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Original Research Article

An audit of outpatient prescriptions in a tertiary care center of eastern Uttar Pradesh: a cross-sectional study

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ABSTRACT

Background: Prescription audits are essential for evaluating prescription writing practices, ensuring rational drug use, minimizing errors, and improving patient safety. This study assesses the quality of prescriptions in the outpatient departments (OPDs) of a tertiary care center in Eastern Uttar Pradesh based on WHO guidelines and NABH recommendations.

Methods: A cross-sectional observational study was conducted between August and October 2024 across 10 clinical OPDs, analyzing 1000 prescriptions (100 per department). Prescriptions were evaluated for legibility, completeness, patient follow-up and referral documentation. Data collection was performed using a WHO-based checklist and analyzed using descriptive statistics.

Results: While 100% of prescriptions included patient identifiers, only 18% were legibly written, and 30% had proper prescriber identification. Generic prescribing was low (21%), with a majority of prescriptions using brand names. Allergy status was documented in only 10% of prescriptions, raising patient safety concerns. Follow-up instructions were missing in 41% of prescriptions, and medications were not numbered in any prescription, potentially increasing the risk of errors. Senior residents showed better compliance in prescriber identification, but consultants provided more definitive diagnoses and follow-up instructions.

Conclusions: While basic documentation standards were maintained, deficiencies in legibility, prescriber identification, generic prescribing, allergy documentation, and medication numbering highlight areas for improvement. Strengthening prescriber training, enforcing structured prescription templates, conducting regular audits, and implementing digital prescribing systems can significantly improve prescription quality and patient safety.

Keywords: Prescription audit, Prescription errors, Outpatient department, Prescription completeness, Prescription legibility, Patient safety

INTRODUCTION

By definition, the prescription is a sheet of paper with the prescription information written by a doctor for the

medication or medications that a patient needs. Prescription audits are routine reviews of a facility's prescriptions conducted to evaluate the level of patient care that is being given. It can contribute to better patient

care by making sure that prescriptions are accurate, logical, legible, and comprehensive.

Prescription audits are a component of comprehensive clinical audits, which aim to enhance patient treatment and results using a methodical evaluation of service in comparison to clear criteria and the execution of modifications. The issue of irrational prescription is widespread. Prescription mistakes are prevalent and can impact anywhere from 4.2 to 82% of prescriptions.¹ Prescription audits, which are a component of comprehensive clinical audits, are quality-improvement procedures that aim to enhance patient care and results by systematically evaluating care in comparison to predetermined standards and putting those findings into practice.²

Prescription errors are usually the result of slips, omissions, or typos, including writing a dose that is either more or lower than the right one. Additionally, patient-related factors may lead to mistakes and unfavorable outcomes, such as allergic history and disregard for directions. Consequently, identifying such mistakes is an essential first step toward developing safer systems and avoiding unfavorable incidents. These mistakes can be found by doing a systemic analysis of prescriptions via means of the prescription audit.

Prescription audits are routine facility-level reviews that look over the medications the facility writes. It aids in determining the volume of OPD patient data that is documented on prescriptions and prescribing behaviors of medical professionals, the availability and appropriate use of medications, medication distribution procedures, and the dispensary's workload. Audit of prescription drugs is an improvement activity that, when carried out regularly, guarantees that the patients obtain equitable, economical, and effective high-quality healthcare.³ Thus, prescription audit is a "fact-finding exercise" rather than a "fault-finding exercise". It is "Not" about "who went wrong" in focus, but to determine "why it went wrong" and "where it went wrong" concerning the system's problem; and what can be done to bring about its solution and prevent its recurrence. This study was conducted to examine various Prescription Audit parameters and assess audit data from several departments using various parameters in a WHO-based checklist and NABH recommendations, as well as to compare senior and young physicians' prescription writing practices. This study aimed to collect information and provide suggestions for better prescription writing, to reduce errors in prescription writing, and to establish a database for comparison in the future.

