Nurse Practitioner Spotlight: Prescribing

Nurses Service Organization (NSO), in collaboration with CNA, has published our 5th Edition of the NSO/CNA Nurse Practitioner Liability Exposure Claim Report. It includes statistical data and case scenarios from CNA claim files, as well as risk management recommendations designed to help nurse practitioners (NPs) reduce their malpractice exposures and improve patient safety.

You may access the complete report, and additional Risk Control Spotlights, at: www.nso.com/NPclaimreport.

This Nurse Practitioner Spotlight provides insight into professional liability and license protection exposures related to prescribing - one of the most significant topics in the report and for NP professionals. Claim scenarios from the dataset will be utilized to exemplify specific clinical risks. In addition, risk management strategies for enhancing patient safety and mitigating risk will be discussed.

Professional Liability Claims Related to Prescribing

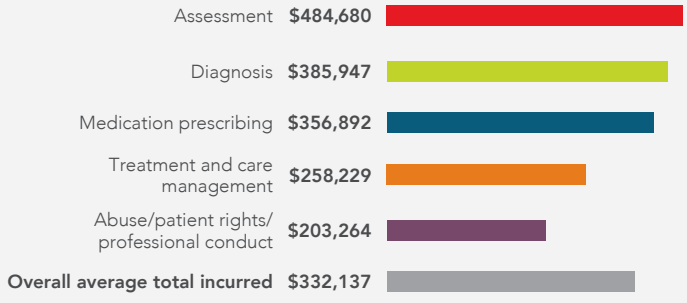
According to the 2022 American Association of Nurse Practitioners® (AANP) Workplace survey, 96.2 percent of NPs prescribe medications, and those in full-time practice write an average of 21 prescriptions per day. While prescribing is an essential daily process for most NPs, it may be a significant source of risk if patient safety measures are not implemented. In the 5th Edition of the *NSO/CNA Nurse Practitioner Liability Exposure Claim Report*, **17.7 percent** of all closed claims involved allegations related to medication prescribing. These claims had an average total incurred of $356,892, which is greater than the overall average total incurred for all claims in the dataset ($332,137). (See Figures 10 and 11.)

The distribution of allegations related to medication prescribing has fluctuated in past CNA/NSO NP claim reports. For example, in the 2017 dataset, allegations related to medication prescribing increased significantly to 29.4 percent when compared to the 2012 dataset of 16.5 percent. The increased frequency of medication-related allegations in the 2017 dataset was due, in part, to the improper prescribing/managing of controlled drugs, including schedule II and schedule III opioids such as methadone, oxycodone, fentanyl and hydrocodone. However, in the 2022 dataset, the percentage of closed claims related to medication prescribing decreased to 17.7 percent as compared to the 2017 dataset of 29.4 percent. This decrease may be attributed, in part, to the changing nature of the opioid epidemic, as well as opioid prescribing guidelines established by professional healthcare associations and state and federal regulatory agencies in response to the opioid epidemic in the mid-2010s. In the 2022 dataset, many of the medication prescribing claims were characterized as being difficult to defend. These claims involved failure to recognize known contraindications/adverse reactions among ordered medications, improper prescribing/management of anticoagulants and improper prescribing/management of controlled drugs.

10 Average Total Incurred of Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

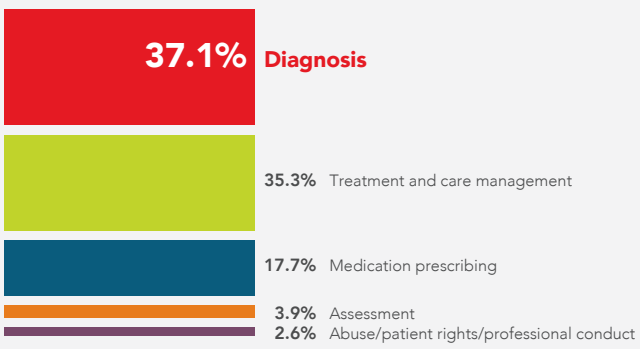
This figure highlights only those allegations with the highest average total incurred.



