5PSQ-069

ANALYSIS AND MONITORING OF ERRORS ASSOCIATED WITH ELECTRONIC PRESCRIPTION SYSTEMS: PRESCRIPTIONS WITH INCORRECT DRUG SCHEDULE

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BACKGROUND

Delays and omissions of medication administration occur due to lack of knowledge of prefixed computerized physician order entry system.

OBJECTIVE

The aim of this study is quantify and analyze medication errors associated with incorrect scheduled prescriptions. To compare the evolution with regard to a study carried out under the same methodology in 2020.

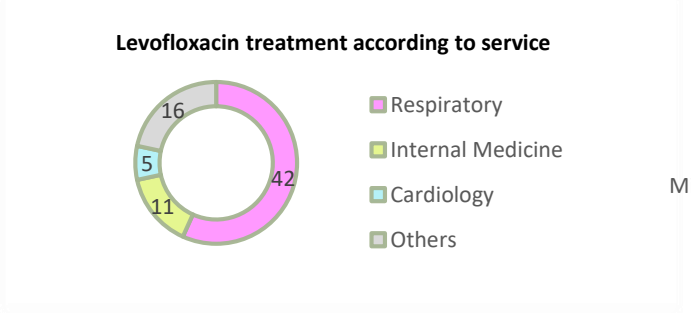
METHODS

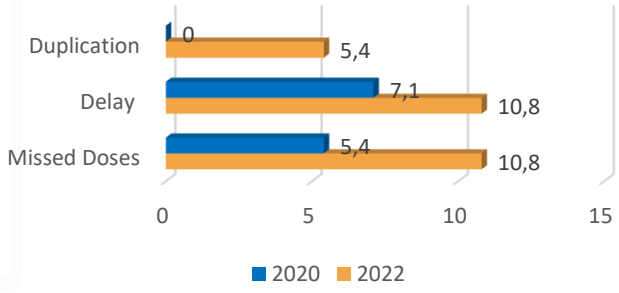
Retrospective observational study of a 10 days period was carried out. Started or modified treatments of levofloxacine and their administration records were reviewed the day after. Omission was considered if the medicine was not administered in a 24h period, and incorrect prescription if prefixed timetable was 8 hours later since the prescription or if dose was repeated in the day.

RESULTS

44 start treatment and 30 modifications with levofloxacin were analyzed (53 oral and 21 intravenous).

20 erroneous prescriptions were detected (27% in 2022 compared to 19.6% in 2020).





CONCLUSIONS

Errors associated with inappropriate prescribing times have increased compared to 2020. After this analysis, it can be concluded that the specific formation provided to facultatives by the Pharmacy Department is still necessary.

It is worth mentioning that during the pandemic, formation was not provided in person, which could have influenced these results.

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