A prescription is a written medico-legal document that is issued by a medical professional with authorization to treat a patient. It is a representation of the standard of healthcare the patient is receiving. It is an ability learned by following instructions and complying with guidelines. Inappropriate prescription practices encourage the illogical use of medications and lower the level of patient compliance and

adherence to treatment suggested.⁴ Irrational pharmaceuticals needlessly raise the treatment's price and duration, also adverse drug responses, drug resistance, and medication interactions arise as a result of these activities. Lastly, it raises the morbidity, mortality, and expenses burden on the injured party.⁵ Prescription auditing is evaluating a prescription's writing style critically about the globally recognized standards provided by the World Health Organization (WHO) which is a collection of fundamentals developed by WHO as prescription indicators for the sensible use of pharmaceuticals.⁶ This collection comprises the patient care, the prescribing indicators, and both the facility's indicators and indications. The studies on prescription auditing are carried out in many locations across the globe depending on the exceeds the recommended thresholds.^{7,8}

The World Health Organization (WHO) and the International Network for the Reasonable Use of Drugs collaborated to create a set of "core drug use indicators". The metrics assess performance in three interconnected areas: patient care, prescribing methods, and elements unique to the facility. The primary signs of drug usage have gained acceptance as impartial measurements that can characterize the state of drug use in a nation, area, or individual health center. Specifying signs include the number of medications prescribed per encounter, the proportion of prescription medications with a generic name, the proportion of patients treated with injections and antibiotics prescription, as well as how many medications are prescribed from the list of essential drugs (EDL).⁹

As per the study conducted by Kandula et al most of the prescriptions were found to be legible, with drug name, dosage, form, and frequency being clearly mentioned and also patient details in most of the prescriptions.¹⁰ In another study conducted by Meenakshi et al in a South-Indian teaching hospital, it was found that the majority of prescriptions were found to be complete as far as patient identifiers, disease diagnosis, and instructions are concerned but capital letters were used in a very small number of prescriptions to write medicines names though dosage, frequency, route, and duration of drugs to be taken were mentioned nicely in most of the prescriptions.¹¹ In one more study conducted in a rural hospital in Delhi by Singh et al it was found that on average 3 drugs were prescribed per prescription mostly using generic names and drugs from the essential medicines list of the hospital. Very few injectables were prescribed and half of the prescriptions had antibiotics included among the drugs prescribed. The majority of prescriptions lacked follow-up advice, reasons for referral, Do's and don'ts, and Doctor's registration number.¹²

METHODS

Study design and setting

This cross-sectional observational study was conducted from August to October 2024 at a tertiary care center in

Eastern Uttar Pradesh. The study focused on prescription writing practices across 10 outpatient department (OPD) specialties: General Medicine, General Surgery, Obstetrics and Gynaecology, Paediatrics, ENT, Ophthalmology, Dermatology, Psychiatry, Orthopaedics and Pulmonary Medicine. The study was approved by the Institute Human Ethics Committee.

Sample selection

A total of 1000 prescriptions (100 per department) were analyzed. Each department contributed 50 prescriptions from consultants and 50 from senior residents, allowing for a comparative assessment of prescription writing practices.

Pre-testing and validation

Before full-scale data collection, a pre-test validation was conducted in May 2024 using a small sample of prescriptions. The objective was to evaluate the clarity, applicability, and effectiveness of the observation checklist used for auditing. Feedback from auditors and healthcare professionals helped refine the checklist to ensure it accurately captured data on legibility, completeness, and adherence to prescribing guidelines.

Data collection procedure

Each departmental OPD was visited for 3–4 days to collect data while minimizing potential biases associated with individual prescribers. Post-consultation patients were randomly selected for prescription review. After obtaining informed consent from the patients, photographs of their prescriptions were taken. Patient-reported information regarding investigations advised and medication instructions was recorded, and data were entered into a structured checklist in real time.

Outcome measures

The primary outcome measures included the prescription legibility rate, defined as the proportion of prescriptions that could be read and interpreted without ambiguity, and the prescription completeness rate, assessed based on the documentation of essential patient information, medication details (generic names, dosage, frequency, and duration), diagnosis, and follow-up instructions. Patient follow-up and referral documentation rates were also evaluated by determining the proportion of prescriptions containing appropriate follow-up advice and referral details, wherever applicable. Additionally, prescription quality was compared between consultants and senior residents in terms of legibility, completeness, and adherence to prescribing guidelines.

Data analysis plan

Descriptive Analysis: Patient demographic characteristics, including age, sex, and department of consultation, were

summarized using appropriate descriptive statistics. Categorical variables, such as the presence or absence of patient identifiers, medication details, diagnosis, and follow-up instructions, were presented as frequencies and percentages.