11 Distribution of Top Closed Claims by Allegation

Closed Claims with Paid Indemnity of ≥ $10,000

This figure highlights only those allegations with the highest distributio



Prescriptive Authority

Prescriptive authority is a significant aspect of every NPs scope of practice, as well as a significant source of risk. The AANP notes that, "prescribing is not a distinct act outside of or differentiated from NP practice. The authorization of NPs to prescribe legend and controlled medications, devices, health care services, durable medical equipment and other equipment and supplies is essential to providing timely, cost-effective, quality health care" (AANP, 2020). According to the AANP, the majority of states currently have enacted full practice authority laws, authorizing NPs to evaluate patients, diagnose, order/interpret diagnostic tests, and initiate/manage treatment, including prescribing medications. Prescriptive authority, as a subset of practice authority, is state-specific. Therefore, it is important for NPs to remain abreast of state-specific regulations regarding prescriptive authority as this information may be subject to change. A state-specific chart promulgated by the Drug Enforcement Administration (DEA) provides details related to NP prescriptive authority for controlled substances.

DEA Licensure

Federal regulation requires NPs who administer or prescribe controlled substances to obtain a Drug Enforcement Administration (DEA) license for the purpose of tracking controlled substances prescriptions and overseeing prescribers. For additional information on how to register for a DEA license, see the AANP website.

Prescribing Controlled Medication via Telehealth

Prescribing controlled medications via telehealth presents unique risks to NPs, as rules and regulations vary from state to state and may change with respect to the expansion of telehealth. During the COVID-19 public health emergency, authorized providers were allowed to prescribe controlled substances via telehealth, without the need for an in-person medical evaluation. With the end of the COVID-19 public health emergency on May 11, 2023, laws and regulations may change the flexibilities established during the pandemic. Therefore, NPs must be knowledgeable about federal legislation, as well as telehealth licensure requirements regarding telehealth encounters where controlled medications are prescribed. Additional information will be available in an upcoming Spotlight on the topic of telehealth.

Common Prescribing Risks

Controlled Substances

One of the major factors leading to medication prescribing allegations for both professional liability and license protection matters in the 5th Edition of the NSO/CNA Nurse Practitioner Liability Exposure Claim Report involved prescribing opioids and other controlled substances in a manner inconsistent with the applicable standard of care. In prescribing controlled substances, another critical challenge involves discerning the clinical need for pain control while minimizing the risk of misuse, overuse, toxicity, diversion or the development of an opioid use disorder.

Commonly used prescribing screening tools include:

- CDC Clinical Practice Guidelines for Prescribing Opioids for Pain
- Diagnosis, Intractability, Risk, Efficacy (DIRE)
- Screener and Opioid Assessment for Patient in Pain (SOAPPR -R)

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Patients experiencing pain should be given a comprehensive physical and have a history taken, including an assessment of psychosocial factors. NPs should reevaluate the level of pain and the efficacy of the treatment plan at every visit, as individuals have different pain tolerance levels and require variable opioid doses to achieve pain relief. The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain offers recommendations for clinicians pertaining to opioid selection, indications for use, dosages, duration of treatment, follow-up and the potential risks, among others. The guideline provides recommendations for primary care clinicians and other clinicians providing pain care, including those prescribing opioids, for outpatients aged ≥18 years. It also includes recommendations for acute pain (duration of 3 months), subacute pain (duration of 1–3 months), or chronic pain (duration of >3 months). The recommendations do not apply to pain related to sickle cell disease or cancer, or to patients receiving palliative or end-of-life care.

To minimize the risk of abuse, NPs must comply with applicable state Prescription Drug Monitoring Program (PDMP) requirements, conduct an opioid risk assessment and depression scale test before prescribing opioids, and perform periodic screening thereafter. The focus of the PDMP is to identify patients who may be misusing or diverting opioid medications. State-specific PDMP information, including training and state statutes, can be found here.

Remember that NPs, similar to all healthcare providers, have the right to determine whom they will treat. However, improperly discharging a patient in chronic pain also may lead to State Board of Nursing (SBON) complaints or legal action. NPs can help protect themselves against allegations of abandonment by rigorously documenting instances of patient non-adherence, communicating clearly and straightforwardly with patients, establishing and consistently implementing formal policies and procedures, as well as providing the patient and/or their caregiver with a written plan of care. Care plans often will include pain management agreements, which help to establish patient expectations about the treatment with the goal of creating a shared understanding between the NP and patient. Pain management agreements represent a means to facilitate provider-patient communication. These agreements also may be used to educate patients preparing to undergo treatment with opioid analgesics or other controlled substances about their roles and responsibilities regarding treatment and reasons why the treatment may need to be discontinued.

