
PHARMACY PRACTICE



Prescriber Identification Program

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Illegible signatures on hospital prescriptions can lead to delayed processing of orders and administration of drugs. This is particularly true when prescribing errors are identified and require clarification before processing. A recent study by Lesar et al¹ emphasizes the frequency and significance of prescribing errors in the teaching hospital setting. A review of inpatient prescriptions at Vancouver General Hospital during 1989 revealed that approximately 40% contained illegible physician signatures. Two levels of intervention were sequentially implemented at this site to address the problem.

The first level of intervention involved a voluntary program in which a letter from the Pharmacy and Therapeutics Committee was distributed to all prescribers requesting that they provide their prescriber identification code (PIC) or printed name along with a signature when ordering inpatient medications. The PIC refers to the physician's medical services plan (MSP) billing number and/or hospital dictation number. Residents use a hospital dictation number only while medical student

interns provide the PIC of their supervising physician. This program was implemented on January 9, 1989. A 12-month follow-up review revealed that only 9% of prescriptions included a PIC, 53% included a discernable name, and the incidence of prescriptions with illegible signatures remained virtually unchanged at 38%. As the first level of intervention had no apparent impact on physician identification compliance rate, a second, more intense level of intervention was required.

In the second level of intervention, a two-phase prescriber identification code program was implemented with endorsement from the Pharmacy and Therapeutics and the Medical Advisory Committees. During Phase I of the program (February 5-9, 1990), prescriptions without a signature and a printed name or PIC were considered incomplete and the prescriber was contacted to obtain verbal verification. Approximately 100 hours of additional pharmacist time was required to contact physicians during this phase and a review of prescriptions revealed that the compliance rate had subsequently

increased to 85%. Phase II was initiated on February 12, 1990 and is an ongoing program requiring that any incomplete prescription be returned to the nursing unit with a memo (Figure 1) to be attached to the health record identifying that the prescription could not be honoured. For 'essential' drugs, a 24-hour supply of medication is provided with the memo. A review of compliance during Phase II reveals a further increase to approximately 94% and this has remained stable during the subsequent four-month period.

The prescriber identification program instituted in our hospital has proven to be very effective in decreasing the number of prescriptions received by pharmacy for which the prescriber cannot be identified. It is apparent that the program has facilitated prescription processing and problem resolution which can reduce drug delivery time. An added expected benefit to the program is an increase in discharge prescriptions containing discernable physician names, thus reducing a common problem associated with the transition from hospital to community setting.

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The success of our program required the support of the Pharmacy and Therapeutics Committee, Medical Advisory Committee and the Department of Pharmacy, as well as the co-operation of physicians, nurses and pharmacists. A small number of physicians who initially

refused compliance with the program were identified and contacted directly by Medical Administration resulting in a successful modification of prescribing behaviour. We would recommend this program to other hospitals who have identified similar prescriber identification problems.

REFERENCE

1. Lesar S, Briceland L, Delcours K, et al. Medication prescribing errors in a teaching hospital. *JAMA* 1990; 263(17):2329-34.

NURSING
PLEASE INSERT IN FRONT OF DOCTOR'S ORDERS
IN PATIENT'S CHART

THIS PATIENT HAS RECEIVED A
PRESCRIPTION WITH AN UNIDENTIFIABLE
SIGNATURE

DATE: _____

A PRESCRIPTION FOR THE FOLLOWING DRUG(S),
_____ HAS BEEN WRITTEN FOR THIS
PATIENT, _____. THIS PRESCRIPTION
IS CONSIDERED INCOMPLETE BY THE MEDICAL
ADVISORY COMMITTEE OF THIS HOSPITAL AND
THEREFORE CAN NOT BE HONOURED.

NO DRUG SUPPLIES HAVE BEEN
DISPENSED.

24 HOURS OF DRUG SUPPLY HAVE BEEN
PROVIDED ONLY.

TO CONTINUE DRUG THERAPY, A NEW COMPLETE
PRESCRIPTION IS REQUIRED INCLUDING DOCTOR'S
SIGNATURE AND PRINTED NAME/PIC.

DR. C.J. WRIGHT, VICE-PRESIDENT, MEDICAL ADMINISTRATION
DR. L.C. JENKINS, CHAIRMAN, MEDICAL ADVISORY COMMITTEE
DR. M.R. LAWRENCE, PRESIDENT, MEDICAL STAFF
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Figure 1: Memo re Prescriber Identification