

Title:**Audit of Medication Transcription Errors in Inpatient Wards at CK Birla Hospital, Jaipur**

Introduction:

Medication transcription errors are among the most frequent causes of preventable harm in hospitals. This study audited prescriptions from **January to April 2025**, focusing on errors during the transcription phase in inpatient medication charts, including ICUs and HDUs.

Objectives:

- To identify and categorize transcription-related medication errors.
 - To evaluate the frequency of errors per patient and per drug.
 - To assess the documentation practices of healthcare providers.
 - To understand how EMRs and training can help minimize errors.
 - To recommend policy changes to improve medication safety.
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Methodology:

- **Design:** Retrospective observational audit.
 - **Setting:** CK Birla Hospital – MICU, SICU, CCU, NICU, HDUs.
 - **Sample:** 468 patient charts, 3,878 medications reviewed.
 - **Tools:** Chart audits, prescriber interviews, qualitative observations.
 - **Analysis:** Descriptive statistics, error categorization, consultant-wise comparison.
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Key Findings:

- **Total errors:** 1,523.

- **Error rate:** 39.27% of all drugs.
 - **Average errors per patient:** 8.29.
 - Most common errors included:
 - Illegible handwriting.
 - Use of non-standard/unsafe abbreviations (e.g., “IU”, “OD”).
 - Omission of dose, frequency, or route.
 - Use of brand names instead of generic names.
 - Higher error rates were observed in medical ICUs compared to surgical units.
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Recommendations:

- Implement **electronic medical records (EMR)** to eliminate handwriting-based errors.
 - Conduct **prescriber training** sessions focused on safe writing practices.
 - Use **standardized prescription templates** with mandatory fields.
 - Engage **clinical pharmacists** in prescription audits and reconciliation.
 - Institutionalize **periodic audits** with feedback to departments.
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Conclusion:

The study revealed a high burden of preventable transcription errors in CK Birla Hospital. It highlights the need for systemic reforms, digital prescription systems, and continuous clinical audits to enhance patient safety and reduce the risk of medication-related harm.