therapy and reduces financial burden. [29,30,31]

As per our study 75.04% of the drugs were prescribed from national list of essential medicine 2022 and 60.58% were prescribed from WHO list of essential medicine 2023 whereas, Maharani B *et al.,* [2] reported utilization of drug from the WHO essential drug list as 87.4%. Higher percentage of drugs being from essential medicine list implies a good and healthy prescription pattern.[32]

A total of 714 potential drug-drug interactions were noted in our study, among which 46.64% were moderate, 44.96% were minor, 8.12% were serious and 0.2% of the prescribed drugs combinations were contraindicated together. Venkat *et al.,* [1] reported 55% drug-drug interactions as moderate and 45% as major interactions. Patients in whom drug combination is unavoidable regular monitoring and follow up in essential to prevent hazardous effects. [33]

In our study, cases with acute liver failure had maximum treatment adherence which was 89% to national guidelines followed by treatment of neurotoxic snake bite which was 80% adherent to national guidelines. Since the adherence to recommended guidelines is frequently less in critical care settings, implementation of stringent hospital policies and compliance to standard guidelines for treatment can help to eliminate hurdles and facilitate evidence-based medicine. [36]

In conclusion, this prospective study provides a comprehensive overview of drug prescribing patterns and potential drug interactions among ICU patients at Goa Medical College. The patient population predominantly consisted of middle-aged males, with road traffic accidents being the leading cause of ICU admission. Common comorbidities included systemic hypertension and diabetes mellitus, highlighting the increasing burden of non-communicable diseases.

The study revealed a high average number of drugs per patient (8.6), indicating widespread polypharmacy, especially among patients with multiple comorbidities. This practice, while often necessary in critical care, increases the risk of drug-drug interactions and healthcare costs. Gastrointestinal drugs and antibiotics were the most frequently prescribed, with pantoprazole, ondansetron, and metronidazole being the most commonly used agents.

Parenteral administration was the predominant route, aligning with the critical nature of ICU care. Although only 27.13% of drugs were prescribed by their generic names well below WHO recommendations this figure is still an improvement over similar studies, suggesting gradual progress toward rational prescribing.

Overall, the findings emphasize the importance of regular audits, education on rational drug use, and greater adherence to national and international guidelines to optimize patient outcomes and minimize the risks associated with polypharmacy and to promote generic prescribing in the ICU setting.

Funding: This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of interest: No Conflict of interest.

Acknowledgments

I am grateful to my guide, Dr. (Mrs) Lois James Samuels, Lecturer, Department of Pharmacology, for her invaluable support, and I sincerely thank Dr. P. V. Rataboli, Professor and HOD, Department of Pharmacology, for his constant guidance and encouragement. I also extend my thanks to the Department of Anaesthesia for their cooperation, which greatly contributed to the successful completion of this study.

Author Contributions

Dr Sweety Ramesh Deikar: Contributed to methodology, formal analysis, data curation, writing of the original draft, and review and editing of the manuscript. Dr (Mrs.) Lois James Samuel: Contributed to Validation, Writing - Review & Editing and Supervision

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How to cite this article:

Sweety Ramesh Deikar. 2026. Study of Prescription Pattern in Intensive Care Unit of a Tertiary Care Hospital. *Int.J.Curr.Res.Aca.Rev.* 14(2), 25-35. doi: https://doi.org/10.20546/ijcrar.2026.1402.004