Objective-specific analysis

Prescription errors were classified by type and analyzed descriptively in terms of their frequency and distribution, with thematic analysis applied to qualitative observations, where appropriate. The proportion of legible prescriptions was calculated to assess prescription legibility, and logistic regression analysis was planned to identify factors associated with legibility. Similarly, prescription completeness rates were calculated, and logistic regression was used to explore factors influencing prescription completeness. Comparisons between consultants and senior residents were performed using the chi-square test to assess differences in prescription legibility and completeness. Where appropriate, multivariable analysis was planned to adjust for potential confounding factors, including the department of consultation and patient demographic characteristics.

RESULTS

In the present study, 1000 prescriptions from OPDs of 10 departments, namely General Medicine, General Surgery, Obstetrics and Gynaecology, Paediatrics, ENT, Ophthalmology, Dermatology, Psychiatry, Orthopaedics, and Pulmonology, were taken as a sample. Hundred prescriptions from each department, out of which 50 prescriptions were written by the consultants, and 50 prescriptions by the senior residents. The mean age of the patients whose prescriptions were studied was 40 years, excluding the Paediatric patients whose mean age was 4 years (Figure 1).

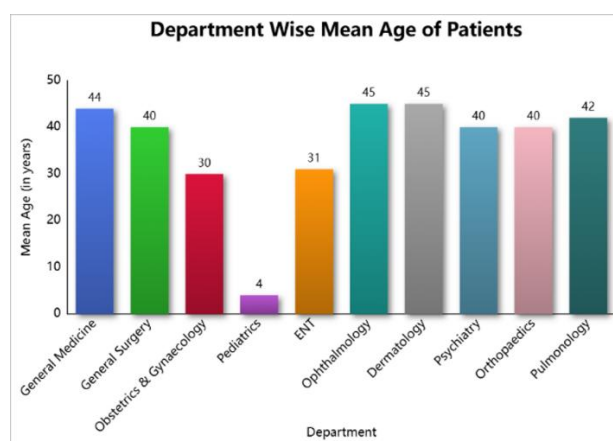


Figure 1: Department wise mean age of patient's prescription studied.

Among the entire prescriptions studied 44% of prescriptions were of male patients. While calculating the

gender ratio Obstetrics and Gynaecology patients were not included to avoid gender bias. (Figure 2).

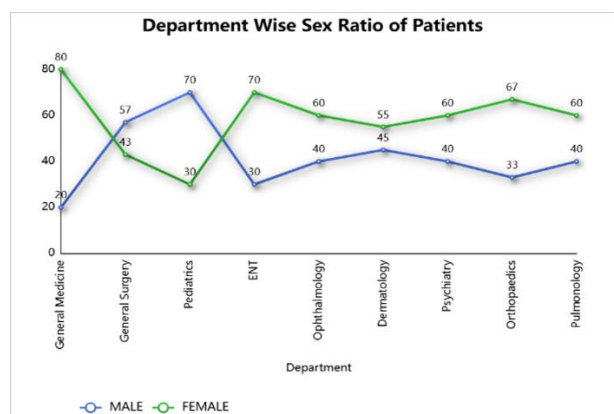


Figure 2: Department wise sex ratio of patient's prescription studied.

Table 1: Showing department wise comparison between consultants and senior residents for prescription legibility rate among prescriptions studied.

Department	Prescribing doctor	Prescription legibility rate (%)
General medicine	Consultant	20
	Senior resident	40
General surgery	Consultant	0
	Senior resident	0
Obstetrics and gynaecology	Consultant	0
	Senior resident	0
Pediatrics	Consultant	80
	Senior resident	60
ENT	Consultant	0
	Senior resident	0
Ophthalmology	Consultant	0
	Senior resident	0
Dermatology	Consultant	10
	Senior resident	10
Psychiatry	Consultant	50
	Senior resident	30
Orthopaedics	Consultant	50
	Senior resident	50
Pulmonology	Consultant	10
	Senior resident	10

Another index used for prescription legibility was a legible signature by the prescribing doctor (prescriber identification). Most prescriptions were found to be legibly signed by doctors from General Medicine (80%) and least by doctors from Dermatology (0%).

Overall, only 30% of prescriptions were signed with proper prescriber identifiers (Table 2).

