Reviewing the problems associated with outpatient prescribing - written and electronic prescriptions

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Background

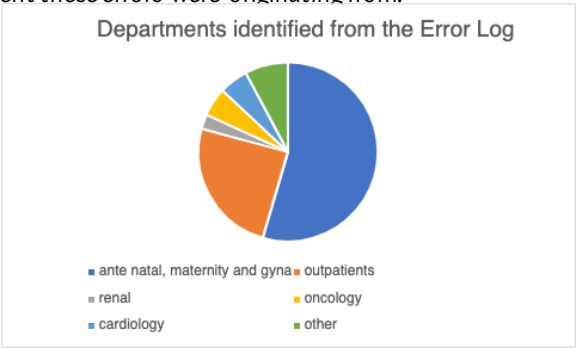
There have been many issues outlined with outpatient prescriptions which has led to delays when dispensing and checking prescriptions. Various errors have included: no unique patient identifiers, legal errors such as not including words and figures for a quantity for a controlled drug prescription, no "D' number being identified which would take the pharmacist straight to the current episode for the patient. Due to errors like the above, the patient waiting area can become very busy which is not ideal due to COVID-19 and current social distancing guidelines. Due to COVID-19, there has also been an increase in the number of telephone consultations leading to remote prescribing. As well as this, patients are more likely to complain and be unhappy with the service that is being provided, due to the prolonged waiting times.

Objectives

- Identifying the problems associated with outpatient prescribing by using an error log to track errors
- Grouping errors together to see if any problems are linked
- Speaking to the relevant individuals involved to see if any solutions can be made
- Implementing solutions if it is appropriate to do so.

Method

A total of 77 patients were included in this retrospective service improvement project. They were identified using the outpatient error log from a period between November 2020 to January 2021. The outpatient error log was initially a handwritten log; the data from this was formatted to a Microsoft Word document in order to visualise the data clearly. The data was then analysed according to types of errors made and what department these errors were originating from.



Results

42 errors were found from the outpatient error log which were from Ante-Natal, Maternity and Gynaecology. These errors were linked to specific medications which were being prescribed. Other errors were found from a variety of other departments. These were also linked to the types of medications being prescribed. Various errors found included items being dispensed at another site but patients presenting at the outpatient hatch on site. Clinical errors were found which needed to be amended by contacting prescribers leading to increased waiting times.

Conclusions

The errors found were related to specific medications being prescribed. There needs to be more communication between prescribers and pharmacy teams when trying to amend prescriptions in case of errors. Ultimately, this will result in better patient care and a greater service being provided. There needs to be increased communication between prescribers and patients so that patients are aware of what is expected of them when they are at the outpatient hatch. Patients should also be made aware of any issues in a timely fashion so they are kept up to date with regards to their prescription. There may also need to be signs put in place in the pharmacy department with regards to waiting times and any extra patient details which are needed such as an 'X' number or 'D' number.