AUDIT OF IN PATIENT PRESCRIPTIONS IN PSYCHIATRY WARD IN A TEACHING HOSPITAL

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ABSTRACT

An audit of inpatient prescriptions in a Psychiatric ward in a teaching hospital was conducted. Audit identified important shortcomings in prescription writing & recording. Intervention resulted in significant improvements in most of these areas. It is concluded that continuous evaluation & feedback by means of regular audits can be used as an effective tool in improving prescriptions writing & thus indirectly patient care in our setup.

Key words: In patient, Prescriptions, Audit.

INTRODUCTION

Among the most important and basic clinical skills needed by doctors, is the prescription writing and it needs to emphasized during undergraduate and postgraduate teaching. Unfortunately errors in prescription writing are commonly reported. Bates et al reported 28% of preventable adverse drug events in their study and found 56% of those occurring at the time of ordering[1]. One third of prescriptions showed incomplete information and 20% were illegible in a study of prescriptions in a psycho-geriatric unit[2]. Reasons for errors in prescription writing may be related to fatigue, poor training, lack of interest etc among many others. Clinical audit can be used as an effective tool in clinical practice to assess the nature of prescription errors against agreed standards and introduce changes where indicated. A few audit cycles reports have been published related to psychiatry in the last few years[3-5], but despite the prescription related errors being common in Pakistan, this important area remains under researched.

The overall aim of the audit described here was to examine the standard of prescription recording in inpatients' case notes and to improve prescribing; recording and staff knowledge via targeted interventions.

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SUBJECTS AND METHODS

The study was undertaken in the inpatient unit of a tertiary care hospital in Lahore in beginning of 2012. It included an initial baseline audit, an intervention (teaching session by faculty members on prescription writing) and a subsequent re-audit around three months later.

An audit tool was designed to ascertain whether each of the standards as mentioned in the results tables were met for each randomly selected prescription card assessed. Each prescription was assessed by two members of the audit team.

The audit findings were discussed at a departmental medical audit team meeting. It was agreed that the standard of prescription writing was unacceptably poor. Mandatory teaching sessions were conducted by the consultants in the department in the following 2 weeks. Various causes of prescription writing errors including inconsistent faculty expectations, time management issues, lack of residents' education and mis-information about documentation were identified. Residents were taught what and how the prescriptions need to be recorded as well as the clinical importance of doing so.

Following the intervention, the prescription cards of randomly selected patients on the ward were re-evaluated 3 months later by using the same criteria.

RESULTS

In the first phase of the audit cycle, 236 prescriptions were reviewed (229 regular and 7 were as required prescriptions. Only 1/7 as required medicines had documentation for the reason of its prescription) Majority of prescriptions were legible however poor record of signing and dating the prescriptions was observed (Table 1). Similarly generic names were being written occasionally rather than as a routine. The second audit showed overall improvement in the quality of prescriptions writing. (Table 1) Use of trade name, signing of prescription, mention of start dates of medicines as well as improvement in cancellation and alterations of drugs were noted.

Table 1

Prescriptions Medications Details

Parameters	N (%) Meeting standards in initial audit (Total n=236)	N (%) meeting standards in re-audit (Total n=250)
• Legible	225(95.3)	241(96.4)
• Generic drug name used.	12(5.1)	180(72)
• Block capitals used	0	53(21.2)
• Dose in acceptable abbreviations	178(75.4)	196(78.4)
• Frequency given	225(95.3)	233(93.2)
• Route in acceptable abbreviations.	223(94.4)	240(96)
• Start date given	57(24.2)	237(94.8)
• Signed for by prescriber	56(23.7)	240(96)
• Administration times mentioned/circled	143(60.5)	235(94)
• Alterations re written	21/62(33.8)	61/79(77.2)
• Cancellations completed correctly/stop date mentioned.	2/81(2.4)	41/66(62.1)

DISCUSSION

This study suggests that clinical audit and feedback can help as a significant tool in improving the prescription writing. First audit showed that prescription writing standards were not being adhered to and considerable room for improvement was noted. Re audit showed positive response with improvement noticed in all the highlighted areas.

During medical training , little emphasis is placed on prescription writing.[6] Furthermore rotation of trainees every few months perhaps give them little time to become fully familiar with drug policies. A proper induction at the beginning of each rotation may address and manage these difficulties. Involvement of consultants in supervising the medicine records highlighted the importance of appropriate training. Prescription related errors reduction by adopting a three step strategy was suggested by Barber et al.[7] It includes improving the prescribers competence, controlling the prescribing environment and to change organizational culture to allow open discussion of errors. The audit showed that it can be used as a cost effective tool in developing countries to identify prescription related errors and improve the overall standards of prescription writing ultimately linked to better patient care. Similar audits can be used in future for improving performance in clinical settings.

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