

**"AS  
DIRECTED"**

**AUDIT**



## Background

This audit came about through the concern that prescriptions with unspecified / omitted instructions and thus products labelled with "as directed" could lead to a potentially dangerous situation. Confusion over dose and dosage interval(s) being at crossed purposes as to how a product should be used, or not catching what the doctor said, can and does occur. As a result of performing this audit in a community pharmacy it is hoped the following will be achieved:

- To check that the patient knows the instructions for their prescribed medication when they are not stated on the prescription.
- To prevent accidental overdose or misuse of prescribed medication
- To prevent accidental sub therapeutic regimes
- To highlight the situations in a community pharmacy where it is difficult to check if a patient knows the instruction for his/her prescribed medication.
- To find a way around these aforementioned situations.
- To demonstrate the pharmacists input into improving patient compliance with prescribers' instructions in these circumstances.

## Criteria - Audit Question

How many people with prescription instructions "as directed" or with instructions omitted know what to do with their medication?

## Standard

100% of customers presenting a prescription with unspecified directions, know how to use/take their medication safely and correctly on leaving the pharmacy.

## Audit Plan

Suggestions for:

- ◆ Method of data collection - tally
- ◆ What to collect - see tally sheets
- ◆ Time span of the collection period - one month
- ◆ Who to involve - preferably carried out by the pharmacist, however pharmacy support staff could help where they are instructed to get the pharmacist if the patient is at all unclear about the medication.
- ◆ Resources needed - paper and pen, B.N.F, telephone.



# "AS DIRECTED " AUDIT tally sheet I

MONTH / YEAR ...../.....

## SUCCESSFULLY COUNSELLED

(i.e. pharmacist satisfied that the patient knows how to take / use the medication safely and correctly.)

	TALLY (each item)	TOTAL
PATIENT ALREADY KNOWS (i.e. repeat script, verbal directions given by prescriber.)		
PATIENT UNSURE (Pharmacist confirms, reassures, corrects etc.)		
PATIENT DID NOT KNOW (Pharmacist finds out and informs patient)		
OTHER REASONS:- (please state )  e.g. Nurse injecting		

NUMBER of prescription items with unspecified directions, where the patient leaves the pharmacy knowing how to use / take the medication correctly .....



## "AS DIRECTED" AUDIT tally sheet 2

MONTH/YEAR ...../.....

### UNSUCCESSFULLY COUNSELLED

(i.e. Pharmacist unable to determine if patient knows how to take/use the medication correctly.)

	TALLY (each item)	TOTAL
PATIENT NOT PRESENT		
PHARMACIST UNABLE TO SPEAK TO THE PATIENT BECAUSE:-(please state reason, date, time.)		
OTHER (please state reason, date, time.)		

NUMBER of prescription items with unspecified directions, where the pharmacist is unsure if the patient knows how to use / take the medication .....

TOTAL NUMBER of prescription items with unspecified directions dispensed in the month of .....

TOTAL NUMBER of prescription items dispensed that month.....



Results

The following percentages could be calculated from data collected:

X % of prescription items presented during the month of..... were without specific directions for use.

Y% of X% DID NOT KNOW or WERE UNSURE how to take / use the medication safely and correctly.

(Y% also represents a measurable contribution the pharmacist has in improving patient care in these circumstances.)

Z% of X% the pharmacist was unable to determine if the patient knew how to take / use the medication.

(Z% represents an area of potential improvement. The reasons recorded, see tally sheet 2, would help to point towards the changes required.)

A PIE CHART could be used to illustrate the results.

Implement Change

Key findings would direct you towards possible action necessary to reach your personal aims.

E.g. if finding the time in busy spells in the dispensary prevents the pharmacist speaking to the patients, it may be a more practical to train the member(s) of staff who gives out the completed prescriptions to be able to identify those who would benefit from speaking to the pharmacist. This would use the pharmacist's time more effectively.

The pharmacist is unable to deal with the fundamental problem, which is the absence of adequate instructions. We would, therefore, suggest that the results of the audit be shared with the local prescribers who may be unaware of the extent of the problem.

*When this audit was piloted the major hindrance was the absence of the patient. It was therefore decided to ask the patient's representative to invite the patient to phone the pharmacy if there were any uncertainty as to the dosage instructions.*

Continue the Cycle

Repeating the audit may be useful to see if improvement has taken place.

If PMRs are available, they could be used to highlight who had already been spoken to, thus using the pharmacist's time more efficiently.

The initial audit may uncover more aspects you want to audit.

What have you learnt from undertaking this audit?



How will you alter your practice in the future?

