Safe Medication Practices in the Physician Office

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In the 5 year period from 2018-2022, 27% of SVMIC's paid closed claims, across all locations, included a contributing factor of medication prescribing or management thereof. Top medications involved in claims are analgesics, anticoagulants, and antibiotics.

The Agency for Healthcare Research and Quality (AHRQ)[1] defines and categorizes medication events. An adverse drug event (ADE) is defined as harm experienced by a patient as a result of exposure to a medication. The occurrence of an ADE does not necessarily indicate an error or poor quality care; as only about half of ADEs are preventable. Preventable ADEs result from a medication error that reaches the patient and causes any degree of harm. Reducing the incidence of these events is the focus of this article. The majority of SVMIC claims involve the wrong drug or the wrong dose, which are considered preventable claims. The list below includes the other categories in SVMIC medication-related claims:

- Prescribing variance from the "Five Rights" (Right Medication, in the Right Dose, at the Right Time, by the Right Route, to the Right Patient)
- Contraindicated drug
- Prescription of drug despite documented allergy
- Injection-related injury (includes IV related injury)
- Drug reaction/side effects/toxicity (overdoses)
- Refusal to prescribe medication

Preventable ADEs are common 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 ADEs and protect patients.

Analysis of serious medication errors reveals a myriad of system flaws such as failure to follow protocols, not reviewing medication records, overriding alerts, poor communication, failing to act on results requiring medication management. Successful and thoughtful integration of information technology solutions along with consistent adherence to existing protocols can decrease system errors. Remember that effective communication can be another safety net. This is especially important during transitions of care such as handoffs and hospital discharges. It is important that patients understand the treatment plan, (including medications), expectations and patients should also have a post-discharge appointment.

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. While this may seem oversimplified, it is often a neglected step in the medication process. 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.

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.

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 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. Without a standardized protocol

for medication reconciliation, the reliability of the information recorded is variable and prone to error.

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. In addition to medications with an actual black box warning label, the Institute of Safe Medicine Practices (ISMP) has compiled a list of high-alert medications and drug classes/categories[2]. These medications may require extra precautions when administered, prescribed or dispensed. Drugs with a narrow therapeutic index should be closely monitored. Mistakes in dosing or insufficient monitoring of high-risk medications can lead to serious complications and adverse health effects.

Tips for Reducing Risk

Safe medication practices in medical offices include many simple, low-cost system changes. The key strategies include simplifying and standardizing your systems related to medications. Inconsistent or cumbersome processes often lead to increased risk and error.

- Provide patients with clear medication instructions 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 discussion, 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 medication usage, including the indication, potential side effects (including substance use disorder) and any necessary testing or follow up.
- Ask patients to use one pharmacy for all prescriptions.

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 medications in your sample or storage areas and control access to medications.
- Store injectables "label side up" and not "cap up".
- Pay attention to EHR alerts and other clinical decision support tools.
- Utilize medication 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 who you spoke with and what information/ instructions provided. Utilize technology that can assist in documenting care provided outside of the clinic.

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. For more information, please visit svmic.com.

[1] https://psnet.ahrq.gov/primer/medication-errors-and-adverse-drug-events

[2] https://www.ismp.org/assessments/high-alert-medications
