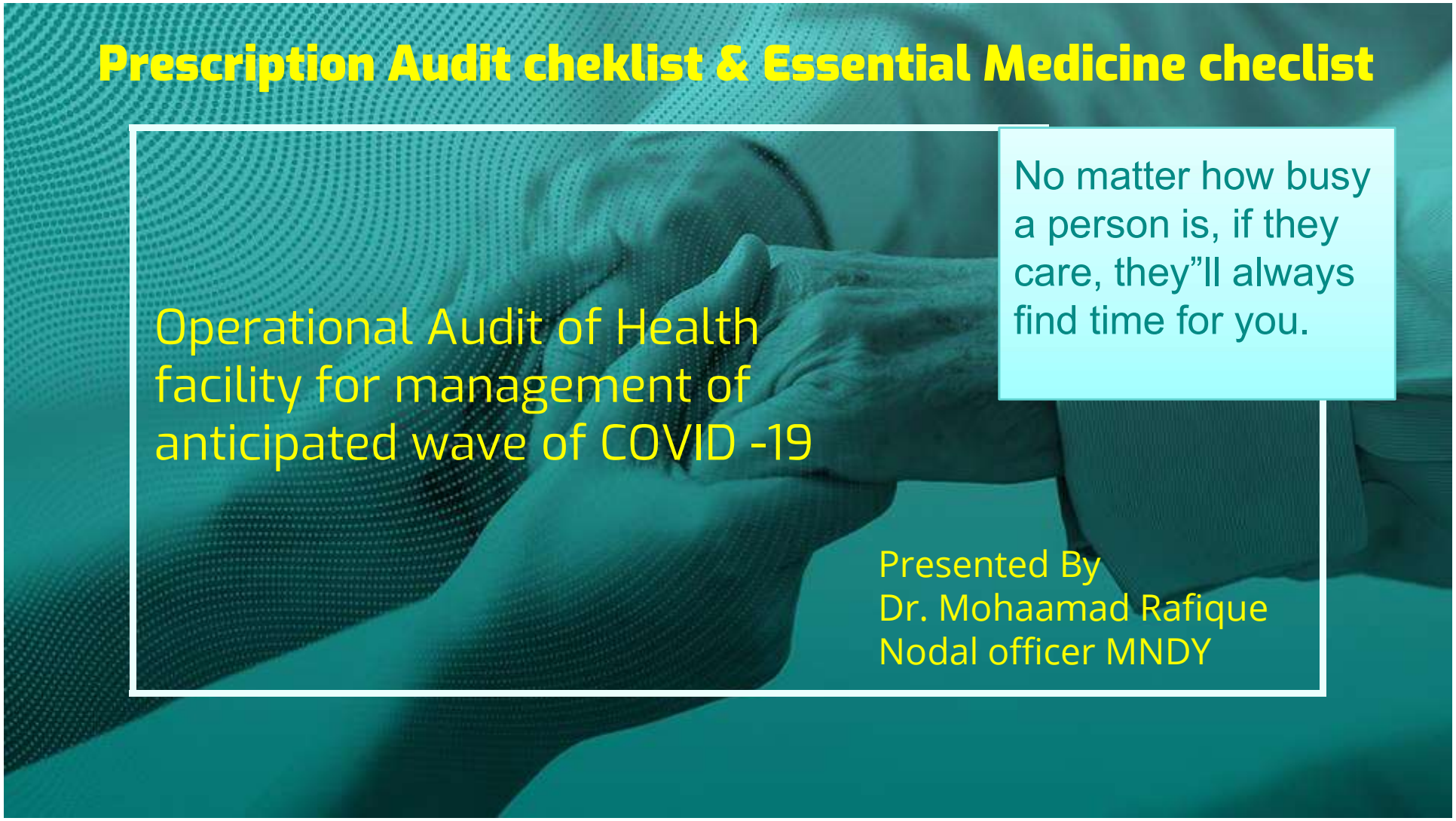
Prescription Audit cheklist & Essential Medicine checlist



Operational Audit of Health facility for management of anticipated wave of COVID -19

No matter how busy a person is, if they care, they”ll always find time for you.

Presented By
Dr. Mohaamad Rafique
Nodal officer MNDY

INTRODUCTION

1. A prescription is a written communication from a registered medical practitioner to a pharmacist regarding instructions on dispensing of prescribed medication.
2. Prescription audit is a quality improvement process that seeks to improve patient care.
3. Medical Audit may be defined as a process with the aim of making improvements in patient care and proper use of resources.
4. It is systematic and critical analysis of the quality of medical care.
5. It is a continuous cycle implementing changes and to develop a new practice.
6. Thus medical audit is a systematic approach which gives a clear review of medical care.

INTRODUCTION

7. Effective prescription audit is important for health care professionals and managers, patients, and the public also supports the health professionals in making sure the patients receives the best care.
8. Prescription audit or medication audit seeks observation, evaluation and further recommendation on the prescribing practices of medical practitioners to make rational prescribing and cost-effective.
9. The most important part of healthcare system is to deliver the right medicine to the right people.

