Notifying pharmacies of discontinued prescriptions helps reduce safety events

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Many prescriptions are sent to the pharmacy via electronic health record systems; however, correct routing of discontinued medications continues to be a problem, which increases the risk for medication safety events. In

an abstract presented at the American College of Cardiology Quality Summit Virtual, taking place Sept. 29—Oct. 1, 2021, Intermountain Healthcare examined several methods to alert community pharmacy staff about canceled medications, potentially avoiding almost 200 safety events over two months.

"Currently there is no ideal way to notify a pharmacy that a clinician has discontinued medication for a patient, often leading to a discontinued medication or incorrect dose to be refilled and causing confusion for the patient," said Jeffrey A. Goss, FNP-c, MSN, APP Director of Heart Failure for Intermountain Healthcare in Murray, Utah, and one of the study authors. "Patients are at risk for taking a medication that is no longer indicated or at the wrong dose, which has important medication safety indications."

The study was designed to determine why pharmacy communication on canceled medications was not occurring and identify the best way to communicate those changes from the patient encounter to the pharmacy. According to the researchers, Intermountain Healthcare had a number of safety events occur involving discontinued medications being taken along with new medications, resulting in hospitalization.

Initially, the team at Intermountain Healthcare tried temporary fixes, including clinical staff (registered nurses or pharmacists) personally calling the pharmacy to alert them of medication changes and requesting the medication be removed from the patient's profile. Clinicians were also asked to document medication changes in the "comments" box of a prescription being sent electronically to alert pharmacy staff about medication changes. This includes documenting information such as, "this prescription replaces…," but not all pharmacies see this information and it was not a reliable method of communication.

Over the course of 60 days, 16 advanced practice providers at the

Intermountain Medical Center Advanced Heart Failure/Transplant team turned on the CancelRX functionality in their electronic medical record system. CancelRX is a function that notifies the pharmacy of a discontinued medication as it would a new prescription. The functionality was initially turned off due to a high number of associated error messages to clinicians. It is also dependent on the pharmacy also having this functionality turned on to receive the messages.

During the CancelRX trial, the Intermountain Medical Center Advanced Heart Failure/Transplant team tracked a totally of 558 discontinued medications. The team received 359 error messages and made 148 phone calls to pharmacies. In total, 196 potential safety events were avoided using both phone calls and CancelRX during the 60-day trial. The five pharmacies or chains where error messages were received by the trial team included Intermountain Pharmacies (210), Smiths (117), Walgreens (38), Costco (25) and CVS (23).

"Effective communication between the clinician and the pharmacy is paramount to ensuring patients only received medications they require. In addition to the safety implications, this will also reduce the likelihood of a patient purchasing a discontinued prescription, resulting in cost savings for patients and insurance payers," said Steven Metz, PharmD, BCPS, Advanced Clinical Ambulatory Care Pharmacist, Intermountain Healthcare in Murray, Utah, and one of the study authors.

According to the researchers, better outcomes are inherent if the correct medications are being dispensed to patients based on clinician recommendations. They recommend health systems review how their electronic medical record system interface with their local pharmacies to ensure one less area of potential error in patient care.

More information: Summit: cvquality.acc.org/acc-quality-summit

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