

Tip #3: Prescription Medications and Patient Safety

The Risk: Medication errors result in a significant portion of medical liability claims. Patient harm can result from known risks, adverse or allergic reactions, drug interactions, and errors in prescribing. Careful attention to detail in prescribing and monitoring the use of medications promotes patient health and safety.

Recommendations:

- 1. Physicians must discuss the indications, risks, benefits, and alternatives of prescription medication with their patients and document these discussions in the medical record.
- 2. The patient's allergy history should be reviewed prior to prescribing.
- 3. Allergies/sensitivities should be documented in a highly visible and pertinent part of the record.
- 4. Medication reconciliation should be performed on a routine basis, including the use of herbal supplements and over-the-counter drugs. Patients should be encouraged to bring a list of medications or actual prescription bottles to their visit(s) to facilitate this process.
- 5. Written consent should be obtained for high-risk medications such as allergy shots, joint injections, fertility medications, chemotherapy, etc.
- The blood levels/side effects of certain medications should be monitored with laboratory and/or diagnostic tests as indicated. Test results should be reviewed, and adjustments made as necessary.
- 7. Discontinuance of or a change in medication(s) should be documented in the medical record, including the rationale for the change.
- 8. Patient visit intervals should be established for the continuance of prescription medications.