Claim scenario involving substance use disorder

The following claim scenario exemplifies the importance of obtaining a complete medical history, and performing medication reconciliation, prior to prescribing controlled substances. In this claim, a psychiatric patient died by suicide via a medication overdose. The treating Psychiatric Mental Health-NP (PMH-NP) failed to review the patient's history and to order the required drug screen, which would have revealed the patient's history of misusing controlled substances. The patient had a past psychiatric history of depression, anxiety and ADHD, including a long history of using controlled substances for back pain. The patient was referred to the insured PMH-NP for outpatient psychiatric treatment and medication management. There were indications, i.e. "red flags," of a potential substance use disorder in the patient healthcare information record, including multiple prescriptions for controlled substances by several providers. A notation also stated that the previous provider had discharged the patient for non-adherence with the opioid medication plan. However, the PMH-NP failed to contact the referring provider to discuss the patient's history and reason for the referral and did not request the previous providers' healthcare information records prior to initiating treatment. After several months of treatment, the PMH-NP recognized that the patient was not adhering to the medication treatment plan. As a result, the PMP-NP discharged the patient from the practice and referred the patient to alternative providers for continued care. Subsequently, the patient sought treatment with another provider who continued to prescribe controlled substances. Shortly after initiating treatment with a new provider, the patient expired from an overdose.

Although it was unclear if the medications prescribed by the insured PMH-NP were used in the lethal overdose, defending the PMH-NP was challenging due to the lack of documentation of critical information such as patient history, drug screens and telephone encounters. Although the PMH-NP's prescriptions for psychiatric medications were appropriate, ultimately, the failure to obtain a comprehensive medical history and refer the patient for substance use disorder treatment complicated the defense of the PMH-NP's care. The claim was resolved on behalf of the insured PMH-NP with a total incurred amount of more than $425,000.

FDA Box Warnings: FDA Box Warnings, formerly known as "Black Box Warnings," may be added, by the manufacturer, to the label of a drug to notify providers about potential serious adverse side effects. In addition to "box warnings," the FDA may require a manufacturer to send out a "Dear Health Care Provider" (DHCP) letter to alert physicians and other health care providers about important new or updated information. The FDA provides the following advisement to clinicians regarding the purpose of "box warnings":

- "To highlight for clinicians that there is an adverse reaction so serious in proportion to the potential benefit that it is essential that it be considered in assessing risk/benefit of using;
- There is a serious adverse reaction that can be prevented or reduced in frequency or severity (e.g., patient selection, avoidance of concomitant therapy, addition of another drug or managing patients in a specific manner, avoiding use in a specific clinical situation) or
- The FDA approved the drug with restrictions because the FDA concluded that the drug can be safely used only if use is restricted."

It is important for NPs to be cognizant of "box warnings." Professional liability risk exposures may be related to whether or not the medication with a "box warning" was prescribed and monitored appropriately. NPs should periodically review the product labels of commonly prescribed drugs and monitor them for FDA alerts.

Informed consent should be conducted by NPs when prescribing controlled substances, drugs with "box warnings," off-label medications or other medications that may have the potential for serious side effects. Informed consent is a process, and not simply a form. It should include a discussion with the patient about the risks and benefits associated with the proposed medication, alternative treatment options, as well as the risks associated with not taking the medication. For informed consent specific to opioid medications, patients should be informed of the short- and long-term side effects, drug-drug interactions, as well as the risks related to misuse, physical dependence and tolerance. Patients also must be educated about proper disposal methods and warned against sharing or selling opioids.

The informed consent discussion must be documented in the patient healthcare information record and include the NPs rationale for prescribing the medication based upon the patient's condition. Questions asked by patients and caregivers and the NP's responses should be included in the informed consent documentation. Documenting that effective alternatives were considered, as well as the rationale for proceeding with prescribing a medication with a "box warning," may assist in the defense of a claim or license protection matter involving prescribing medications with "box warnings."

Prescribing Off-label Medications

Pharmaceuticals and medical devices are approved or cleared by the FDA for specific clinical indications. Providers may determine that, in their professional judgment, a drug or medical device may be beneficial for conditions other than those approved or cleared by the FDA. This practice, known as "off-label use," may involve:

- Prescribing a drug or using a medical device for a clinical indication or therapeutic purpose that has not been officially approved or cleared by the FDA.
- Selecting a drug dose, duration of use or mode of administration, or a medical device setting or treatment length, which differs from what the FDA has approved or cleared.
- Combining, compounding or mixing drugs into a product not approved or cleared by the FDA.
- Prescribing a drug for patients of a gender or age cohort other than the population for which it was approved or cleared by the FDA.

