MEDICATION SAFETY

Medication errors and adverse drug events are a major cause of injury to patients in all types of care settings – including physician offices. Many of these events are preventable with careful attention to the numerous components of medication safety including medication storage, prescribing, administering medications in the office, patient education, and record keeping.

Medication Storage and Control

Systems for medication storage and control that help prevent unauthorized access and guard against errors in dispensing (e.g. the use of expired drugs) are important components of patient safety in an office practice. To safeguard medications in your office you can:

- Store drugs, syringes, and needles in a secure room or location.
- Restrict access to controlled substances to authorized individuals, and take regular inventory.
- Require pharmaceutical sales representatives to log in sample drugs with their name, drug(s) delivered, lot numbers, quantity, and expiration date.
- Maintain logs for controlled substances and sample drugs that account for every dose distributed – note the date of dispensing, the patient's name, medication name, amount dispensed, manufacturer, lot number, and the dispensing practitioner's name (may document sample medications given out on the logs started by the pharmaceutical representatives to avoid duplication of efforts).
- Report the loss or theft of drugs to the police, the Drug Enforcement Agency (DEA), and applicable state authorities, as required.
- Check expiration dates of all medications, including vaccines and sample drugs, on a regular basis.
- Dispose of outdated medications in a manner that prevents unauthorized access and that conforms to local/state regulations regarding disposal of drugs.
- Secure prescription pads from unauthorized access.
- Report the loss or theft of prescription blanks and/or pads to the Office of Drug Control (NJPB Unit) within 72 hours of notice of loss or theft, and local pharmacies.

Medication Lists

Patients may see more than one physician or other practitioner; they are also likely to medicate themselves with over the counter (OTC) medications and supplements. Understanding all the drugs that your patient is taking may help you make decisions on their care. It is important, therefore, to:

- obtain a complete drug history – including prescription, OTC, vitamins, herbal products, and illicit drugs – at every patient's initial visit and update it upon each visit or patient call
- consider doing periodic "brown-bag check-ups" by having patients bring in for review in your office all prescription, OTC, vitamins and herbal medications they take
- use a medication flow sheet for all prescriptions and file it in a prominent place in the patient charts in order to have ready access to the patient's current and past drug history for treatment efficacy, to avoid medication interactions, and to track refills and renewals
- document all medication orders – including refills – in a prominent location (perhaps on or with the medication flow sheet) in the patient's chart
- if a patient is referred or transferred to another practitioner outside of the practice, provide a complete list of the patient's current medications

Allergy Documentation

- list patient drug allergy/sensitivity information in a prominent location in the patient's chart
- allergy information should include the name of the drug or other allergen such as latex, the date the allergy is identified, and the type of reaction or intolerance
- update the allergy list regularly and whenever you prescribe a new medication or make a change in medication
- if no known allergies, state so in the record – do not leave blank

Prescriptions

Prescriptions are a routine part of most practices. If the practice has a carefully developed set of processes to guide prescription writing and refills, and if the practice follows those processes faithfully, their liability should be minimized. Examples of these processes are:

- write or print prescriptions clearly and legibly to avoid errors
- use a current *Physician's Desk Reference*
- restrict handling of prescription refills and medication administration to staff that have been appropriately trained and credentialed
- do not routinely prescribe medications by telephone; if done on occasion do only when the prescriber is sufficiently familiar with the patient and his/her history
- document all medication orders in the patient's chart
- require that verbal orders be repeated or "read back" by the person taking the order, and again by the prescriber
- verbal orders to office staff for medication prescriptions or refills must be entered in the chart at the time of ordering, and signed later by the prescriber
- the patient's chart should be reviewed prior to refilling a prescription per phone request
- if the patient asks for a refill of a prescription and has not been seen in the office for that condition for a while, a limited amount may be prescribed until the patient can be reevaluated (this is particularly important for patients taking medications which require monitoring like anticoagulants, or which can be abused like opioids)
- medications such as anticoagulants which require routine lab tests for blood levels should be tracked as a group; that is, all patients taking that type of medication should be followed as a high-risk group within the practice, utilizing a special flow sheet which tracks their dosages, prescriptions, refills, and lab work; careful monitoring of their condition is necessary for good patient safety and reduced liability

Patient Drug Education

Take time to teach patients about new prescriptions and provide the following information:

- name (brand and generic) and purpose of the drug
- dosage and frequency
- route
- possible side effects and those that need to be reported to the doctor
- foods, beverages, or other medications/herbal remedies to avoid
- duration of the medication therapy
- refill status

Document any special instructions given. Also, if you prescribe an off-label use of a drug, document the applicable professional reference regarding this decision.

Medication Samples

In addition to recording the dispensing of medication samples in the patient's medical record, it's important to have a comprehensive system to track all medication samples received and dispensed, in case of a recall. This information should be maintained for at least six months to a year. Though there are various types of systems you can use, one type is a log located near the sample closet/area.

When using a log system, your practice can use one log to track receipt and dispensing of samples, or it can use a dual log system to do the same thing. In either case, to reduce staff workload, the pharmaceutical representative who drops off samples should be required to fill in the log for samples received. Staff and/or physicians would then fill in the part of the log which records which samples are dispensed.

Administering Vaccines, Medications, and Allergens in the Office

If your practice includes the administration of medications, allergens, or vaccines there are special concerns to be addressed. Injectable medications may have special side effects, or require specific injection techniques. Vaccines require very precise storage and are to be matched carefully by technique and route to the right age group (especially in children). With that in mind, your processes may include:

- proper vaccine storage, which includes using refrigerators without freezers to maintain temperatures with minimal fluctuations
- removal and non-use of any vaccine which has been exposed to freezing temperatures
- use of the seven ”rights” of vaccine administration as advised by the Centers for Disease Control (CDC)
    - right patient
    - right vaccine
    - right time (patient is right age, vaccinated at the right interval)
    - right dose (based on age of patient, not weight)
    - right route (oral, intranasal, subcutaneous, or intramuscular)
    - right site (dependent on right route and age of patient)
    - right documentation
- proper handling of injectable medications
    - note if injection requires a special technique such as a ”z” technique for injectable iron
    - make sure that staff are aware of this need and trained in the technique
    - advise patients of possible side effects of some injectables, such as tissue atrophy with some injected steroids
    - use of a double-check system for routine injections such as allergens, where the routine nature of the task can lead to error