PHARMACY'S STAFF OPINION ON PRESCRIBING ERRORS MADE BY DOCTORS IN SEBERANG JAYA HOSPITAL, PULAU PINANG

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TABLE OF CONTENTS

ABSTRACT

Introduction: Prescribing errors primarily occur due to inadequate knowledge and unavailability or failure to recognise important patient information or drug properties during prescription screening process. Methodology: This study was conducted in OPD, Hospital Seberang Jaya. A cross-sectional study by random sampling was chosen to conduct this project. Our study samples were prescriptions that contain errors and pharmacy staff working in OPD from July 2010 until September 2010. The criteria include all prescriptions that have errors regardless of age, race and gender. Non error prescriptions and other population in pharmacy department such as trainees were excluded in this study. Data were statistically analysed and presented in a form of table, pie chart and graph. Result: The total amount of prescribing errors are n=252. The incomplete prescription errors were contributed by no sign and chop from the prescriber (n=56), not stated the date and patient's data (n=33) and do not countersign the List A item by the specialist (n=77). Inappropriate drug regime contributed by no duration of prescription (n=15), not stated the dose of drug (27) and no frequency to take the drug (n=16). Inappropriate prescription contributed to the lowest errors made through wrong spelling or use abbreviation (n=16), polypharmacy prescription (n=10) and prescription with drug interaction (n=2). Conclusion: The most common categories of prescribing errors followed by inappropriate drug regime and inappropriate prescription. The more alert the prescribers, the less pharmacy staff workload and patient waiting time will be reduce.

5 key words: Prescription errors, incomplete prescription, inappropriate drug regime, inappropriate prescription, prescribing errors.

CHAPTER 1

INTRODUCTION

One of the important departments in hospital pharmacy setting is **Out-patient Department** (**OPD**). OPD supplies prescribed medicines to the ambulatory patients.

In OPD pharmacy unit of Hospital Seberang Jaya, the medicines are dispensed to patients via three counters. The front part this pharmacy unit consist of five counters namely *screening counter* (counter 1) where the prescription will be screened and number will be given to the patient, *express counter* (counter 2) where patient with less number of medicine prescribed will be dispensed and *dispensing counter* (counter 3,4,5) where patient with 4 or more prescription item will be dispensed.

Everyday, OPD pharmacy receives many prescriptions prescribed by doctors from different clinics that contain a variety of medicines ordered to be given to the patient. There is also a service through *Sistem Pendispensan Ubat Bersepadu* (SPUB) where patient from other hospital came and collect their medicines at another hospital and *Blue Card System* where the medicine will be given partly supply to the patient according to the types of prescription.

Normally, some prescriptions contain prescribing errors when being screened at the screening counter. In such case, pharmacists have to confirm the prescribing errors with the respective doctor before filling the prescription. Based on the study, prescribing errors primarily occur due to inadequate knowledge, unavailability of, or failure to recognise important patient information or drug properties.

The prescribing errors are classified into three categories; incomplete prescription, inappropriate drug regimen and inappropriate prescription.

The purpose of this study is to identify the prescribing errors made by doctors. The rationale of this project is to reduce prescription errors made by doctor in Hospital Seberang Jaya. In addition there were no research that have been done regarding on this topic at this hospital. This project will help in reducing pharmacist workload in the future thus ensuring the patient safety.