

~~added to aspirin, NOACs demonstrated favourable efficacy compared to aspirin alone. Further studies analysing safety and efficacy of NOACs will provide additional data on the risk-benefit profile.~~

~~P3.12~~

~~The electronic prescription system in development – step 2: assessing the pharmacists' perspective~~

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~~**Introduction:** E-prescribing is defined as the process of electronically generating and sending a prescription using a technological framework. The use of a computer-generated prescription has been suggested to have a positive impact on the prescribing and dispensing process. The system was introduced in Malta in 2016 as part of the Pharmacy of Your Choice (POYC) scheme and it was rolled out to health centre doctors. The aim of this project is to describe the use of and experiences with an E-prescribing system from the pharmacists' perspective and explore in more detail the issues that pharmacists encounter with the system in their day to day work. This project ties in with another study aimed at assessing the general practitioner's perspective.~~

~~**Methods:** A questionnaire has been prepared using Google Forms. This is divided into several sections aimed at assessing the satisfaction of users with the IT system used for dispensing drugs, their experience with learning how to operate the software, the usability of the system and safety issues that arise with E-Prescribing. The questionnaire is based on binary and Likert Scale questions with a limited number of open-ended questions included in areas where further exploration was required. The questionnaire will be distributed to pharmacists through the POYC Unit via e-mail.~~

~~**Results:** Descriptive analysis will be carried out by November 2018 and results issued thereafter.~~

~~**Conclusion:** The experiences and issues encountered by pharmacists will be documented and forwarded to the POYC unit for consideration. More in-depth information will be sought through individual interviews and eventually focus group discussions.~~

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~~P3.13~~

~~Students' and doctors' handwriting on a pre-set prescription: how great is the potential for medical error?~~

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~~**Introduction:** Poorly legible handwriting and prescription errors within the healthcare system result in significant patient morbidity and mortality, and may lead to serious medico-legal complications. This study analysed~~

~~the handwriting and prescription standards of students and doctors in Malta.~~

~~**Methods:** A questionnaire was distributed to 3 5th clinical year medical students at the University of Malta, and doctors of various grades working in Mater Dei Hospital. Participants were asked to complete a pre set prescription sheet, along with a questionnaire that focused on their attitude towards handwriting in the clinical setting. The handwriting of the participants was analysed by 2 researchers (YZ and NZ) and graded independently by two teachers and a lawyer who were not associated with the study, from 1-5, ranging from 'illegible' to 'print quality'. Each prescription was also scrutinised by YZ and NZ for any errors in transcription, typography, omission, dosage, etc.~~

~~**Results:** 166 from a total of 250 questionnaires were completed, including 137 students and 29 doctors. 15 had prior training in handwriting. 43 participants (26%) had print quality handwriting, 82 (49%) were clearly legible, 36 (22%) moderately legible, 5 (3%) barely legible and none were illegible. There was no difference between students and doctors. 111 mistakes were documented in transcribing patient information (e.g. weight, DOB, ID, allergies, etc). 422 errors in prescriptions included: omissions committed by 53% of participants; dosage in 49% and incorrect instructions in 47%. The majority of participants (78%) reported being bothered by the legibility of handwriting in hospital, but 22% would chose to ignore this problem.~~

~~**Conclusion:** This study demonstrated a significant number of prescription errors, which may reflect issues seen in actual clinical documents. Education and simple interventions can reduce the chance for error and may drastically improve patient safety.~~

~~P3.14~~

~~A re-audit of Mater Dei treatment chart writing standards~~

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~~**Introduction:** Studies have shown that up to 70% of medication errors are the result of prescription errors (Velo et Minuz, 2009). This relatively common occurrence in practice of medicine needs to be minimized through continuous clinician education and re-auditing. To establish the current types of inpatient medication errors and their prevalence following the introduction of new treatment charts at Mater Dei Hospital, Malta. This was coupled with assessing adherence of local prescribing standards to those of international practices, whilst also comparing to a previous local audit performed prior to implementation of the new treatment charts.~~

~~**Methods:** A total of 100 treatment charts were randomly selected from 42 different adult wards in MDH. Prescriptions were reviewed and compared to NHS Wales Prescription Writing Standards.~~

~~**Results:** Following implementation of the new treatment charts in Mater Dei Hospital, improvement in the use of generic names and use of block letters in~~