Brief report

Prescription chart writing practices in an acute psychiatric unit

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Abstract

Objectives: The survey was designed to evaluate the current prescribing practice of the doctors in our local psychiatric unit against the standards outlined by the National Health Office in the *Code of Practice for Healthcare Records Management*, and to assess the changes in practice by completing an audit cycle.

Method: The survey was carried out in a 27 bed acute psychiatric unit. A single assessor reviewed 51 inpatient drug prescription charts using a standardised data collection form derived from the Code of Practice document. Results were presented to the relevant clinical staff and a repeat survey was conducted a few months afterwards. All data were categorical and the frequencies were computed using SPSS 13.0.

Results: A total of 51 medication prescription charts were analysed on each occasion during the period of the study. The information contained on the drug charts were assessed against explicit predefined criteria as per the approved standard. At the initial survey, allergy documentation was absent in 59% of charts, only 18% of charts had generic only prescriptions, 90% of 'as required' medication lacked review dates, and only 33% of charts were considered to be reasonably neat. The repeat survey showed improvements in these practices, generic only prescribing increased to 39%, and 55% of charts were considered to be reasonably neat by the assessor.

Conclusion: Our study has identified deficiencies in prescribing practices and we have shown improvement in some of these practices at the repeat survey, however, further improvement is required. Given that the non-consultant hospital doctors are mostly involved in prescribing on drug charts, approved standards should be incorporated into the induction programme at the commencement of training in this unit. This standard should be monitored and maintained through the means of regular audits.

Key words: Doctor's prescribing practice; Inpatient drug charts; Generic name prescribing.

Introduction

The prescribing practices in hospitals are a vital component in efficient and safe delivery of care. Drug errors are avoidable and this requires regular audit of the prescribing practices of doctors. It is also widely acknowledged that prescribing drugs in their generic forms serves as a very effective cost saving tool for the government. Up to a 52% reduction in the daily costs of medications could be achieved if a patient's prescription consisted only of generic names.[1]

In their study, Bates *et al*[2] identified about 6.5 actual and 5.5 potential adverse drug events – errors or adverse reactions involving drug treatment – per 100 hospital events. Over a quarter of the observed events resulted from errors, and these were generally more serious than the adverse reactions. Drug errors are an important cause of morbidity, accounting for one-fifth of the deaths due to adverse drug events, and are therefore becoming an increasingly common subject for litigation.[3] The Department of Health guidelines[4] advise that the legal responsibility for prescribing lies with the doctor who signs the prescription and the *British National Formulary* (BNF)[5] has explicit guidance on prescription writing.

In the Republic of Ireland, the National Hospital Office (NHO) is responsible for the strategic management of acute hospital services for the country. Its publication, *Code of Practice for Healthcare Records Management*[6] outlines a framework for best practice in ensuring consistent, coherent healthcare record management, including standards for prescribing in all public and private healthcare facilities throughout the country.

This inpatient-based study was designed to evaluate the current prescribing practice of the doctors in our local psychiatric unit against the standards set in this *Code of Practice* and to assess the extent of the change in local prescribing practice by completing an audit cycle.

Method

This study was performed in a 27 bed psychiatric inpatient unit with a catchment population of 143,029.[7]

A standardised data collection form was designed to assess several areas of prescribing using the *Code of Practice* document published by the NHO. The evaluated parameters are shown in *Table 1*.

A total of 51 inpatients prescription charts were reviewed by a single assessor at the initial phase of this study in December 2008, the results were presented to the relevant clinical staff and a repeat chart review was carried out after five months. The clinical staff were unaware of the repeat review and the timeframe of five months was decided to allow for results feedback to the relevant trainees before the completion of their six months rotation on the unit. All prescribed drugs including oral and parenteral were reviewed and all prescription charts were included in the study.