The FDA views off-label use as an acceptable practice, as long as prescribers are familiar with the product, base the decision on scientific rationale and established guidance, and maintain records of the product's use and effects. Most states have not specifically prohibited off-label prescribing by NPs. In general, NPs must prescribe within their state scope of practice, and, unless the protocol or practice agreement with the supervising physician has express restrictions on off-label use, NPs may prescribe medical products for a non-FDA approved purpose if the use is supported by peer-reviewed literature. In states where protocols are required, the protocol should be incorporated in the practice agreement, with verbiage indicating that the physician agrees to off-label use, naming the specific drug and condition to be treated.

Off-label use of drugs is not without risk. Adverse patient outcomes may result in professional liability claims against providers alleging negligence and failure to obtain informed consent. Research revealed the most common adverse outcomes associated with off-label drug use were nonspecific gastrointestinal symptoms, hemorrhage, anticholinergic syndrome, neuroleptic malignant syndrome, and injuries due to drug side effects, interactions or misuse.

An informed consent discussion should be conducted with the patient, a consent form signed and a progress note included in the healthcare information record indicating that the patient understood the meaning of off-label use, had an opportunity to ask questions and that alternative treatments were discussed. The informed consent process should include, but is not limited to, the following:

- Patient education about the proposed off-label use and the use for which the medication received FDA approval.
- The potential risks, complications, side effects, and contraindications associated with the medications and if known, those specific to the off-label use,
- The fact that not all of the risks relating to the off-label use may be known, and that there are no guarantees about the results.

Risk Evaluation and Mitigation Strategy (REMS): REMS is an FDA program that requires providers to engage in medication safety protocols for the purpose of preventing serious adverse events associated with high-risk medications. This program may require that healthcare settings, prescribers, and/or pharmacies become certified and monitor patients according to a specific protocol. A REMS protocol also may be required for medications requiring laboratory testing for screening or monitoring purposes. NPs should be knowledgeable about and adhere to applicable REMS protocols.

Medication Reconciliation

Ensuring the accuracy of patient medication lists is of paramount importance for safe prescribing. Medication reconciliation is defined by the Centers for Medicare & Medicaid Services (CMS) as "The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider." Medication reconciliation, especially during transitions of care, is a shared responsibility between all members of the healthcare team across the continuum of care.

According to the Institute for Healthcare Improvement (IHI), incomplete or erroneous medication lists have been shown to be a causative factor in medication errors and adverse drug events. National patient safety initiatives aimed at ensuring up-to-date medication lists underscore the importance of medication reconciliation in preventing medication errors. For example, The Joint Commission (TJC) National Patient Safety Goal® (NPSG.03.06.01) highlights the need to eliminate medication list discrepancies involving "omissions, duplications, contraindications, unclear information and changes." TJC acknowledges that there may be impediments to the process, as it relies upon the patient's ability to provide accurate information.

Challenges often arise when care is being provided in acute or episodic care settings, where patients may not be able to communicate about their medications due to the acuity of their illness, or in aging services settings where residents may undergo more frequent care transitions and have multiple comorbidities. Information- sharing during these encounters may rely on caregivers, family members or emergency transport teams, who may not possess accurate knowledge about the patient's medications. Individual patient factors, such as advanced age, health literacy, language differences, and hearing or cognitive impairments, among others, may also confound the matter. Other barriers to the process include the interchangeable use of brand and generic drug names, which may result in patient confusion, and technology risks associated with multiple users inputting medication information into the electronic medical record.

Although there is no panacea for the challenges associated with the complex and labor-intensive process of medication reconciliation, efforts to improve the process should focus on standardization of systems and community education. Multidisciplinary teams should routinely evaluate organizational processes in order to identify gaps and opportunities for system-wide improvement. Patient/caregiver involvement in the medication reconciliation process is critical and should include accommodations for issues limiting their ability to understand and/or communicate about medications.

