

Queen Alexandra Hospital, Portsmouth

Medicine for Older Persons Rehabilitation and Stroke (MOPRS)

Re-Audit of prescription chart completion

Audit number: Code A

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Background

Prescription charts are a key source of patient information both in terms of the patients themselves and the medications we give them, therefore prescription chart completion is essential in maintaining good clinical practice both during their hospital admission and beyond.

The initial audit was carried out in August 2010. This showed key areas requiring further input including clearer identification of the prescriber, rewriting prescriptions for individual drugs when changes are required, allergies and legibility. This was re-audited subsequently however deficiencies in these areas were still found.

This re-audit aims to identify if any improvement has been made in MOPRS department to ensure Trust guidelines and good prescribing procedures are being followed. This is critical in ensuring good medical care is provided, especially by optimising good communication between the multidisciplinary team via prescription charts and to ensure no drug errors occur.

The initial audit indicated areas of drug charts requiring more accurate completion; legibility, completion of any allergies, rewriting prescriptions for individual drugs with dose changes and clearer identification of the prescriber. It is hoped significant improvement has been made in these areas and to ensure no further areas of poor completion have appeared.

Methodology

A retrospective audit looking at drug chart completion over 9 MOPRS wards (F1-4, G1-4, Cedar) was carried out from 6-8th August 2014. Data was collected by Dr Sophie Russell and Dr Elena Cowan, from a random selection of 5 prescription charts from each ward, using the same audit questionnaire used in previous audits. Data was collated and analysed with help from tools developed by the Audit Department and Microsoft Excel.

Data for each patient was anonymised. The audit had no exclusion criteria

Results

All of the intended medicine charts were included (n=45). It was noted that the wards included were not the same as the initial audit due to wards changing speciality.

Patient information

Overall completion of information on the first page of the drug chart was still done well with 98% completed legibly, with full patient identification information (93%) and ward (98%).

Drug allergies were mostly completed fully (93%), a significant improvement on 2011 (78%) reversing the downward trend from 2010 (84%)

Unfortunately weight records were done very poorly, with on 53.3% charts with weight correctly recorded. This however is a significant improvement on 2011 when only 28% were documented and 26% in initial audit in 2010. (figure 1)

Prescriber information

One of the main problems identified was lack of prescriber identification both in terms of a printed name and bleep number. In only 48% of cases a printed name was present; however this is again a notable improvement from 8% in 2011 and 0% in 2010 (figure 2). A bleep number was only given in 48% cases, a reduction on previous recording; however it was noted that on many drug charts for longer term admissions no space for bleep numbers is identified e.g. Ward F1. This alteration may need to be reversed to ensure bleep numbers are printed.

Prescribing information

One of the main issues with prescribing were inadequate dating of the prescription with only 56% fully recorded a decrease from 58% in 2011 (figure 3). Most often year was missed; however a vast number had no recorded date.

Most drug charts had no altered prescriptions, but of those altered only 2/3 were re-written in full, similar to pattern seen in 2011.

Of those medications discontinued most drugs (70%) were not clearly crossed out, countersigned and dated (mostly just crossed through) (figure 4)

On charts where drugs were held (X placed), mostly reasoning was not given (42%), but an improvement on 2011 where 0% were completed fully, suggests significant progress in this area. (figure 5)

On a positive note, the prn and variable dose prescriptions were applicable were fully and completely written (95% and 100% respectively)

Conclusions

In conclusion, overall progress has been made towards better prescription chart completion with improvement seen since both 2010 and 2011. However, more work still needs to be done focussing on weight documentation, prescriber identification, dating of prescription and reasoning behind stopping/holding medications.

It should be possible with targeted education to all members of health care team about the importance of this information and supported by seniors leading by example for further progress to be made.

