

Doctor's Digest PODCAST Best Practices: Patient Safety "Medication Safety"

Hello and welcome to this new series of podcasts brought to you by the publishers of *Doctor's Digest*, bridging the gap between the business of medicine and the practice of medicine, with single-topic manuals that provide practical solutions from the experts.

Given the alarmingly high number of medication errors, how hard is it to ensure medication safety for your patients? As it turns out, it may be easier than you might imagine, given today's tools like electronic prescribing and medication reconciliation.

The first of these—electronic prescribing, or e-prescribing—not only streamlines the entire prescription process; it also eliminates written errors and prevents misinterpretation. No more struggling on the part of a nurse or pharmacist to decipher your scribbled prescription, which too often leads to the wrong drug or the wrong dose. No more efforts to figure out whether a word is Celexa or Celebrex or another name entirely. No more confusion when a prescription gets faxed to a pharmacy. Most e-prescribing programs allow you to select from a list of medications that have already been loaded into the program, according to Dr. Bruce Bagley, medical director for quality improvement for the American Academy of Family Physicians. In his internal medicine practice in Albany, New York, only the pharmacist can add a drug to the e-prescribing module—an effective way to maintain quality control, according to Dr. Bagley.

One way e-prescribing programs make it harder to introduce quantity errors is by narrowing your options. "If a medicine is available only in 20 milligrams, there's no way to select 200 milligrams by mistake," Dr. Bagley explains. You can even use e-prescribing tools to check for medication allergies and drug-drug interactions, especially in elderly patients, who may be taking a long list of medications. According to Dr. Bagley, that complicated cross-referencing check "is something you just can't do in your head, no matter who you are." More and more physicians are taking notice of the benefits of e-prescribing. Between 2007 and 2008, the volume of e-prescribing messages doubled to over 240 million nationwide.

Medication reconciliation is another tool that can help ensure medication safety. This two-step process can keep your practice current on exactly what medications your patients are taking. For example, suppose you haven't seen Mr. Smith for a year: In that time he may have been prescribed any number of new medications by his ophthalmologist, his dentist, his mental healthcare provider, or any other member of his healthcare team. And Mr. Smith may have decided on his own to take nutritional supplements that could affect his prescriptions and his overall health. All these changes need to be logged into his record.

The first step is for you or a member of your staff to compile a list of your patient's medications. This list should, of course, be as current as possible and should include each medication's name, dosage, frequency, and mode of administration. The second and final step is for that same staff member to compare, update, and reconcile this list with any other lists of his or her medications that may exist from a hospital, a walk-in clinic, or any other place the patient has been treated.

It's critical for your practice to take this step since a given medication list is not always updated and reconciled at each transition point as your patients moves through the various stops in the healthcare system. Medication reconciliation, in fact, is so essential that it has been named one of the Joint Commission's National Patient Safety Goals.

How will this procedure affect medication safety? According to *Medication Reconciliation Review* by Luther Midelfort of the Mayo Health System, "Experience from hundreds of organizations has shown that poor communication of medical information at transition points is responsible for as many as 50% of all medication errors and up to 20% of adverse drug events in the hospital."