Prescription Audit Exercise & Discussions

Quality Improvement Division

National Health Systems Resource Centre

Prerequisite of Prescription Audit

- Generation of correct prescription format with patient's details
- Typed or electronic Prescriptions are most suited for prescription audits. (Random selection)
- The next best option is to have a prescription in three copies:-
  - The first copy:- Patient
  - The second copy:- Pharmacist
  - The third copy:- Auditing
- Essential Medicines List (EML) for different levels of facilities and provisioning of the medicines as per EML.
- State-specific Standard Treatment Guidelines and Policy on Medicine Usage
- Standardize Prescription

Prescription Audit format

- A Prescription audit template for data collection is provided here.
- You may follow this format.
- However, the states have the flexibility to make any changes (addition/deletion/modification) in the attributes as per the state's policy after approval of the State Quality Assurance Committee (SQAC).

Prescription Audit Format

Prescription Audit Format		
S.No.	**Criteria**	**Response (Yes/No/NA)**
1	OPD Registration Number mentioned	
2	Complete Name of the Patient is written	
3	Age in years (≥ 5 in years) in case of < 5 years (in months)	
4	Weight in Kg (Only patients of paediatric age group)	
5	Date of consultation - day / month / year	
6	Gender of the Patient	
7	Handwriting is Legible in Capital letter	
8	Brief history Written	
9	Allergy Status mentioned	
10	Salient features of Clinical Examination recorded	
11	Presumptive / definitive diagnosis written	
12	Medicines are prescribed by generic names	
13	Medicines prescribed are in line with STG.	
14	Medicine Schedule / doses clearly written	

Prescription Audit Format

15	Duration of treatment written	
16	Date of next visit (review) written	
17	In case of referral, the relevant clinical details and reason for referral given	
18	Follow-up advice and precautions (Do's and Don'ts) are recorded	
19	Prescription duly signed (legibly)	
20	Medicines prescribed are as per EML/Formulary	
21	Medicines advised are available in the dispensary	
22	Vitamins, Tonics or Enzymes prescribed	
23	Antibiotics prescribed	
24	Antibiotics are prescribed as per facility's Antibiotic Policy	
25	Investigations advised	
26	Injections Prescribed	
27	Number of Medicines Prescribed	Number

Format for Prescription Audit

- **OPD Registration Number mentioned**: A Unique Health Identification Number (UHID) is given to each patient.
- **Complete Name of the patient is written**: It should have first, middle (if have) and last name of the patient written on the prescription.
- **Age**: It should be written in years (≥ 5 in years) in case of < 5 years (in months).
- **Weight in Kg**: Weight of paediatric patients need to be recorded up to two points after the decimal. Weight of low birth weight neonates needs to be recorded in grams.
- **Date of consultation**: In the format (day/month/year).
- **Gender of the patient**: Male/Women/Others

Format for Prescription Audit

- **Legibility:** Prescription should be written in Capital letter for clear understanding of the pharmacist.
- **Brief history written**: For dispensing of correct and proper medication to the patient.
- **Allergy status mentioned**: Mention about a drug that has caused allergy/side effects/unexpected outcome.
- **Salient features of Clinical Examination recorded**: It includes Temperature, Pulse, Blood Pressure, Respiratory rate, etc.
- **Presumptive/definitive diagnosis written**: For dispensing of correct and proper medication to the patient

Format for Prescription Audit

- **Medicines prescribed are in line with STG** or as per National/State programme guidelines.
- **Medicines are prescribed by generic names**: Medicines are not prescribed by brand/trade name.
- **Medicine schedule/doses/duration of treatment clearly written**: Write the quantity of tablets/capsules/liquid & number of times the medicine needs to be taken.
- **Date of next visit (review) written with follow-up instructions:** Oral instructions to be followed by the patient are written on the prescription.

Format for Prescription Audit

- **In case of referral**, the relevant clinical details and reason for referral given: It should include the name of the referral health facility, department referred to, name of the doctor/speciality to be visited, along with the detailed reason for referral.
- **Prescription duly signed (legibly):** Signed by consulting doctor along with the stamp marked to confirm the authenticity of prescription and to avoid misuse of blank prescription.
- **Medicines Prescribed are as per EML/Formulary:** Medicines advised are available in the dispensary.
- **Vitamins, Tonics or Enzymes prescribed:** Must be in line with the standard treatment guidelines.
- **Antibiotics prescribed**: Antibiotics are prescribed as per facility's Antibiotic Policy.

Format for Prescription Audit

- **Investigations advised:** Must be in line with the standard treatment guidelines.
- **Injections prescribed:** Exclude immunization injections.
- **Number of medicines prescribed:** To avoid polypharmacy, as per WHO average no of drugs prescribed is expected to vary from 2 to 2.9 in a general OPD. However, number of drugs per prescription would increase at health facilities, taking care of senior citizens.

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असुरक्षित यौन सम्बन्ध एड्स का प्रमुख कारण है। निरोध अपनाएं एड्स से मुक्ति पाएं।

बाह्य रोगी पर्ची
OUT-PATIENTS TICKET

धूम्रपान, ... के सेवन स्वास्थ्य के लिए हानिकारक है।

तारीख Date 7/11/14 | विभाग Deptt. | शल्य चिकित्सक / काय चिकित्सक Surgeon/Physician

बा.रो.वि. संख्या O.P.D. No. 29579 | नाम Name Rajendra prasad

आयु Age 58y | लिंग Sex M | निदान Diagnosis

दिनांक Date	उपचार Treatment
	URE Ts Cetrizine Pcm Rapid ...