Technology Risks

Computerized Provider Order Entry (CPOE): CPOE was developed to improve medication safety and has been shown to mitigate risks related to transcribing and illegible orders. Although CPOE affords NPs ease of medication ordering and provides numerous safety features, including clinical decision support tools, unintended risks also may result in prescribing errors including, but not limited to, the following:

- **Drop-down lists/Look-alike Drug Names:** Drug names with similar appearances on CPOE drop-down screens may create the potential for a prescribing error, e.g. hydrOXYzine and HydrALAZINE. Documenting an indication or reason for prescribing the medication serves as a safety net for the pharmacist dispensing the medication. In addition to including the drug indication in the order, listing both the generic and brand names may help to provide further clarification in the dispensing and administration processes. The ISMP recommends "Tall Man" lettering and provides a 2023 updated list of "Look-Alike" drug names with recommended "Tall Man" lettering.
- **Timed-released dosages for the same drug:** Often there are multiple options for prescribing similar dosages of the same medication, i.e. extended release, delayed release, sustained release. This may cause confusion and wrong dose prescribing errors. Diligent prescribing practices and clear instructions as to the frequency and formulation may help to mitigate this risk.
- **CPOE system defaults:** Electronic medical record (EMR) systems may be programmed to default to commonly ordered dosages, leading to the inadvertent ordering of a wrong dose.
- **Use of mobile technology:** Use of mobile devices, such as Smart phones and tablets, may result in a prescribing error due to visual limitations, including screen size and screen calibration. Also, there may be a tendency to multitask when using mobile technology, leading to distraction and the potential for prescribing errors.
- **Alert fatigue:** CPOE systems include clinical decision support tools that provide guidance related to dosing, drug interactions and other safety guardrails. If providers become overwhelmed by a plethora of non-critical alerts, they may choose to ignore or "override" them. A 2020 study published in the Journal of the American Medical Informatics Association identified that most high priority drug-drug interaction alerts were overridden, including 90 percent of the highest-severity alerts. Tracking overrides to identify and remove superfluous and redundant alerts may help providers focus on the more critical alerts requiring their attention.

Unapproved abbreviations and leading/trailing zeros: When prescribing is performed on paper and electronically, use of unapproved abbreviations and leading/trailing zeros may result in medication errors. According to The Joint Commission, trailing zeros may be used to report values related to laboratory and diagnostic studies, but should not be used in medication orders. Similarly, the lack of a leading zero on a medication dosage starting with a decimal point may result in an erroneous medication dispensing and administration. ISMP

Patient-related risks

- **History of renal disease:** Prescribing drugs to patients with chronic kidney failure or other renal disease should include diligent monitoring of renal function. Renally excreted medications should be used with caution in elderly patients or patients with compromised renal function.
- **Weight-based dosing:** Pediatric prescribing errors are frequently related to incorrect weight-based dosages and calculations. There may be confusion/errors relating to documenting weights in kilograms versus pounds. Because there is little room for error in pediatrics, policies should be established and implemented to ensure consistency in documentation of patient weights.
- **Pregnancy/lactation:** A comprehensive patient assessment and review of the potential pharmacological untoward effects should be carefully evaluated prior to prescribing any medications for patients who are lactating, pregnant or planning to become pregnant.
- **Medications requiring laboratory testing and/or ongoing serum monitoring:** Policies and procedures should be established and implemented in order to ensure that all required laboratory tests results are reviewed when prescribing medications in this class, e.g. warfarin, vancomycin, testosterone, among others. The ISMP offers a self-assessment tool related to antithrombotic therapy.
- **Age:** The unique risks associated with prescribing drugs for geriatric patients must be recognized and addressed. Polypharmacy and "potentially inappropriate medications" (PIMS) are common prescriptive challenges in the elderly population due to the physiologic changes associated with the aging process. "PIMS are drugs for which the risk of potential adverse events is greater than the clinical benefits, particularly when there are safer or more effective alternatives that are recommended to be used in older adults". The American Geriatrics Society (AGS) provides a list of medications that should be avoided, or used with caution, when prescribing for elderly patients. This list, referred to as the Beers Criteria®, was originally published in 1991 by Mark Beers, MD, and is updated every three years. The AGS is currently in the process of updating the 2019 PIMS list. The most common PIMs were associated with benzodiazepines and proton pump inhibitors (PPIs).

