

“How To” Maximize Patient Safety When Handling E-Prescriptions in the Pharmacy

E-prescribing can greatly reduce adverse drug events and significantly streamline pharmacist workflow for new prescriptions and refills, but a new awareness is needed to manage potential risk to patient safety.

Getting Ready

Ensure the basics are in place to support electronic prescribing:

- The pharmacy system is capable of sending and receiving e-prescriptions in the electronic digital interchange format (direct to computer, not fax).
- All staff (including temporary and float staff) are trained to receive new e-prescriptions and generate electronic renewal requests.
- A disaster plan describes how to handle electronic prescriptions when the power is out or connectivity to the network is lost.

What to Look for

Selection Error: Provider systems frequently use drop-down lists and table formats. Selection error may occur with pharmacy, drug name, formulation, dose, or instructions. Have a low threshold for clarification with the provider for:

- Prescriptions for an unknown patient or from an unknown provider.
- Medications with alphabetical proximity.
- Medications available in multiple formulations.
- Medications with multiple dosing regimens.

The best defense: Ask for the medication’s indication.

The opportunity: Office staff often assist with prescriptions, but are confronted with unfamiliar drug names and formulations in electronic systems. Take a moment to provide education.

Clerical Error: Auto complete, auto-calculation, and different ways of presenting dispense quantities may lead to clerical errors. Watch for:

- Dispense quantities greater (or less than) three times the expected.
- Doses and quantities for topical, liquid, injectables, compounded, and inhaled medications as these are most prone to auto-calculate errors.

Other Tips

- Remember: a computer is not a substitute for clinical knowledge. Just because the information is on the computer screen does not mean it is correct.
- Be on guard for any electronic prescription that contains spelling errors in the drug name. This indicates a free-text prescription that was not checked for interactions in the provider system.
- For larger pharmacies, develop an early warning system to notify both the local pharmacy and providers when e-prescribing is not working.

Resources

For more information about technology and safety:

<http://www.ismp.org/>

<http://healthit.ahrq.gov> (Click on e-prescribing)

<http://www.surescriptsrxhub.com>

[Healthcare stakeholders release "How-To" Guide to help clinicians switch from paper to e-prescribing systems.](#) (Article link in PSQH)

For more information on implementing safe e-prescribing habits in your practice:

Hale, Patricia L: *Electronic Prescribing for the Medical Practice: Everything You Wanted to Know But Were Afraid to Ask*. Chicago: HIMSS; 2007.

<http://marketplace.himss.org/acct618b/Default.aspx?tabid=39&action=T&args=ERX>

Van Ornum, Michael: *Electronic Prescribing: A Safety and Implementation Guide*. Jones & Bartlett: Sudbury, MA; 2008. <http://www.jbpub.com/catalog/9780763758493/>