Prescription legibility rate, which was considered as the ability of someone other than the prescriber to read and understand the prescription without ambiguity and the medicine name must be written in capital letters, was found to be highest in pediatrics prescriptions (70%), and lowest in General Medicine, General Surgery, O&G, ENT, and Ophthalmology which accounted to nearly 0%. Overall, only 18% of prescriptions were legibly written with medicine names written in capital letters (Table 1)

Prescription legibility was also compared between consultants and residents of different departments. In most of the departments, the prescriptions were found to be more legibly written by consultants as compared with residents. The prescription legibility rate was found to be the highest among consultants of the Paediatrics Department (80%) (Table 1).

When the legibility of signatures on prescriptions was compared between consultants and senior residents it was found that senior residents were more inclined towards signing legibly and putting a stamp also at the bottom side of the prescription. When compared between departments it was found that SRs of the General Medicine and Psychiatry Department were very particular about signing the prescriptions legibly with stamp mentioning name and designation (Table 2).

Table 2: Showing department wise comparison between consultants and senior residents for legibility of signature and stamp on prescriptions.

Department	Prescribing doctor	Legible signature with stamp on prescription (%)
General medicine	Consultant	60
	Senior resident	100
General surgery	Consultant	100
	Senior resident	0
Obstetrics and gynaecology	Consultant	5
	Senior resident	5
Pediatrics	Consultant	20
	Senior resident	20
ENT	Consultant	0
	Senior resident	40
Ophthalmology	Consultant	20
	Senior resident	80
Dermatology	Consultant	0
	Senior resident	0
Psychiatry	Consultant	10
	Senior resident	90
Orthopaedics	Consultant	10
	Senior resident	10
Pulmonology	Consultant	10
	Senior resident	10

The prescription completeness rate was also studied as an indispensable part of a prescription audit. In this completeness was defined as the inclusion of all necessary elements such as patient name, age, gender, medication details (including generic names, dosage, frequency, and duration), diagnosis, and follow-up advice.

These days' online registration has become a compulsory part of hospital information systems. Patient details like Name, Age, Sex, OPD Registration number address, etc., and other identifiers are invariably recorded especially in tertiary care centers like ours where after registration patient is provided with prescriptions in which patient details are printed neatly and clearly. So, parameters like OPD Registration number, Patient Complete Name, Age, Sex, Date of Consultation, Weight (in case of the pediatric patient), and address were found to be invariably present in all prescriptions of all departments. In continuation to another parameter of completeness of prescription, names

of medicines written by generic name were also studied. It was found that none of the departments were inclined towards writing medicines by generic name. Other than Psychiatry, Orthopaedics, and Paediatrics, departments using generic names for prescribing medicines were negligible. Overall, 21% of prescriptions from various departments included medicines by generic name rest 79% of medicines were prescribed by brand names. (Table 3)

When a comparison between consultants and senior residents was made towards writing generic names for prescribing medicines, it was found that only senior residents in Psychiatry were completely compliant (100%) towards writing generic names of medicines in their prescription and to an extent of 50% Orthopaedics senior residents and consultants were compliant, while senior residents and consultants of rest of the departments were negligibly interested in writing medicines by generic names. (Table 3).

Table 3: Showing department wise comparison between consultants and senior residents for medicines prescribed by generic names.

Department	Prescribing doctor	Medicines prescribed by generic names (%)
General medicine	Consultant	0
	Senior resident	0
General surgery	Consultant	0
	Senior resident	5
Obstetrics and gynaecology	Consultant	5
	Senior resident	5

Continued.

Department	Prescribing doctor	Medicines prescribed by generic names (%)
Pediatrics	Consultant	25
	Senior resident	25
ENT	Consultant	5
	Senior resident	5
Ophthalmology	Consultant	0
	Senior resident	0
Dermatology	Consultant	10
	Senior resident	10
Psychiatry	Consultant	30
	Senior resident	100
Orthopaedics	Consultant	70
	Senior resident	42
Pulmonology	Consultant	5
	Senior resident	5

Another important index i.e. recording of brief history in prescription was also taken into account towards fulfillment of completeness of prescription. It was found that most of the departments very nicely wrote brief patient histories on the prescription. So was the practice followed by senior residents, and thus there was no major difference observed between senior residents and consultants in writing brief histories on prescription. Overall, 88% of prescriptions contained a brief history as part of the prescription. Mentioning of allergic status from medicines is also an important point in prescription completeness but unfortunately, it was not at all mentioned by any of the departments except Pulmonology, in which it was mentioned in all prescription i.e. in 100% prescriptions allergic status from medicines was mentioned. Thus, the overall percentage of the prescriptions mentioning allergic status comes to 10%.