In the 2022 dataset, the majority of gerontology claims arose in an aging services setting. The two allegations that occurred most often included improper or untimely management of a pressure injury and improper prescribing/management of anticoagulants and controlled medications. As noted above, prescribing medications that require serum monitoring is an area of risk exposure for NPs. The following claim scenario from the 5th Edition of the NSO/CNA Nurse Practitioner Liability Exposure Claim Report exemplifies claims involving this risk:

Claim Scenario: Allegations Related to Improper Prescribing and Management of Anticoagulants

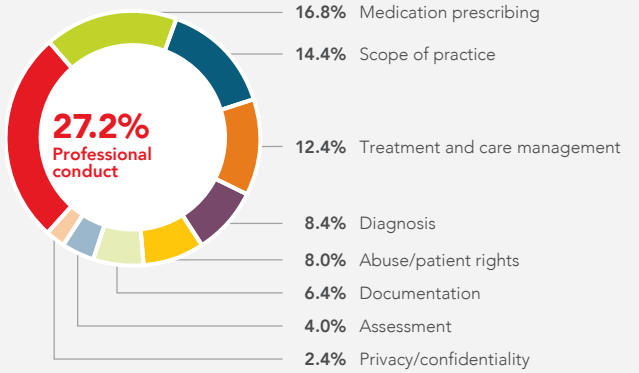
- The insured NP was contacted by nursing staff regarding a nursing home resident's recent international normalized ratio (INR) lab result. The nursing staff verbally reported that the result was in the therapeutic range. Therefore, the NP did not order any adjustments to the warfarin dosage. However, the NP was not familiar with this resident's medication list and failed to discontinue the resident's Lovenox® when the INR became therapeutic on warfarin. For two additional weeks, the nursing staff continued to administer the Lovenox® to the resident. The resident began to complain of abdominal pain that was attributed to fecal impaction. Over a six-day period, the NP ordered a saline laxative enema on two occasions. The day following the second enema, the resident became hypotensive, pale and unresponsive and was transferred to the emergency department. The resident was diagnosed with acute coagulopathy and expired due to complications of a retroperitoneal and pelvic hemorrhage. The claim resolved with a total incurred of more than $425,000.

When medication errors occur, these errors typically involve workarounds and at-risk conduct where the NP failed to follow the proper procedures. This is exemplified in the above scenario in which the NP based the medication order solely on the nurse's verbal report and failed to review the resident's clinical history and current medication list. Failure to adhere to medication safety procedures can make it more difficult to defend the NP's actions in a professional liability claim and also may lead to SBON complaints. A review of the patient's/resident's history and medication list should be incorporated into the NPs routine prescribing process.

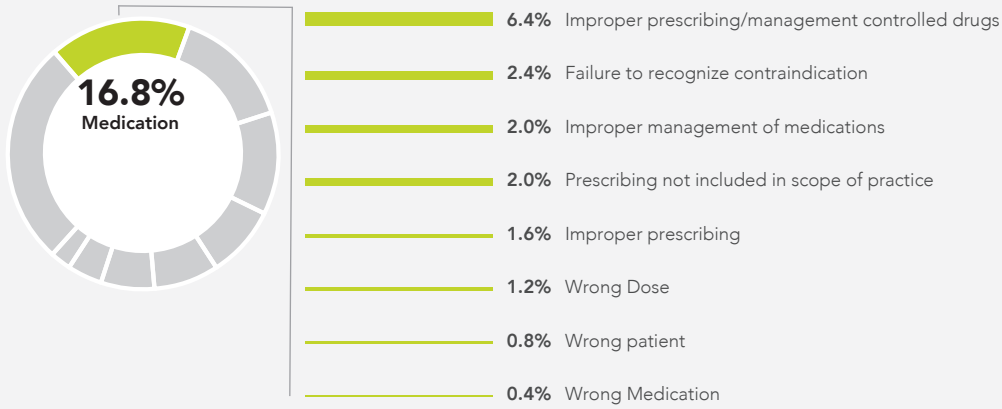
License Protection Allegations Related to Medication Prescribing

In addition to professional liability claims, medication prescribing errors also contribute to complaints made to the SBON with respect to nurse license protection matters. Allegations related to medication prescribing constitute 16.8 percent of all license protection matters in the Nurse Practitioner Professional Liability Exposure Claim Report: 5th Edition. Within this category, allegations are primarily due to prescribing or administration errors, such as improper prescribing or management of controlled medications, failure to recognize a contraindication prior to prescribing a drug, scope of practice issues or prescribing the wrong dose or wrong medication. (See Figures 29 and 31)