LOGO

NAME OF THE HOSPITAL/CLINIC
Address and Phone No:

Patient's Name: Mr. RAM RATAN SINGH UHID: 64378
Age: 38 years Sex: Male
Address: H.No - 348, Railway Colony, Sarai Rohilla, N. Delhi - 110035

Diagnosis/Prov. Diagnosis: Acute Gastroenteritis & mild dehydration. Date: 16/01/2020

Chief Complaints:
Loose Stools | 2 days.
Nausea
Fever

Past History of Illness:
NKH/O any allergy.
DM/HTN/IHD.

Vitals: BP - 110/70 mmHg
Pulse - 92/mt reg
Temp. - 99°F.

General Physical Examination:
Head & Neck: ✓
Chest: B/L clear.
CVS: S.S. (N)
Abdomen: mild tenderness in epigastrium
CNS:
Extremities: ✓

Investigations advised:
Stool C/M.
Urine C/M.

℞

1. Tab RANITIDINE 150mg
   सुबह शाम
2. Tab DICYCLOMINE
   सुबह शाम
3. Tab PCM 650mg (बुखार होने पर 1 गोली)
4. Tab DOMPERIDONE (उल्टी होने पर 1 गोली)

- ORS का घोल: 1 पैकेट को 1 लीटर उबले हुए ठंडे पानी में मिलाकर बनायें.
- दही, केला, खिचड़ी, लौकी, नारियल पानी

Review after 2 days with Urine + Stool reports

Signature of the Doctor

Prescription Audit Format		
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Data Analysis

- Detailed analysis is required to understand the prescription practices, identification of the bottlenecks and opportunities for improvement.
- Once the calculated number of prescriptions have been received, all attributes need to be written in a tabular form.
- Afterward, each prescription is evaluated against these attributes in the form of observed response as ‘YES’ or ‘NO’.
- The collected information is then transferred into an excel sheet to get a comprehensive view of prescription practices, indicators’ calculation, gap identification, and best practices.

% of prescription with OPD Registration Number

Numerator:- Number of prescriptions with OPD Registration

Denominator:- Number of Prescriptions audited

Formula:-

$$\frac{\text{No. of Prescriptions with OPD registration X 100}}{\text{No. of prescription audited}}$$

OPD Registration Number mentioned	1	1	1	1	1	100
Complete Name of the Patient is written	1	1	1	0	1	80
Age in years (≥ 5 in years) in case of < 5 years (in months)	0	1	1	1	1	80
Weight in Kg (Only patients of paediatric age group)	1	NA	NA	NA	NA	100
Date of consultation - day / month / year	1	1	1	1	1	100
Gender of the Patient	1	1	1	1	1	100
Handwriting is Legible in Capital letter	0	0	0	0	1	20
Brief history Written	1	1	0	1	0	60
Allergy Status mentioned	1	1	1	0	0	60
Salient features of Clinical Examination recorded	0	1	0	1	1	60
Presumptive / definitive diagnosis written	0	0	0	0	0	0
Medicines are prescribed by generic names	1	1	1	1	1	100
Medicines prescribed are in line with STG.	1	1	0	1	1	80
Medicine Schedule / doses clearly written	0	1	1	1	1	80
Duration of treatment written	0	1	1	1	0	60
Date of next visit (review) written	0	1	1	1	0	60
In case of referral, the relevant clinical details and reason for referral given	NA	NA	0	1	1	66.66667
Follow-up advice and precautions (Do's and Don'ts) are recorded	1	1	1	1	0	80
Prescription duly signed (legibly)	1	1	1	0	1	80
Medicines prescribed are as per EML/Formulary	0	0	0	0	1	20
Medicines advised are available in the dispensary	1	1	1	1	1	100
Vitamins, Tonics or Enzymes prescribed	0	0	0	1	1	40
Antibiotics prescribed	0	0	0	1	1	40
Antibiotics are prescribed as per facility's Antibiotic Policy	1	1	1	0	0	60
Investigations advised	1	0	0	1	1	60
Injections Prescribed	1	1	1	1	1	100
Number of Medicines Prescribed	6	4	10	7	8	7

Data Analysis

- All attributes can be categorized into positive or negative indicators for further action.
- Out of 5 analyzed prescriptions, top 3 areas of concern were: 0% had the Presumptive/ definitive diagnosis written, 20% had the medicines prescribed as per EML/formulary. Handwriting was legible in capital letter in 20% of Prescriptions. Based on the findings and suggestive recommendations, an action plan should be prepared for taking corrective and preventive measures (as described in section-III) to improve the identified opportunities.

Sample action plan

Gap statement	Root causes	Actions required	Responsibility	Time framework	Prioritization
Presumptive /Definitive diagnosis is not written	Clinicians think its not important to write in the perception	A letter from MS for compliance Discussion with all clinicians during monthly meeting	MS	31st August 2021	Implement immediately
Hand writing in not legible-	Clinicians think its not important to write in the CAPITAL letter	A letter from MS for compliance Discussion with all clinicians during monthly meeting	MS	31st August 2021	Implement immediately
Medicines are not prescribed as per EML	Clinician think facility medicines are not effective	Show QA report of the medicines to the clinicians	MS	15th September 2021	Implement immediately

Thank you