Completeness assessment of prescriptions in primary health care centers in Nablus

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Abstract

Introduction: The quality of prescribing affects to a large extent the patients' health outcomes, as errors-making may result in adverse drug reactions. The aim of this study was to analyze prescriptions issued by the governmental primary health care centers in Nablus to assess the completeness of information.

Materials and Methods: A descriptive cross-sectional study was conducted including 500 prescriptions. All prescriptions were assessed for presence of (a) Patient's information: Name, age, address and date of issue (b) physician's information: name, clinic number and signature of physician (c) Details of each prescribed medicine: Strength, frequency, instructions for use and duration of therapy.

Results: A total of 500 prescriptions were collected and patient's information completeness domain assessment found that patient name was absent in 18.2% of prescriptions. The date of issue and patient's age were not present on 60.2% and 66.2%, respectively. The address was not mentioned in any prescription. On assessing physician's information domain, it was found that 43.4% of prescriptions lacked physician's name and 50.6% missed clinic number. Also 15.6% of prescriptions were not signed by the prescriber. Assessment of medication's information domain found that 32% of prescriptions missed the strength of medication. Frequency of administration and instructions for use were missing in 11.8% and 37.6%, respectively. In addition, more than half of the prescriptions were lacking the duration of therapy (68.6%).

Conclusions: The results demonstrate that missing data or errors in prescriptions frequently occur and may lead to medication errors. There is a need to critically manage the legibility of prescriptions with the correct frequency, strength and all other data on a prescription concerned with medications, patient and prescriber to minimize the medication errors incidence.