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MLMIC Risk Management Tips

Tip #3: Prescription Medications and Patient Safety

The Risk: Patient injuries and malpractice claims can result from known risks and side effects, allergic reactions, drug interactions or errors in prescribing.

Recommendations:

- 1. Since there are significant risks and side effects associated with prescribed drugs, physicians must discuss this information with their patients and document these discussions in the medical record.
- 2. The patient's allergic history must be reviewed <u>before</u> a new drug is prescribed. Known allergies must be documented and flagged in a prominent, easily viewable place in the medical record.
- 3. Medication updates, including dosage changes and refills, and the use of any over-the-counter drugs, must be clearly documented in the medical record. A medication flow sheet can be used to monitor and track current and past medication usage, as well as allergies.
- 4. Any specific instructions provided to patients regarding the medications must also be written in the record.
- 5. There must be written confirmation that the laboratory and/or diagnostic tests necessary to monitor certain drugs for their effectiveness or side effects are ordered, as recommended by professional guidelines, and the test results viewed and necessary adjustments made.
- 6. The rationale for the discontinuing a medication must be documented in the medical record.