



Do You Have a Consistent Prescription Process?

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Do You Have a Consistent Prescription Process?

Approximately two out of every three office visits result in a prescription. A study by the Agency for Healthcare Research and Quality indicated that 60 percent of reported errors in the office setting associated with harm involved prescription errors. The following are recommendations to improve the medication prescription process in the office setting:

- Physicians should write understandable, legible prescriptions and include the indication for the medication on the prescription.
- Use sample medications with care, if at all. If you have them in your office and give them to patients, do you keep an inventory and purge samples as they expire? If a patient gets samples, does the record reflect what the patient got and why? Sample medications contain the pharmaceutical insert which is usually written at a post-graduate level and not readily understood by patients. The patient might be better served receiving the instructions provided at their level by their pharmacy.
- Maintain accurate and usable medication lists and reconcile medications regularly. Physicians and their staff need to confirm the medications that all their patients are taking at every visit,

including herbal and over-the-counter. When discrepancies are found, it is the physician's task to resolve these.

- Institute consistent policies and procedures for medication refills. There is a risk that an experienced staff member, who does not have the authority to prescribe but who thinks they know what the physician would do, will authorize refills. Refills should be approved by the physician or a designated and properly trained member of the staff - preferably an advanced practice professional.
- Consider using an electronic prescribing system. An electronic prescribing system, especially when interfaced with an electronic health record (EHR), has the potential to decrease errors from illegibility and interactions. Direct electronic transmission to pharmacies has the potential to decrease errors even further, although little data currently exists to support this.

According to the National Institutes of Medicine, prescription errors are among the most expensive allegations when claims are made. If the errors are made by staff working outside their scope of practice, the allegation of failure to supervise or monitor care comes into play, which can be even more costly.

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