
# Medication Transcription Errors in Inpatient Settings

**Company** – CK Birla Hospital, Jaipur, Department of Clinical Pharmacology

Presented by: Rajat Saini

# Understanding Transcription Errors

## Occurrence

Transcription errors happen when transferring medication orders.

## Root Causes

Illegible handwriting, abbreviations, and missing information are common causes.

## Clinical Risks

Serious risks include adverse reactions, treatment delays, and incorrect treatment.

# Audit Objectives

1

## Chart Audit

Audit inpatient charts for transcription errors.

2

## Trend Analysis

Analyze error trends across departments and consultants.

3

## Improvement Recommendations

Recommend improvements to reduce medication errors.

# Methodology Overview

### Total Files Audited

468 inpatient charts were reviewed.

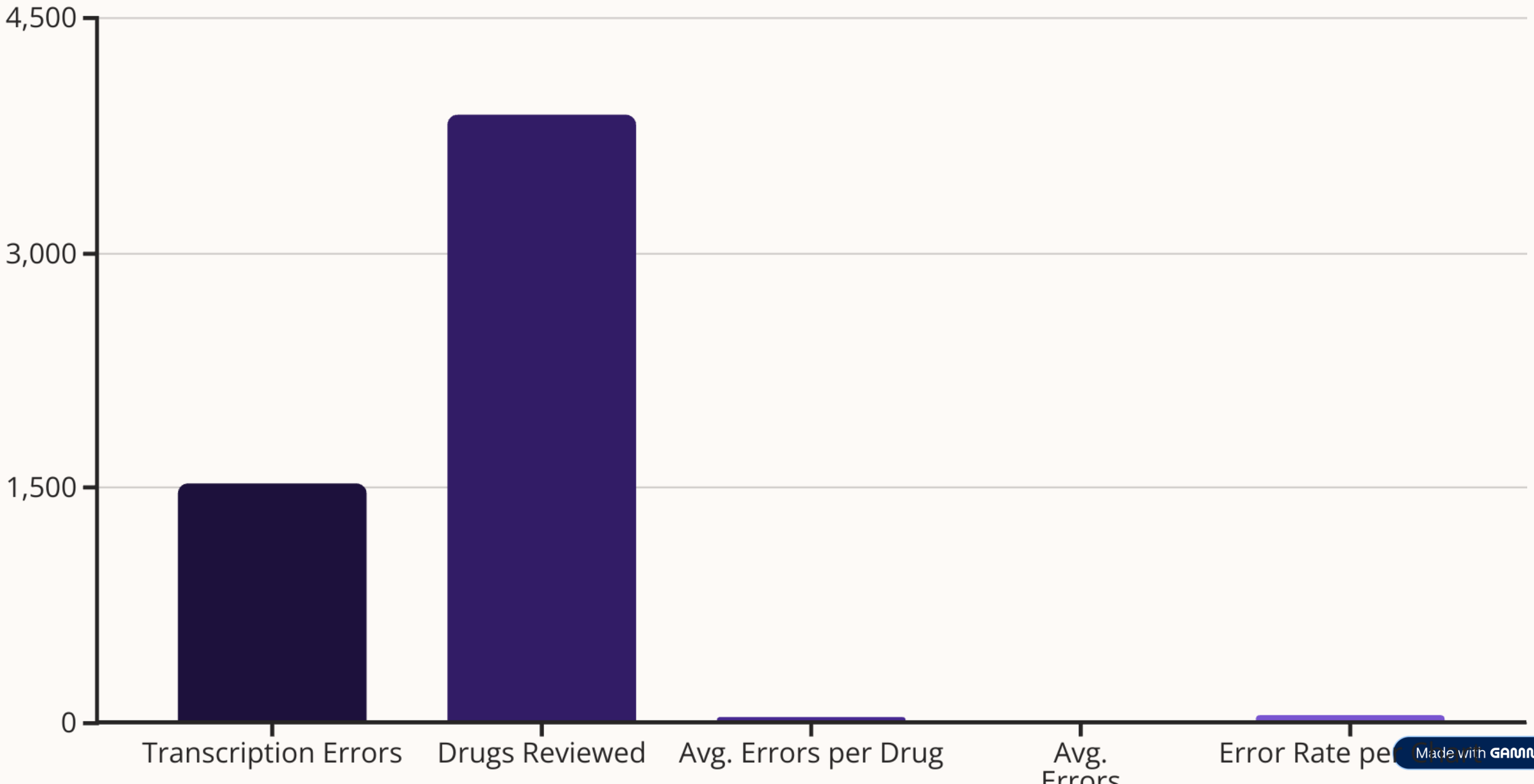
### Departments Covered

MICU, SICU, CCU, NICU, Neuro ICU were included.

### Data Points Analyzed

Drug name, dose, frequency, route, and documentation style were examined.

# Key Audit Findings



# Common Types of Errors

**Illegible Handwriting Handwriting**

**Non-Capitalized Drug Names**

**Brand Name Usage**

**Unsafe Abbreviations**

These categories represent the most frequent types of transcription errors identified in the audit. Unsafe abbreviations like OD, IU, and µg contribute significantly to these errors.

# ICU-Wise Error Distribution

| Unit | Observations |
| --- | --- |
| MICU/HDU | High error density |
| Neuro ICU | Recurrent handwriting issues |
| SICU/CTVS ICU | 55% medical, 45% surgical cases |
| CCU | Mixed documentation quality |
| NICU | Pediatric-specific error patterns |

Error distribution varies across ICUs, indicating specific challenges in different units. Pediatric units show unique error patterns needing targeted intervention.

# Strategic Recommendations

1

## Prescriber Training

Train on generic writing, safe abbreviations, and legibility.

2

## Standardized Charts

Implement charts with mandatory fields for every drug order.

3

## EMR Implementation

Introduce Electronic Medical Records to eliminate manual risks.

4

## Pharmacist Review

Ensure review during prescription and reconciliation processes.

5

## Regular Audits

Conduct continuous audits for compliance and improvement.

These recommendations aim to standardize practices and leverage technology to enhance patient safety and minimize medication errors.

# conclusion

- **Prescriber education and standardized documentation** are essential to reduce transcription errors and enhance writing accuracy.
- **Electronic Medical Records (EMR)** can eliminate handwriting-related issues and improve prescription clarity.
- **Regular audits** help identify error patterns and support data-driven improvements in medication practices.
- **Future focus should include digital prescription systems** and clinician training to build a sustainable culture of medication safety.