All data were categorical and the frequencies were computed using SSPS 13.0 for Windows

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Table 1: Summary of prescription charts against audit criteria

	Initial survey n = 51	Repeat survey n = 51
	%	%
Date of birth written	86	96
Ward indicated	78	94
Consultant name written	92	96
Allergies documented	41	86
Generic names only	18	39
Identifiable prescriber	82	86
Legible hand writing	98	98
Dose frequency clearly stated	98	98
Route of administration clearly stated	98	96
Use of standard unit	65	67
Appropriate use of decimal points	94	96
Dated cancellations	78	96
Review dates on PRN	10	49
Commencement date clearly stated	100	100
Overall neatness	33	55

The above figures represent the percentages of charts that were positive for the audit parameters

Results

A total of 51 medication prescription charts were reviewed both at the commencement of the study and during the repeat survey. *Table 1* summarises the results of both reviews and allows for some comparison.

At the initial review, basic demographic data such as date of birth was written only in 86% of the charts and the prescriber was unidentifiable in 22% of charts. Only 41% had allergy documentation and only 18% of charts had generic only prescribing. Drugs that were prescribed 'as required' were often left without review dates on 90% of the charts and only 33% were subjectively assessed as reasonably neat.

The repeat survey showed improvements in most of the prescribing practice albeit a few assessed parameters with minimal change. Most remarkable are the improvements in allergy documentation and the indication of review dates on 'as required' medications. We have also shown an improvement in generic name prescribing pattern and 55% of charts were assessed as reasonably neat. There was a very minimal improvement in the use of standard units.

Discussion

This study is a cross-sectional survey of the prescribing practice of the psychiatrists working in this inpatient unit, comprising of both consultant and non-consultant hospital doctors. We reviewed the process from prescribing up to the point where the patient takes the medication. The prescriber is required to be knowledgeable enough to choose an effective treatment suitable for the individual patient, taking into account age, infirmity, and possible interactions with other drugs. The prescriber is then required to transmit the message in form of a written prescription to the dispenser who in the case of an inpatient would be the local pharmacist. The medication is eventually handed to the patient by a nurse, who has to ensure that the drug is given exactly as prescribed. The process is prone to errors and these might even be undiscovered and unreported.

Table 2: Audit criteria derived from the 'Code of Practice for Healthcare Records Management'[6]

- Always write clearly when prescribing, using un-joined lower case text or block capitals
- Prescribe medications, including intravenous fluids by generic names except in the case of multi-ingredient preparations and modified release formulations
- Always document patient drug allergies or idiosyncratic reactions
- Never abbreviate drug names
- Use only approved abbreviations
- Never abbreviate the following: International units, micrograms, nanograms, units
- Never use a decimal point before a trailing zero, and always use zero before a decimal when the dose is less than a whole unit
- Always specify the dose and frequency
- Always specify the minimum dose interval for 'as required' medication
- Directions must generally be in English except for approved Latin terms and abbreviations.

Our audit criteria were derived from the *Code of Practice* document[6] and some of the explicit criteria are shown in *Table 2*. Most of the practices compared favourably with the audit parameters against which the charts were evaluated at the initial survey and the improvement in prescribing pattern at the repeat survey is commendable, however some practices showed little changes. The practice of not documenting allergies declined from 59% to 14%, however it is our view that this remains unacceptable as adverse events resulting from non documentation could potentially result in death and medicolegal complications.

Given that most PRN medications are usually written during periods of emergency, it is imperative that they should be discontinued as soon as the indication for continued use expires. This is possible if the prescriber indicates a review or discontinuation date at the time of prescription. Failure to do this often leads to prolonged and inappropriate use of PRN medications especially if they are benzodiazepines. We showed an improvement in this practice 10%-49%, however, we believe more improvement is required. Prescribing practice of generic names only remained low at 39% at the repeat survey.

The authors have recommended that prescription charts should be reviewed at the weekly multidisciplinary team meetings. There should be a close collaboration with nursing staff and they should be encouraged to point out untidy charts and PRN medications which do not have review dates. Approved standards of prescribing practice should be incorporated into the induction programme at the commencement of training in this unit and this standard should be monitored and maintained through the means of regular audits.

Declaration of Interest: None.

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