Recommendations

- 1) Increased education for all members of health care team on ward for the importance of weights (including importance for drug dosage) and careful documentation
 - a. For nurses and HCAs to carry out weights and to record initially on drug chart when weights are recorded
 - b. For doctors to remember to copy across all weights, when charts are re-written and if weights are requested to record it on drug charts
- 2) Encourage proper date documentation
 - a. To encourage ease of backtracking when medication was started or stopped when reviewing patients e.g. duration of antibiotics course
- 3) Encourage reasons to be documented when a medication is stopped or held
 - a. To help other doctors who manage the patient e.g. on weekends to understand the reasons for medication changes, especially when a review date is fixed for a day when the initial doctor is not available
 - b. To help when future doctors see the patient on future admissions, in clinic or queries from GP for the reason why it was stopped.
- 4) Encourage printing name of prescriber
 - a. Importance to reassure this is not for a blame culture but to try to improve prescribing practice and allow easier contact if future health care professionals wish to clarify something about the prescription.
 - b. Make sure drug charts are produced with a box/space identified requiring printed name and bleep. Potentially space on the front of the drug chart where the prescriber identifies their name and bleep with signature once with which to refer to throughout the chart.

Acknowledgement

1. *Dr Alison Bartens, Consultant Geriatrician, for her supervisory role.*
2. *Dr Elena Cowan, for help with data collection*
3. *The Audit Department for formatting the questionnaire, help in collating results and analysis.*

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Appendices

Appendix 1. Audit Questionnaire. An electronic copy developed by the audit department was also used to ease result collation and analysis:

Code A

Medical Prescription Audit for DMOP Portsmouth Hospitals NHS Trust

Q1 Date of data collection:

Q2 Name of ward:

Standards, on front page:

Q3 Is information completed in indelible ink, legibly in capitals or printed?

Yes.....
No.....

Q4 Are patients, Surname, Forename, Hospital number and date of birth all completed correctly?

Yes.....
No.....

Q5 Is patients weight completed correctly?

Yes.....
No.....

Q6 Is ward documented clearly?

Yes.....
No.....

Q7 Is the drug allergies section completed fully?

Yes.....
No.....

For Drug Prescriptions:

Q8 Are names of all drugs written clearly (legibly) and not abbreviated, in indelible ink, in capitals or printed?

Yes.....
No.....

Q9 Are doses written without unnecessary decimal points, with clear quantity and appropriate units circles or written in full for "units"?

Yes.....
No.....

Q10 Are route, frequency and times written clearly?

Yes.....
No.....

Q11 Is prescription fully dated with (day/month/year)?

Yes.....
No.....

Q12 Is prescription signed?

Yes.....
No.....

Q13 Is signature identified with printed name?

Yes.....
No.....

Q14 Is signature identified with a bleep number when appropriate?

Yes.....
 No.....
 N/A.....

For drug alterations/omissions:-

Q15 If dose has been altered, has the prescription been completely rewritten?

Yes.....
 No.....
 N/A.....

Q16 If drug is discontinued, has it been clearly crossed through name and administration parts and countersigned & dated by doctor?

Yes.....
 No.....
 N/A.....

Q17 If drug is to be omitted has "X" been inserted into box and has entry been made on back of chart as to why?

Yes.....
 No.....
 N/A.....

PRN/Variable dose charts:-

Q18 Have any PRN prescriptions been completed fully with Name, Dose, Route, Frequency, Maximum dose & Indication?

Yes.....
 No.....
 N/A.....

Q19 Have any variable dose prescriptions been completed fully?

Yes.....
 No.....
 N/A.....

AppendicesTable 1 Questions 3 to 19 relating to audit questionnaire, comparing % responses.