INTRODUCTION

10. Prescription auditing is one of the important tool to avoid misuse of drugs and improves rational use of drugs.
11. Worldwide, it is estimated that over half of all medicines are prescribed, dispensed or sold inappropriately, and that half of all patients fail to take their medicine correctly.
12. Examples of irrational use of medicines include: poly-pharmacy, inadequate dosage, and use of antimicrobials even for non-bacterial
13. infections, excessive use of injections when oral forms are available and inappropriate, self-medication and noncompliance to dosing regimes.

Parameters analyzed in prescription auditing

The parameters which has to analyzed in the process of prescription auditing are,

1. Patient demographics

i. Patient name
ii. Sex
iii. Age
iv. Body weight
v. Date of prescription received

Parameters analyzed in prescription auditing

The parameters which has to analyzed in the process of prescription auditing are,

1. Patient demographics

i. Patient name
ii. Sex
iii. Age
iv. Body weight
v. Date of prescription received

Parameters analyzed in prescription auditing

2.CLINICAL DIAGNOSIS:

- A diagnosis made on the basis of medical signs and patient-reported symptoms, rather than diagnostic tests.
- Clinical Diagnosis plays an essential part in the delivery of quality health care.
- The clinical diagnosis helps the pharmacist to check whether if there is any error in the prescription order written by the physician.

Parameters analyzed in prescription auditing

3.DEPARTMENT:

- Mentioning a department in a prescription by the physician helps the pharmacist to clarify any possible doubts in the prescription order.
- By considering the department in auditing researchers can get a clear view on the percentage of patients visited per department.

4. **PRESCRIBING STANDARDS:**

A. The prescribing standards include: Dose, Dosage form, Generic name, Brand name, Duration of treatment, Time of administration.

B. Prescribing standards has to be tailed as per the prescribing guidelines which aids in rational prescribing.

C. Poor handwriting is a well-known and preventable cause of dispensing errors. Accuracy and legibility are essential.

Parameters analyzed in prescription auditing

5.DEMOGRAPHIC DETAILS (Superscription):

- ✓ The superscription includes the date of prescribing; the name, address, weight, and age of the patient; and the Rx. The symbol "Rx" is said to be an abbreviation for the Latin word recipe, meaning "take" or "take thus," as a direction or order to a pharmacist, preceding the physician's "recipe" for preparing a medication.
- ✓ The patient's name and address are needed on the prescription order to ensure that the correct medication goes to the exact patient.
- ✓ For the dose calculation, a patient's weight, age, or body surface area, also should be listed on the prescription.

Parameters analyzed in prescription auditing

6. DOCTORS NAME AND SIGNATURE:

- Prescriber identity, name, address and qualification.
- It requires that prescriptions for controlled substances include the name, address, and registration number of the physician.
- Most of the prescription slacking the physician's information are one of the drawback and chance to get medication errors.

Prescription Audit for COVID-19

Name of Patient	Age	Sex
Date of Assessment	Type of Facility	
Facility Name		
OPD Number	IPD Number	
Date Of Admission:	Date Of Discharge/Referral:	
Date of RT-PCR Positive	HRCT Score:	SpO2 Level:
Symptoms at the time of admission:		
Provisional Diagnosis		
Final Diagnosis		
Any other Co-morbidity		

Prescription Audit for COVID-19

Prescribing Medicine					
Name of Drug	Class of Drug	Route of Administration	Quantity	Frequency	Days

Prescription Audit for COVID-19

- Whether Oxygen given to Pt. Yes/No
- If Yes what is the resource of O_2 Supply: Oxygen Concentrator/O_2 Cylinder/O2 through MGPL via Oxygen Generator plant/ Liquid Oxygen
- Were all the Drugs included in the State EDL Yes/No
- Total Number of Drugs Prescribed _____
- Were all the drugs mentioned in Generic Name Yes/No, If NO how many drugs were mentioned with brand names _____
- Any registered adverse event of drug documented Yes/No
- If yes describe in brief:

Signature of auditor

Name of Hospital .....

District .....

Zone. .....

PROGREES NOTES

Name .....C.R. No. .....

DATE & TIME	CLINICAL NOTES	ADVICE

Name of Hospital .....

District .....

Zone. .....

MEDICATION CHART

Name .....C.R. No. ..... I.R. No. .....Consultant .....

Age/Sex..... Ward..... Bed No.....Diagnosis .....

DATE		A.M.												P.M.											
DRUGS	DOSE	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12

Name of Hospital .....

District .....

Zone. .....

Investigations related to Radiology Department/ECG/ECHO

Patient's Name : _____

Sex/Age : _____

C. Reg No. : _____

I.R. No. : _____

Investigations (X-ray/USG/ECG/ECHO)	Date (S)	No. Of films copy	Bed Side/Routine	Remarks

Name of Hospital .....

District .....

