Reducing The Percentage Of Transcribing Errors In Pharmacy Information System (PhIS) At Pharmacy Departments Under Pejabat Kesihatan Daerah Kampar

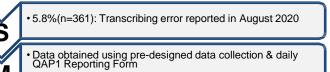
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INTRODUCTION

Transcribing errors is defined as any deviation in transcribing medication order from the prescribing step and is due to data entry error that is commonly made by the human operator1

1.0 SELECTION OF OPPORTUNITIES FOR **IMPROVEMENT**

1.1 PROBLEM PRIORITIZATION-SMART									
PROBLEM	S	М	Α	R	Т	TOTAL			
Low recruitment of	15	18	18	15	15	81			
Therapy Adherence									
Low recruitment of	15	18	18	12	12	78			
Therapy Adherence									
High quantity of	15	18	18	15	15	81			
High incidence of transcribing errors in Pharmacy Information System (PhIS)	18	18	18	15	15	84			

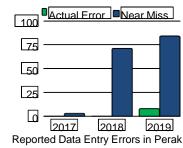


- This study is suitable to be conducted because it involves significant impact on the patients medication safety
- Remedial measure can be implemented to reduce transcribing errors in PhIS.
- The study & remedial measure can be carried out within a

1.2 LITERATURE REVIEW

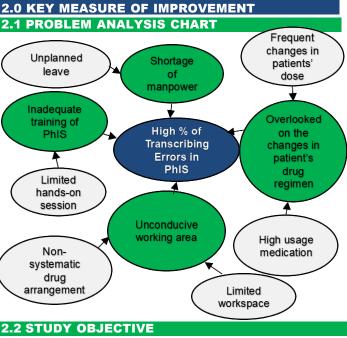
- Fahimi et al., transcription error is defined as any deviation in transcribing medication order from the previous step and this could be found on an order sheet, notes and/or documentation in the pharmacy database1
- Lisby et al., discrepancies in the names of drugs, their formulations, route of administration, doses, dosing regimens, omission of drugs, or addition of drugs which were not ordered or prescribed that be found during transcribing stage are defined as transcription error
- Study in Iran showed that medication transcription errors occurred in about 30% of the 558 opportunities for errors1
- Study in Pakistan showed medication transcription errors occured in 16.9 and 13.8% of the 6583 and 5329 medications transcribed onto inpatient profiles and discharge charts, respectively3

1.3 SITUATIONAL ANALYSIS



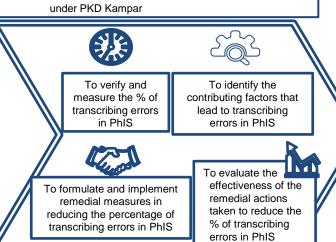
STATEMENT

In August 2020, out of 6224 prescriptions received at Pharmacy Departments under PKD Kampar, 361 (5.8%) prescriptions with transcribing errors were detected. This might increase the tendency of patients getting wrong medications and unsafe treatment. Multiple factors including handwriting of prescribers, use of abbreviation, lack of familiarity with drug names and did not check the prescription carefully such as overlook any changes of doses of medications may contribute to this problem. This study aims to reduce percentage of transcribing errors in PhIS at Pharmacy Departments under PKD Kampar.

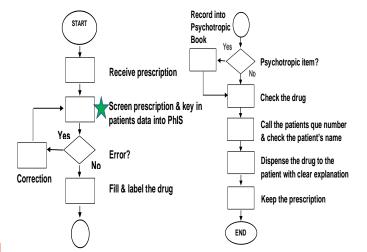


2.2 STUDY OBJECTIVE

GENERAL: ↓ % Transcribing errors in PhIS at Pharmacy Department under PKD Kampar



2.3 PROCESS OF CARE (POC)



Process of Care: Drug Dispensing

2.4 INDICATOR & STANDARD

INDICATOR: Percentage of transcribing errors in PhIS at the Pharmacy Departments under PKD Kampar

FORMULA:

% of Transcribing = $\underline{\text{Numbers of Transcribing Errors in PhIS}}$ X 100% Errors in PhIS Total Number of Prescriptions Received in Pharmacy Departments

