How the standard of prescriptions received in a hospital outpatient pharmacy can be improved

By Tejal Dave, preregistration trainee at University Hospitals Coventry and Warwickshire NHS Trust

The poor quality of written prescriptions can contribute to medication errors.1,2 Pharmacists regularly come across poorly written and illegible prescriptions and it can be argued that prescribers’ failure to follow guidelines can put the pharmacist checking the prescription at risk and ultimately affect patient care.3 The potential for misinterpreting poorly written prescriptions is a concern for pharmacists because it increases the likelihood of errors, the investigating and correcting of which lengthens the dispensing process and leads to delays for the patient.

University Hospitals Coventry and Warwickshire NHS Trust (UHCW) has its own medicines policy, which sets its standards for prescription writing, although general standards do exist.4 It is from these that the standards for this audit have been devised.

The audit’s purpose was to assess the quality of prescriptions and monitor the interventions made by the pharmacy team on all prescriptions received by the UHCW’s outpatient pharmacy. The aim was to identify if prescriptions complied with the law and if prescriptions complied with the law and were complete to allow safe and accurate issuing of medicines. To achieve this, the different types, numbers and outcomes of prescription queries and subsequent interventions were monitored. All prescriptions had to:

- State the patient’s name, address, date of birth and identification number
- Comply with legislation relating to prescription writing
- State the correct drug name, form, dose, duration of treatment, and instructions for use
- State the prescriber’s contact details

Method

All prescriptions received by the outpatients’ pharmacy between 18 and 30 January 2010 were assessed by attaching an audit form to each prescription, which was then completed by pharmacy staff.

The audit forms were collected and analysed daily to ensure all errors and interventions had been documented correctly.

Results

A total of 1,966 prescriptions were audited in the two-week period. Problems were identified in 1,036 of them (53 per cent): 729 (37 per cent) had a problem with the actual form and 307 (16 per cent) had a problem with the prescribed item. Therefore, approximately half of all prescriptions (104 on an average day) did not fully meet trust standards. Of the 1,036 prescriptions that had a problem:

- Half were trivial, meaning that it was clear what the prescriber had intended to prescribe
- 28 per cent (equating to 29 queried prescriptions on an average day) were deemed to be a minor nuisance, eg, the prescription was not dated
- 15 per cent were major nuisances, which necessitated the prescriber being contacted
- 7 per cent (equating to seven prescriptions per day) had a potentially serious problem that might have resulted in patient harm, eg, a prescription for Oramorph was written up as dexamphetamine and this was only spotted when the dosing regimen was queried

47 per cent either did not comply with legal requirements or had a problem with the prescribed item; the remaining 53 per cent were in breach of trust policy (eg, missing or illegible contact details) but raised no queries in terms of legality or the prescribed item and so did not require action by the pharmacy team.

Action taken by the pharmacy team included consulting the patient (20 per cent), looking at past medical records (6 per cent) or taking an executive decision, eg, rounding up analgesia doses and frequencies in adults (42 per cent). Of most concern was that 32 per cent of queries needed to be resolved by contacting the prescriber which equated to nearly 16 times a day. This was not always easy because 64 per cent of prescriptions did not have a contact number and 52 per cent did not list a clinic or ward to contact.

A number of recommendations were formulated (see Panel).

Discussion

Prescribing errors on outpatient prescriptions are common. This is a problem for patient safety and for service quality — time taken to resolve even trivial errors is time away from patient care. This audit emphasises the need for interdisciplinary communication and cooperation in identifying and resolving errors and irregularities in order to achieve optimal therapeutic outcomes for patients.

REFERENCES

4 Fox A. Safer prescribing workbook. Prescription writing. Available at: www.suhf.nhs.uk (accessed 27 October 2010)