Zone, ...

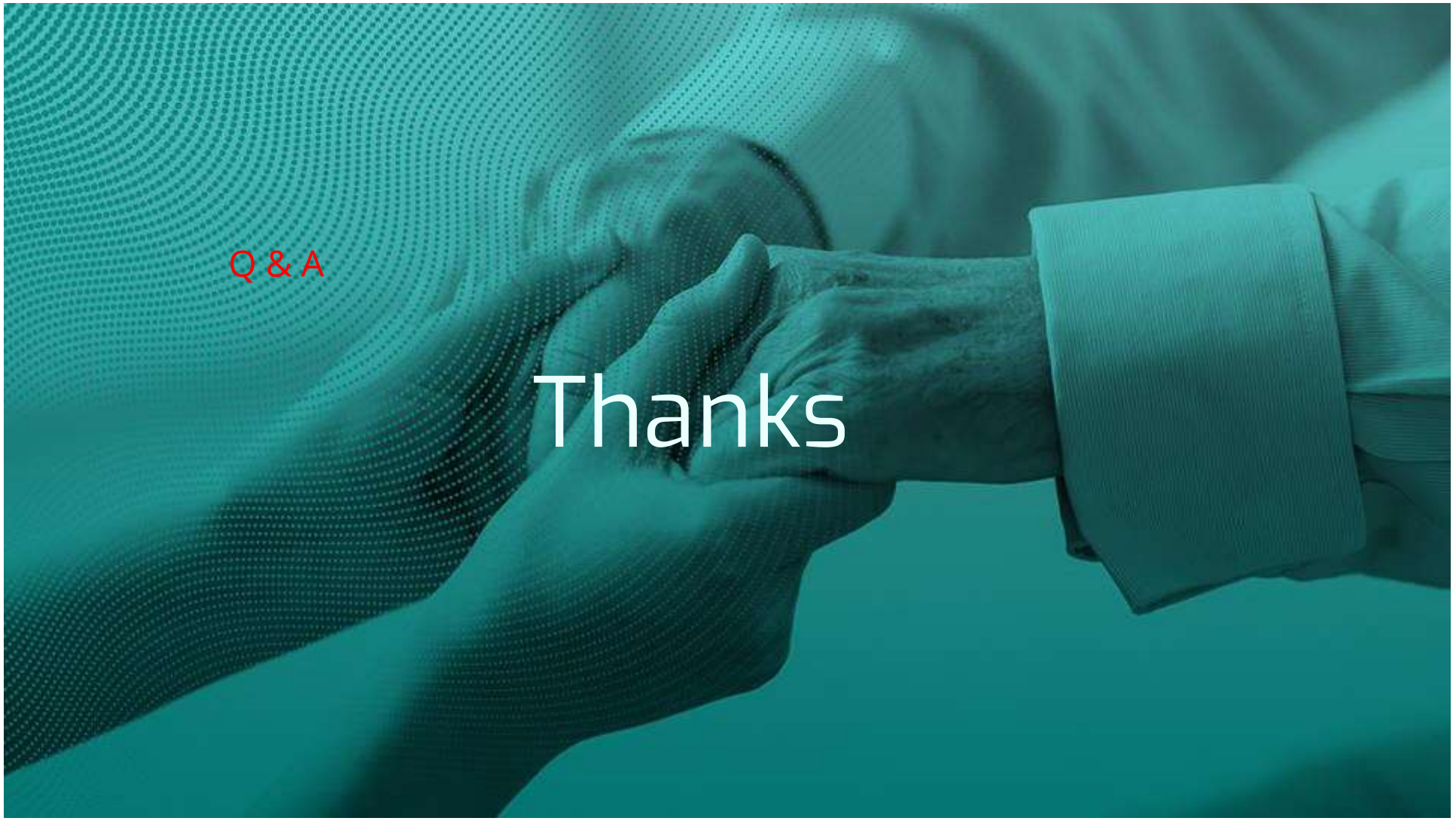
	NUMBER	HANDED BY NURSING STAFF (NAME & SIGN, DATE & TIME)	RECEIVED BY RECEPTION STAFF (NAME & SIGN)	HANDED BY RECEPTION STAFF (NAME & SIGN, DATE & TIME)	RECEIVED BY (RADIOLOGY/ DEPT)
X-RAY FILES					
CT SCAN FILES					

1.	Inpatient Case sheet – Relative/Patient Signature	
2.	Clinical History – Signature	
3.	Progress Notes – Date/Time/Signature	
4.	Consent – OT Name/Patient/Pt Relative Signature / Thumb.	
5.	OT Record – Date/Time/OT Name/Pt Name/Signature	
6.	Anesthesia Record – Signature	
7.	Discharge Card – Patient Name/DOA/DOD/Signature	

TOTAL No. of SHEETS : NURSE'S SIGNATURE :.....

MRD STAFF SIGNATURE : .....

MRD INCHARGE SIGNATURE : .....


Q & A
Thanks