
Safe Medication Practices in the Physician Office

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It might surprise you to learn that in the five-year period from 2013-2017, twenty-four percent, or roughly one-fourth, of SVMIC's paid closed claims in physician offices were attributable to errors in medication prescribing or management thereof.

Medication errors encompass all mistakes involving prescription drugs, over-the-counter products, vitamins, minerals, or herbal supplements; however, the overwhelming majority of errors involve the wrong drug or the wrong dose. The categories of error seen in SVMIC claims:

- Prescribing variance (5 R's- right: patient, drug, dose, route, time)
- Addiction related to prescribed drugs
- Contraindicated drugs
- Prescription of drug despite documented allergy
- Injection-related injury (includes IV related injury)
- Drug reaction/side effects/toxicity (overdoses)
- Refusal to prescribe medication

Errors occur at every stage, from medication verification, to ordering, administration and monitoring of the patient's response. Accurately managing your patients' medications can be a complex and difficult responsibility; however, there are some useful risk management practices that can help prevent errors and protect patients. Although the focus of this article is on safe medication practices in the outpatient setting, remember that effective communication is the key to ensuring continuity of care in any setting. This is especially important during transitions of care such as handoffs and hospital discharges. Physicians should have a mechanism in place to ensure patients have a post-discharge appointment following their hospitalization and understand the treatment plan, including medications.

The sheer volume of prescriptions written in the outpatient setting contributes to an increased potential for medication-related adverse outcomes. Medication-related injuries may seem inevitable. However, injuries due to errors in medication prescribing, dispensing and administration are preventable. A medication error is "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer," according to the National Coordinating Council[1] for Medication Error Reporting and Prevention. The council, a group of more than 20 national organizations, including the FDA, examines and evaluates

medication errors and recommends strategies for error prevention.

High-Alert Medication Use

In 1995, the FDA established the black box warning (BBW) system to alert prescribers to drugs with increased risks for patients. These warnings are intended to be the strongest labeling requirement for drugs or drug products that can have serious adverse reactions or potential safety hazards, especially those that may result in death or serious injury. The most common type of warning is issued when there is a potentially serious adverse effect that must be carefully weighed against the potential benefit of the drug. Warnings are also issued to draw attention to dosing, monitoring requirements, and potential drug interactions. Ultimately, physicians must decide whether to prescribe drugs with boxed warnings. In addition to medications with an actual black box warning label, the Institute of Safe Medicine Practices (ISMP) has compiled a list of 14 high-alert medications, as well as a list of 19 high-alert drug classes/categories, which can be found online [here](#).

Practices should identify a list of "high-alert" medications that require extra precautions when administered, prescribed or dispensed. High-alert medications are those that have a propensity to cause serious patient harm when used in error. Drugs such as Coumadin (Warfarin) are particularly risky because of a narrow therapeutic index and complex pharmacology. Mistakes in dosing or insufficient monitoring of high-risk medications can lead to serious complications and adverse health effects.

Medication Reconciliation

What can be done to reduce the risk in your practice? The entire medication reconciliation process is critically important. Patients should be asked about their current medications at every encounter, not just every visit. The medication name, dosage, frequency and any adverse effects or intolerances should be updated. Ask if the patient has been treated by any other provider since the last visit and specifically inquire about any new or changed medications.

First and foremost, verify patient allergies at each and every encounter. While this may seem oversimplified, it is often a neglected step in the medication process. Your practice should have a protocol that requires a clinical staff member to ask about allergies and reactions to medications, latex and food (e.g., egg allergies for some vaccines) before any prescriptions, samples or office-administered medications are given to the patient. Document the information in a prominent place that is consistently followed by everyone in the practice. For example, on the medication list, on the top of each progress note page or in a prominent place in your electronic medical record.

Unfortunately, many healthcare workers are pressed for time and have fallen into the habit of reviewing medications by asking simple yes/no questions, such as "are all your medications the same?" It's not enough to just quickly review what's already in the record. Consider updating your medication reconciliation template to include the patient's self-reported use of illegal substances or misuse of controlled substances, both of which are important areas to explore with the patient prior to prescribing medications. Although it will

take a little extra time, asking the patient about any new medications, over-the-counter medications or dosage changes pays off in the long run.

Establish Protocols

Have you taken a look at your protocols for prescription medications lately? Updating medication lists, managing renewals, protection of prescription pads, and maintaining drug samples are all processes that require routine evaluation. The goal of successful medication management is to implement protocols that are followed consistently to prevent errors. Staff members should not renew medications without specific provider approval.

Medication management can be quite complicated, so when medication information is obtained from any source, whether it's a phone call, an office visit, hospital or consultant record, your office should establish a protocol to ensure your team appropriately handles the information every time. Your protocol should meet patient safety goals, be consistently followed and periodically revisited. Educate all staff on the intention behind the protocol so he or she will have a better understanding of the potential for harm when protocols are not followed. Without a standardized protocol for medication reconciliation, the reliability of the information recorded is variable and prone to error.

Tips for Reducing Risk

Safe medication practices in physician offices include many simple, low-cost system changes. The key strategies include simplifying and standardizing your systems related to medications. Processes that are cumbersome and inconsistent often lead to increased risk and error.

- Provide patients with clear instructions about medications at the end of the visit by using a visit summary or other discharge summary.
- Ensure tracking systems are in place so the patient is seen in follow-up and medication is appropriately monitored.
- Document any informed consent discussions, particularly when prescribing a high-risk medication. Determining which risks to discuss within the consent process should be based on the severity of the potential harm, the likelihood of occurrence, and the relevance to the patient.
- Keep patient education materials available for medications and document their use in the chart.
- Encourage patients to carry a current list of medications, including OTC and supplements at all times and to bring them to every visit.
- Remind patients to discard expired or unused medications that have been discontinued.
- Educate patients on the use of their medication, including the indication, side effects, potential for abuse and any required testing or follow up.
- Ask patients to use one pharmacy for all of their prescriptions.
- Improve continuity of care between healthcare facilities and providers.

- Improve accurate documentation of medication and monitoring.

The importance of maintaining a well-documented medical record cannot be overstated from both a patient care and a risk management standpoint. Inadequate documentation can negatively impact the ability to defend the care provided to a patient.

Other Risk Management Strategies

Other risk management strategies to ensure safe medication practices include the following:

- Evaluate your patient's medical literacy. Don't take for granted that your patients are as familiar with medical information as you are.
- Separate problematic (such as high-risk or sound-alike) medications from your sample or storage areas and control access to medications. Organize the sample closet by classification rather than alphabetically.
- Pay attention to EHR alerts and other clinical decision support tools.
- Utilize medication educational modules in your EHR or resources, including reminders for serial testing.
- Make certain all medication orders are complete and include the correct drug name, dosage, frequency, indication and refills if approved.
- Watch out for look-alike or sound-alike medications.
- Avoid confusing or non-standard abbreviations.
- Be sure to ask patients about any medication side effect or intolerance at every visit.

- Document the patient's full medical history, including social habits.
- Take the time to document **all** calls in which clinical information is exchanged, including with whom you spoke and the information or instructions given. SVMIC after-hour phone call pads are available [here](#) at no charge. Additionally, technology is now available that can assist physicians in documenting phone calls after hours with encrypted software on mobile phones.

Safe medication practices benefit everyone along the healthcare continuum and should be easy to identify and implement in your medical office. The key is to have well-organized records, consistent policies, well-trained staff and educated patients so preventable medication errors are a rare occurrence.

[1] <http://www.nccmerp.org>

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