Salient features of examination and writing of presumptive/definitive diagnosis were also studied to analyze the completeness of the prescription. Though salient features were nicely written by most of the departments other than Dermatology with reasons not understood only Dermatology and Pulmonology wrote diagnoses in all of their prescriptions. The rest of the departments mentioned presumptive/definitive diagnosis in nearly 50% of prescriptions. Overall salient features were maintained as a part of prescription in 84% of cases while presumptive/definitive diagnosis was written on 2/3rd of prescriptions. (Table 4).

When a comparison was done between the prescriptions of consultants and senior residents taking into account the practice of writing salient features of examination and presumptive/definitive diagnosis, it was seen that senior residents followed the same trend as that of consultants in writing salient features but were less inclined towards writing presumptive/definitive diagnosis as compared with consultants (Table 5).

In all prescriptions from various departments, medicines were invariably prescribed as per Standard Treatment Guidelines (STG) by all consultants and senior residents. The next parameter of completeness of prescription was whether Medicine doses/ Schedule and Duration were written clearly or not. It was seen that 89% of the departments very clearly wrote dose/schedule and duration. However, medicine names were not very legibly written, as already documented in previous findings under the results section. And the same trend was seen when consultants' and senior residents' prescriptions were compared. (Table 6).

When the date of the next review was looked into the prescriptions, it was found that 52% of the prescriptions from nearly all departments mentioned the next date of review but this practice was found to be lacking in prescriptions of General Medicine and ENT departments. Follow-up advice was nicely written by 59% of the departments. (Table 7).

Table 4: Showing department wise prescriptions in which salient features about the patient examination and presumptive/definitive diagnosis were written.

Department	Salient features of examination (%)	Presumptive/Definitive diagnosis written (%)
General Medicine	100	60
General Surgery	100	50
Obstetrics and Gynaecology	100	20

Continued.

Department	Salient features of examination (%)	Presumptive/Definitive diagnosis written (%)
Pediatrics	100	80
ENT	100	80
Ophthalmology	100	30
Dermatology	30	100
Psychiatry	80	80
Orthopaedics	30	60
Pulmonology	100	100

Table 5: Shows a department wise comparison between consultants and senior residents for writing salient features of examination and presumptive/definitive diagnosis.

Department	Prescribing doctor	Salient features of examination (%)	Presumptive/Definitive diagnosis written (%)
General medicine	Consultant	100	20
	Senior resident	100	40
General surgery	Consultant	100	50
	Senior resident	100	0
Obstetrics and gynaecology	Consultant	100	20
	Senior resident	100	0
Pediatrics	Consultant	100	80
	Senior resident	100	80
ENT	Consultant	100	80
	Senior resident	100	80
Ophthalmology	Consultant	100	30
	Senior resident	100	0
Dermatology	Consultant	30	100
	Senior resident	30	100
Psychiatry	Consultant	80	100
	Senior resident	80	60
Orthopaedics	Consultant	30	60
	Senior resident	30	60
Pulmonology	Consultant	100	100
	Senior resident	100	100

Table 6: Showing department-wise prescriptions mentioning dose/ schedule and duration properly.

Department	Medicine doses/schedule written (%)	Duration of treatment written (%)
General medicine	60	60
General surgery	90	90
Obstetrics and gynaecology	100	100
Pediatrics	100	100
ENT	100	100
Ophthalmology	90	90
Dermatology	90	90
Psychiatry	90	90
Orthopaedics	70	70
Pulmonology	100	100

When the same parameter i.e. date of next review and follow-up advice in prescriptions was compared between consultants and senior residents no major difference was observed. As the study center is a tertiary care hospital, so no referrals were made. Vitamins, tonics, and antibiotics

were prescribed as per need though very few. As there is no antibiotic policy in the given institute hospital, antibiotics in prescriptions were prescribed as per ICMR guidelines. The last part of the prescription audit i.e. investigation advised or not, and whether medicines

prescribed were numbered or not. It was found that all the prescribing departments advised necessary investigations in their prescriptions but when looking into the numbering of medicines, none of the departments were found to

number the medicines prescribed. The same practice was followed among consultants and senior residents.

