RISK Q&A
High-Alert Medication Monitoring

MedPro Group
a Berkshire Hathaway company

Question:

Our practice has recently experienced several "near misses" related to either dosing or follow-up of high-alert medications that we have prescribed for our patients. What safeguards should we implement to prevent a medication error that may cause extreme harm to one of our patients?

Answer:

According to the Centers for Disease Control and Prevention (CDC), adverse drug events cause 700,000 emergency department visits and 120,000 hospitalizations annually.[1] Studies show that insulin, anticoagulants, narcotics/opioids, and sedatives are the high-alert medications responsible for the majority of harm due to medication errors.[2]

Consider implementing the following risk strategies to minimize the potential for harm to your patients taking high-alert medications:

- First and foremost, if your practice does not already have a written standard procedure for test tracking, develop one that includes guidance for reviewing test results and documenting communication and follow-up with patients.
- Identify all high-alert medications that your practice prescribes or administers. The Institute for Safe Medication Practices (ISMP) provides a list of high-alert medications for community and ambulatory healthcare settings (http://ismp.org/tools/highalertmedicationLists.asp).
- Develop standard protocols for monitoring patients receiving high-alert medications. At minimum, standard protocols should include frequency of assessment and blood monitoring, parameters for tracking lab results and adjusting medications, and guidance for patient/family education. Consider using a medication monitoring service or implementing one of your own (e.g., a warfarin clinic).
- If you have an electronic health record, enable pertinent medication alerts and track pending test results and patient notifications, as well as other elements of your standard medication safety protocols.
- Conduct medication reconciliation during each patient encounter and resolve medication discrepancies when they are discovered.
- Utilize data obtained from prescription monitoring programs and pain management contracts when prescribing narcotics, or refer patients to pain specialists as appropriate.

- Define and communicate each healthcare team members' role relative to medication management, especially when high-alert medications are involved. Provide staff with medication management education.
- Design a process for tracking adverse events. Debrief "near misses" and adverse events with your team to learn from each occurrence and to prevent future adverse events from happening.

Resources:

- Centers for Disease Control and Prevention: Medication Safety Program — http://www.cdc.gov/medicationsafety/
- Creighton Health Services Research Program: Medication Safety Best Practices Guide for Ambulatory Care Use — https://spahp.creighton.edu/sites/spahp.creighton.edu/files/basic-page/file/BestPractices.pdf
- Institute for Safe Medication Practices: Medication Safety Tools and Resources — http://www.ismp.org/tools/default.asp
- U.S. Food and Drug Administration: FDA and ISMP Work to Prevent Medication Errors — http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm297644.htm
- U.S. Food and Drug Administration: FDA's Safe Use Initiative Report — http://www.fda.gov/downloads/Drugs/DrugSafety/UCM188961.pdf

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[1] The Centers for Disease Control and Prevention. (2012, August). Medication safety basics. Retrieved from http://www.cdc.gov/medicationsafety/basics.html

[2] Health Research and Educational Trust. (2012). Implementation guide to reducing harm from high-alert medications. U.S. Department of Health and Human Services. Retrieved from http://www.ihconline.org/UserDocs/Pages/HRET_HEN_Change_Packages_AllMay2012.pdf