



IMPLEMENTATION OF PRESCRIPTION REVIEW

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INTRODUCTION

Medication errors are described as "mistakes in the procedure of ordering, dispensing, or administering a medication, regardless of whether any harm occurred or whether there was potential for harm." These errors can occur at any stage of the medication management process, encompassing prescription, transcription, preparation, and administration [1]. According to the Institute of Medicine, hospitalized patients, on average, experience at least one medication error per day. Medication errors are not only costly but also have the potential to cause harm to patients [2]. The Institute of Medicine estimates that at least a quarter of all medication-related injuries can be prevented, and it suggests the adoption of electronic prescribing (e-prescribing) through a computerized provider order entry (CPOE) system to reduce medication errors and mitigate patient harm [3].

RESEARCH OBJECTIVES

General Objective:

1. To execute a prescription review by consultants in the In-patient department of Internal Medicine at FMRI, Gurgaon.

Specific Objectives:

1. To conduct a baseline study before introducing the intervention (consultants' prescription review).
2. To introduce the prescription review by consultants for patients in the internal medicine department.
3. To determine the percentage compliance with the prescription review by consultants.
4. To investigate the correlation between prescription review and errors in prescription writing.

RESEARCH METHODOLOGY

Patient information was gathered from the active records of individuals in the internal medicine department using an audit checklist. The audit tool comprised a total of 15 parameters, with 10 parameters scrutinized from the Medication Order and Administration Record (MAR) sheet and the remaining 5 parameters examined from progress notes. Residents were responsible for completing the MAR sheet, while consultants were responsible for filling out the progress notes. Audits were conducted daily for a duration of two weeks following the completion of morning rounds by consultants and the transcription of medications onto the MAR sheet by residents. Consequently, the data was collected in a prospective manner.

RESULTS & DISCUSSION

A separate quality indicator could be created or be integrated with medication errors and data on which should be collected department wise and discussed in monthly meetings of quality. The data gathered on this indicator could be compared across various departments. This could be done after starting the Prescription Review in other departments also. During the training sessions with consultants and feedback this came to light that consultants wanted that Hospital Information system should be made doctor friendly and its use should be initiated. The use of the Hospital Information system will reduce medications errors while transcribing and this will also help doctors to enter notes while they are in their consultation room. HIS with integrated software to detect drug- drug, drug- food interaction could ease out the process of prescription.

CONCLUSION

To document the concerns of the consultants while prescription review existing MAR sheet was edited. The edited version of the MAR sheet had space to document the concerns of the consultants while reviewing the prescription. The use of this edited MAR sheet should be initiated, which would also ensure increased compliance by addressing

the concerns of the consultants regarding the appropriateness of the prescriptions. Proper documentation of the prescription review process will ensure sustainability of prescription review in long run. Unannounced audits can be done to check the compliance after sufficient time has passed after initiation of this project in a particular department.

REFERENCES

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