The overall scenario is presented in Table 8 about all parameters studied for prescription audit.

Table 7: Showing department-wise prescriptions mentioning the date of the next review and follow-up advice.

Department	Date of next review (%)	Follow-up advice and precautions are recorded (%)
General medicine	0	20
General surgery	70	100
Obstetrics and gynaecology	70	100
Pediatrics	100	0
ENT	0	100
Ophthalmology	100	100
Dermatology	90	10
Psychiatry	50	100
Orthopaedics	20	30
Pulmonology	20	30

Table 8: A comprehensive overview of all the parameters analyzed in the prescription audit.

	Overall % of prescriptions mentioning the required input (n=1000)	% of consultants' prescriptions mentioning required input (n=500)	% of senior residents' prescriptions mentioning required input (n=500)
OPD registration number	100	100	100
Complete name of patient	100	100	100
Age in years (≥ 5 in years) in case of <5 years (in months)	100	100	100
Weight in kg (only patients of pediatric age group)	100 paediatric patients	100 paediatric patients	100 paediatric patients
Date of consultation - day/month/year	100	100	100
The gender of the patient	100	100	100
Medicines are prescribed by generic names (%)	21	15	27
Brief history written	88	88	88
Allergy status mentioned	10	10	10
Salient features of Clinical Examination recorded	84	84	84
Presumptive/definitive diagnosis written	66	70	62
Medicines prescribed are in line with STG	100	100	100
Medicine schedule/doses written	89	89	89
Duration of treatment written	89	89	89
Date of next visit (review) written	52	52	52
Follow-up advice and precautions (dos and don'ts) are recorded	59	59	59
Investigations advised	100	100	100

Continued.

	Overall % of prescriptions mentioning the required input (n=1000)	% of consultants' prescriptions mentioning required input (n=500)	% of senior residents' prescriptions mentioning required input (n=500)
Numbering of medicines prescribed	0	0	0
Handwriting is legible in capital letter	18	20	16
Prescription duly signed (legibly)	30	24	36

DISCUSSION

This study systematically evaluated prescription writing practices across 10 clinical outpatient departments at a tertiary care center in Eastern Uttar Pradesh. A total of 1000 prescriptions were analyzed to assess legibility, completeness, adherence to prescribing guidelines, and prescribing behaviours of consultants and senior residents. The findings highlight key areas where improvements in prescription writing can enhance patient safety and healthcare quality.

Patient demographics and prescription characteristics

The mean age of the patients whose prescriptions were studied was 40 years, with most patients falling in the 30–50 years age range. Pediatric patients had a mean age of 4 years. A higher proportion of prescriptions (56%) belonged to female patients, a trend consistent with findings from a tertiary care hospital in Puducherry.¹¹

All prescriptions contained basic patient identifiers such as name, age, sex, OPD registration number, and consultation date, ensuring compliance with record-keeping standards. This is in alignment with previous studies that emphasize the importance of documenting essential patient details for continuity of care and legal purposes.^{11,13}

Legibility and prescriber identification

One of the major concerns identified in this study was the poor legibility of prescriptions. Only 18% of prescriptions had medication names written in capital letters, which is crucial for reducing misinterpretation and medication errors. This finding is significantly lower than reported in other studies.^{11,13,14}

Similarly, only 30% of prescriptions contained proper prescriber identifiers (legible signature, name, and designation), which raises concerns regarding accountability and medico-legal compliance. In contrast, some previous studies reported a higher proportion of prescriptions with prescriber details, suggesting a need for improved adherence to documentation protocols.^{11,13,14}

Generic vs. brand name prescribing

The World Health Organization (WHO) and the National Medical Commission (NMC) recommend prescribing medicines by their generic names to promote cost-effectiveness and accessibility. However, this study found that only 21% of medications were prescribed using generic names, while 79% were prescribed by brand names. This trend was comparable to findings from Nepal, where generic prescribing rates were similarly low. However, it contrasts with studies from Gujarat, which reported higher adherence to generic prescribing guidelines.^{13,14} The variability in prescribing behavior could be attributed to differences in institutional policies, physician training, and pharmaceutical industry influences.