STANDARD

3.0 PROCESS OF GATHERING INFORMATION 3.1 METHODOLOGY

Study Design Cross-sectional

study

Universal

Pre-designed data sampling collection form technique Daily QAP 1 reporting form

Study Duration

- Pre-intervention 1st October 2020 to 31st October 2020 Post 1 – 1st February 2021 to 28th February 2021
- Post 2 1st June 2021 to 30th June 2021



prescriptions received in Pharmacv Department

Exclusion Criteria Prescription from

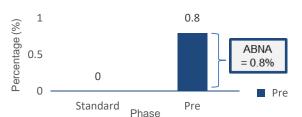
other facilities

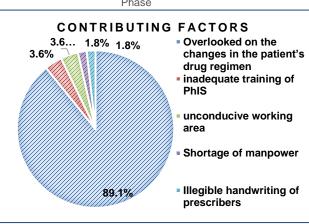
Data Analysis Descriptive

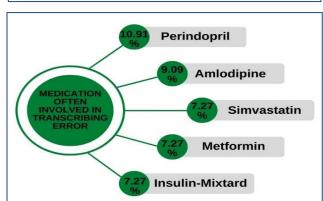
Study Tools

statistic, Microsoft Excel

4.0 ANALYSIS & INTEPRETATION % Transcribing Error in PhIS







5.0 STRATEGIES FOR CHANGE CONTRIBUTING FACTORS 1:

Overlooked on the changes in patient's drug regimen



CONTRIBUTING FACTORS 2:

Hands-on Session

Inadequate training of PhIS



Klinik Kesihatan Klinik Kesihatan Malim Nawar Kampar



Klinik Kesihatan



KK Kampar: 18/6/2022

Continuing Medical

KK Gopeng: 30/3/2022 KK Malim Nawar : 21/5/2022

CONTRIBUTING FACTORS 3: Uncondusive Working Area







Working Space maximised **CONTRIBUTING FACTORS 4:** Shortage of Manpower

Rearrangement of working area



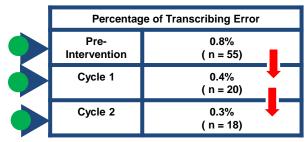


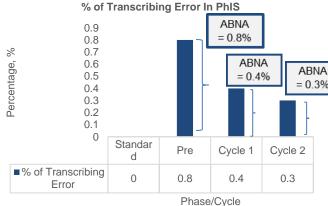
Google Sheet for Daily Staff

Movement

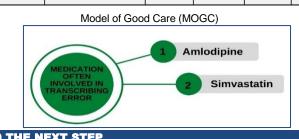
Stagged Appointment TCA

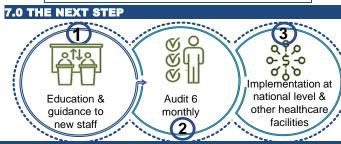
6.0 EFFECT OF CHANGE





	T Hase/Oyele								
	Criteria	Stand	,	Cycle					
Process		-ard	Pre	1	2				
Screen prescription & key in patients data into PhIS	a.Patient registration	100%	100%	100%	100%				
	b.Medication order	100%	100%	100%	100%				
	c.Transcribe normal order	100%	100%	100%	100%				
	d.Ammenment on drug & dose modification (if needed)	100%	91%	99%	100%				
	e.Put on CQDC sticker for partial supply prescription and sign	100%	84%	93%	100%				
	f. Print medication label	100%	100%	100%	100%				
	g.Put the label & prescription into individual basket	100%	100%	100%	100%				
	h.Place it at filling area	100%	100%	100%	100%				





REFERENCE / ACKNOWLEDGEMENT

1Fahimi F, Nazari MA, Abrishami R, Sistanizad M, Mazidi T, Faghihi T, et al. Transcription errors observed in a teaching hospital - PubMed. Archives of Iranian medicine. 2009 Mar 1;12(2) ²Lisby M, Nielsen LP, Mainz J. Errors in the medication process: frequency, type, and potential clinical consequences. Int J Qual Health Care. 2005;17(1):15–22

3Shawahna R, Rahman NU, Ahmad M, Debray M, Yliperttula M, Decleves X. Impact of prescriber's handwriting style and nurse's duty duration on the prevalence of transcription errors in public hospitals. J Clin Nurs. 2013;22(3–4):550–8

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