Question	2014	2014	2014	2011	2011	2011	2010	2010	2010
No.	Yes	No	Not applicable	Yes	No	Not applicable	Yes	No	Not applicable
3	98	2	0	94	6	0	96	4	0
4	93	7	0	94	6	0	92	8	0
5	53	47	0	28	72	0	26	74	0
6	98	2	0	96	4	0	98	2	0
7	93	7	0	78	22	0	84	16	0
8	100	0	0	88	12	0	74	26	0
9	100	0	0	90	10	0	94	6	0
10	87	6	0	94	6	0	94	6	0
11	56	44	0	58	42	0	42	58	0
12	98	2	0	98	2	0	100	0	0
13	48	52	0	8	92	0	0	100	0
14	48	36	16	60	40	0	54	44	0
15	27	11	62	22	16	62	14	30	56
16	18	42	40	8	56	36	28	44	28
17	25	35	40	0	10	90	4	24	52
18	78	4	18	12	58	30	30	56	14
19	11	0	89	2	6	92	4	6	90

Appendices: Figures

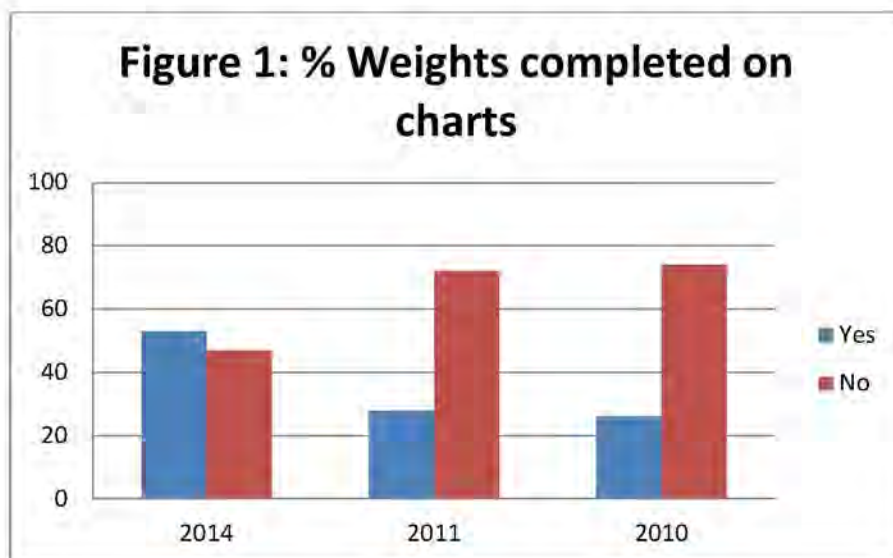


Figure 2

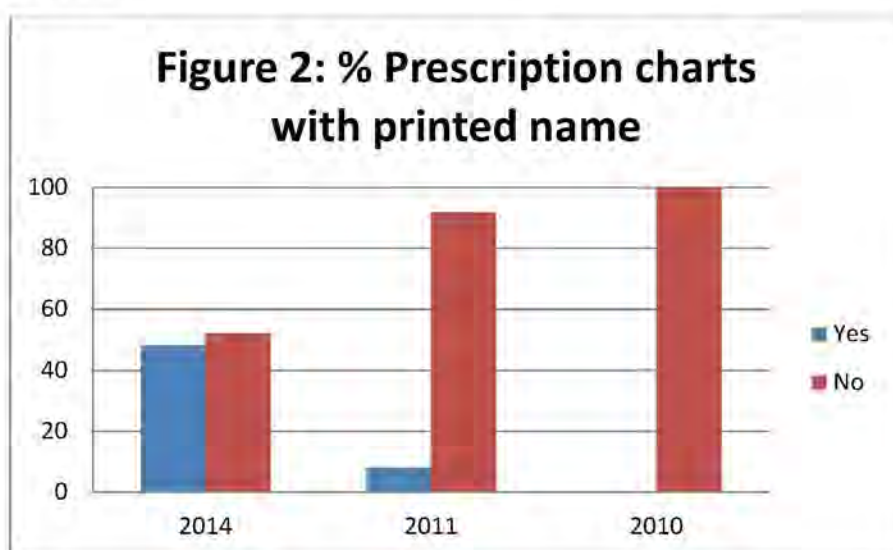


Figure 3

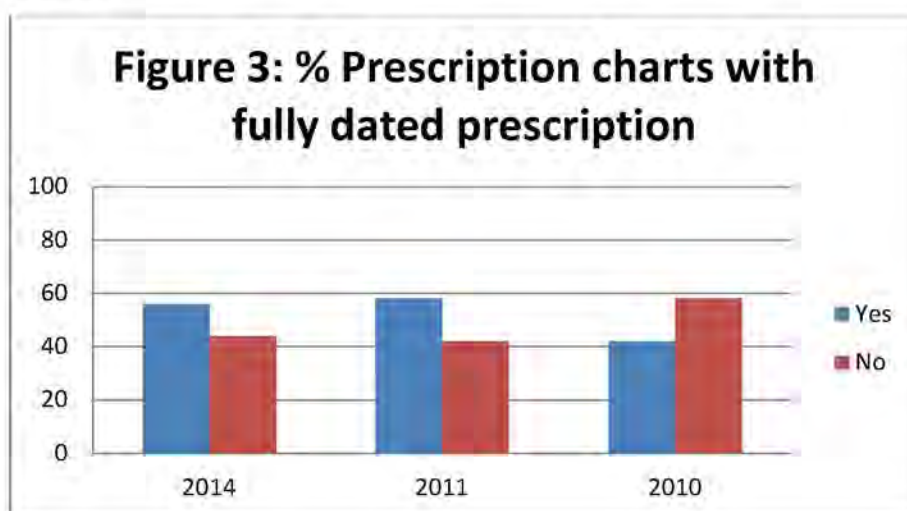


Figure 4

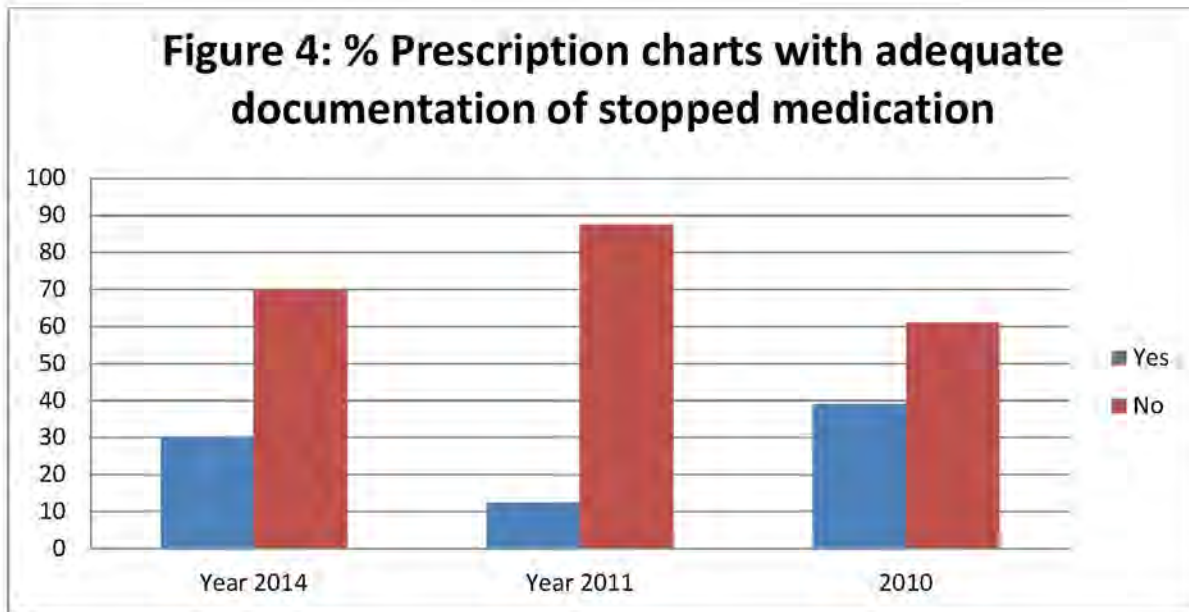


Figure 5