Documentation of clinical information

Proper documentation in prescriptions is essential for ensuring accurate patient care, reducing errors, and improving treatment outcomes. Brief patient history was included in 88% of prescriptions, suggesting that most prescribers provided sufficient clinical background for patient management. Alarming, only 10% of prescriptions included information about drug allergies, which poses a significant patient safety risk. This finding highlights an urgent need for mandatory documentation of allergy history to prevent adverse drug reactions (ADRs). Clinical examination findings were recorded in 84% of prescriptions, providing critical insights into the patient's condition.

Diagnosis documentation was found in 66% of prescriptions, indicating that in one-third of cases, the presumptive or definitive diagnosis was not mentioned. This omission can hinder effective follow-up care and interdisciplinary communication. None of the prescriptions included numbered medications, despite its potential role in improving clarity and preventing confusion. All prescriptions included recommendations for investigations, reflecting thorough diagnostic assessment by clinicians.

Comparison between consultants and senior residents

A key objective of this study was to compare prescription writing practices between consultants and senior residents. The findings revealed notable differences:

Prescriber identification and completeness

Senior residents were more consistent in signing prescriptions and including prescriber identifiers. Consultants were more confident in writing definitive diagnoses and follow-up instructions, whereas senior residents frequently omitted these details. This trend suggests that residents may lack confidence in clinical decision-making due to limited experience.

Legibility

Prescriptions written by senior residents were neater and more structured compared to those by consultants. However, in departments like General Medicine, General Surgery, and Ophthalmology, prescription legibility was found to be extremely poor.

Generic prescribing behavior

The Psychiatry department showed the highest compliance with generic prescribing (65%), followed by Pediatrics (50%) and Orthopedics (56%). Among senior residents, 100% of prescriptions in Psychiatry contained generic names, whereas in most other departments, generic prescribing was minimal.

Follow-up documentation

Only 52% of prescriptions included the date of the next review, and 59% recorded follow-up advice. This suggests that nearly half of the patients were discharged without clear instructions for follow-up, which could lead to treatment non-compliance and complications.

Implications for clinical practice

The findings of this study highlight critical areas for improvement in prescription writing practices. Workshops and CME (Continuing Medical Education) sessions should focus on improving legibility, prescriber identification, and adherence to generic prescribing guidelines. Institutions should enforce policies requiring allergy status documentation to prevent medication-related adverse events.

Standardized prescription templates should be implementing structured, pre-printed prescription templates with designated sections for drug allergies, follow-up instructions, and numbering of medications can help improve completeness and clarity. Moreover, Periodic audits should be conducted to monitor improvements and ensure compliance with national and WHO-prescribed guidelines.

Large sample size (1000 prescriptions) across multiple clinical departments, providing a comprehensive assessment of prescription practices. Use of WHO-based and NABH-recommended parameters, ensuring standardization in evaluation. Comparison between consultants and senior residents, offering insights into how experience influences prescribing behavior.

The study was conducted at a single tertiary care center, limiting the generalizability of findings to other healthcare settings. Patient perspectives on prescription clarity and understanding were not directly assessed, which could have provided additional insights into prescription effectiveness. Factors influencing prescribing behavior, such as physician workload and pharmaceutical influences, were not explored in detail.

Limitations

The study was conducted at a single tertiary care institution over a limited period, which may restrict the generalizability of the findings. The short data collection period may not fully capture variations in prescribing practices over time. The presence of observers may have influenced prescriber behaviour (Hawthorne effect). Patient-reported information regarding investigations and medication instructions may have introduced recall or reporting bias. Assessment of prescription legibility may have involved some degree of subjective interpretation. Furthermore, the study evaluated prescription quality and documentation but did not assess medication adherence, adverse drug reactions, or clinical outcomes.

CONCLUSION

Although basic prescription documentation standards were generally maintained, notable deficiencies in prescription legibility, prescriber identification, generic prescribing, allergy documentation, and medication numbering were identified. These gaps highlight the need for targeted interventions to enhance prescription quality and ensure patient safety. Strengthening prescriber training, implementing standardized prescription templates, conducting regular prescription audits, and adopting digital prescribing systems may improve documentation practices, reduce prescribing errors, and promote safer, more effective patient care.

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