1 22nd Jan 04

From Dr Lord 7th March 04

Best practice meeting 3rd Thur every 2nd month

Guidelines meeting
15/3
14/6
27/9
6th Dec

AUDIT OF STANDARDS OF PRESCRIPTION WRITING

ON ELDERLY MEDICINE ACUTE AND POST ACUTE WARDS

Audit x 2 — Rx handwriting
— Rx district formulary

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STANDARDS AND RESULTS

Standard 1 – Patient Details

All prescription charts should have the following recorded:

a) Name
b) Date of birth
c) Hospital number
d) Allergy status.
e)

Expected standard: 100% for all categories
Exceptions: nil.

Result achieved:	a)	Patients name	51/51	100%
	b)	Date of birth	48/51	94%
	c)	Hospital number	23/51	45%
	d.	Allergy status	47/51	92%

Standard 2 – For all regularly prescribed medication

a) The generic name should be used
b)

Expected standards: 100%
Exceptions: multi-ingredient drugs, Cyclosporin, Lithium, Theophylline (where trade names should be used).

c) The drug name should be legible)
d) The time of dosages stated)
e) Administration route stated)

Expected standard: 100%
Exceptions: nil

Results achieved:

a)	Generic prescribing	408/428 (& exceptions)	97%
b)	Drug name legible	423/446	95%
c)	Timing of doses stated	381/408	93%
d)	Administration route stated	434/452	96%

Standard 3

For all regularly prescribed medication, the dosage should be:

a) Legible
b) Within recommended range stated in BNF
c) The units should be clear.
d)

Expected standard: 100% for each area
Exceptions: nil

Results achieved:

a)	Legible dose	408/443	92%
b)	Within BNF range	415/443	94%
c)	Units clear	362/398	91%

Standard 4

For all drugs prescribed as required (prn):

a) An indication should be given for the use of the drug
b) The dosage should be clear
c) The route of administration should be indicated.

Expected standard: 100% for all areas
Exceptions: nil.

Results achieved:

a)	Indication	12/110	11%
b)	Clear dosage	112/124	90%
c)	Route of administration	114/123	93%

Standard 5 – Prescribers details

For each prescriber:

a) The signature should be legible
b) The name should be printed

Expected standard: 100%
Exceptions: nil.

Results achieved:

a)	Legible signature	217/465	47%
b)	Name printed	69/465	15%

Standard 6

All changes to prescriptions should be re-written in full

Expected standard: 100%
Exceptions: nil.

Result achieved: 55/105 48%

Standard 7

For all discontinued drugs

a) They should be clearly crossed out
b) They should be countersigned by the person stopping the drug
c) The "stop" date should be indicated.

Expected standard: 100% for all areas
Exceptions: nil.

Result achieved:

a)	Drug clearly crossed out	81/188	43%
b)	Counter signature	23/188	16%
c)	Stop date	17/188	12%

DISCUSSION

This audit of our own practice confirms that there are significant problems with standards of prescription writing.

Particular areas of concern are the poor standards related to stopping medication or changing dosage, the prescribing of "as required" (prn) drugs and the legibility of prescribers signatures.

Since reconfiguration of emergency medical services and change to shift pattern working for junior doctors, patients have more moves and come into contact with more doctors. It is therefore important, if errors occur, to be able to identify the prescriber in order to educate and improve standards.

Another difficulty arising from reconfiguration and closer working between the Departments of General Medicine and Elderly Medicine, has been the use of different drug charts in each department, which is confusing for both medical and nursing staff.

In developing an action plan, the literature was reviewed for evidence of effective measures. Electronic prescribing and regular input from hospital pharmacists have both been shown to reduce prescribing errors and adverse drug events (5, 6) and are felt by many to be cost effective. These measures, however, would require significant new investment and are probably important to consider in the longer term.

It is also important to raise the awareness of importance of standards of prescription writing. A "no blame" culture is needed to encourage recording of errors and promoting education (7, 8).

ACTION PLAN

1) Introduction of new prescription chart

This has been done and will be reviewed by the Joint Trusts Formularies and Medicines Group.

2) Feedback results of audit to staff via:

- Departmental education meeting

  This has been done and from the ensuing discussion with junior doctors they felt that one additional way to help them improve standards was to be challenged by nursing/pharmacy staff.

- Prescribing errors subgroup

  To be done by end of January 2004.

- Clinical Governance Groups

  To be done by end of January 2004

3) Discuss with senior nurses how best to empower nursing staff to promote good standards of prescription writing

   One possibility being considered in addition to education is Appendix C laminated and attached to drug trolleys.

4) Raise awareness of drug errors and standards of prescription writing.

- Laminated sheet has been put up in all wards in the doctor's office (Appendix D)
- Presentation of all recent drug errors given by Dr Ravindrane and Mrs J Marshall at a weekly educational session.

5) Raise awareness of drug errors and prescribing standards at a management level to enable longer term options such as electronic prescribing and increased pharmacist support to be considered.

- Audit results to be circulated
- East Hampshire PCT are reviewing Pharmacy requirements for the new Havant Hospital.