29 License Defence Matters by Primary Allegation Class



31 Allegations Related to Medication Prescribing



Claim scenario: License Protection Matter involving a prescribing error

An NP working in a skilled nursing facility was busy assisting another resident when she gave a verbal order for a medication to an LPN who was standing down a long hallway. The NP failed to verify the resident, or even the medication, the LPN was referencing. The NP told the LPN that if it was the resident's "routine medication", then the LPN could simply reorder and administer the medication. However, the LPN placed the order for the medication and administered it to the resident without verifying that the resident had been given that medication previously. The resident was then given 1000 mg divalproex sodium twice per day for one week. By the seventh day, the resident's spouse asked for the resident to be examined due to lethargy. The NP examined the resident but did not notice that the resident had been started on the incorrect medication, which may have been the cause of the lethargy. It was not until the next day, the eighth day, that another nursing staff member identified the error. The resident was then transferred to a local ED to be treated for divalproex sodium poisoning. The resident's family filed a complaint against the NP with the SBON. The SBON reprimanded the NP, and the total costs incurred to defend the NP in this matter exceeded $6,300. This claim scenario reflects the importance of verifying patient/resident medication lists and medical history before ordering a medication, as well as limiting verbal orders to emergency situations.

Risk Management Recommendations for Prescribing: Minimizing Risks, Maximizing Benefits

Prescribing the right drug, for the right patient, in the right dose, by the right route, at the right time, for the right duration and for the right indication(s) may seem relatively straightforward for an otherwise healthy patient, who has no known drug allergies and is not taking medications on a daily basis. However, treating patients with chronic medical conditions who are on a multitude of medications requires diligence in prescribing and managing medications, as well as careful monitoring of potential side effects. This protocol is especially important when prescribing a new medication for both existing patients and new patients. Medication prescribing is not a responsibility to be taken lightly. By prescribing a drug, even as a one-time "favor" for a co-worker, relative, friend or neighbor, the provider has established a patient-provider relationship. Consequently, ethical/legal considerations may arise when prescribing to friends or relatives, which also pose professional liability or licensure risks. The risks related to prescribing for friends/relatives/co-workers are exemplified in this NSO Nurse Practitioner case study.

Nurse Practitioner Spotlights

For risk control strategies related to:

- Defending Your License
- Depositions
- Patient Adherence
- Telemedicine
- Diagnosis
- Documentation

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Risk Control Self-Assessment Checklist for Nurse Practitioners: Safe Prescribing

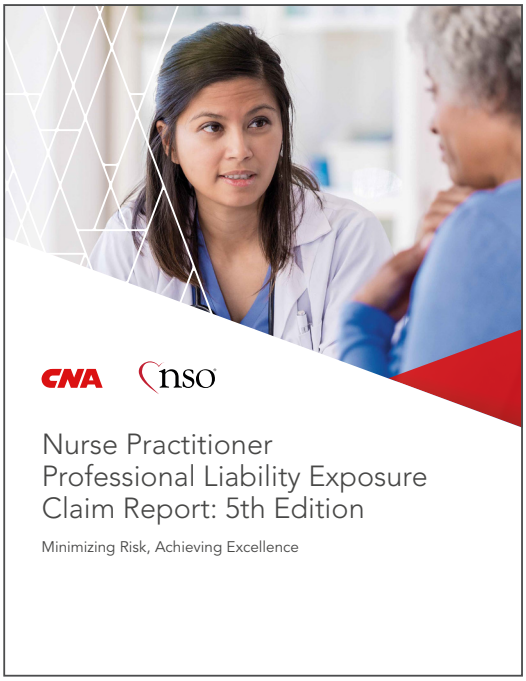
The self-assessment checklist below may be used as a guide for NPs to assess their own prescribing practices and assist them with improving their knowledge of safe prescribing practices. For additional risk, control tools and information see www.nso.com.

Safe Prescribing Self-Assessment Topic	Yes/No	Actions Needed to Reduce Risk
I consider the following when prescribing-- drug allergies, contraindications, drug-drug interactions, box warnings, adverse reactions and monitoring implications- such as serial laboratory testing.		
I prescribe medication in compliance with the state Nurse Practice Act, state prescriptive authority and employer policies.		
I clearly document patient responses to medications and adverse drug reactions in the healthcare information record.		
I educate patients regarding their responsibilities for adhering to medication regimens, as well as the risks of nonadherence, and assess the patient's ability to comprehend the instructions using a "teach-back" approach. I document all patient education in the healthcare information record.		
I review the current medication list with the patient, including prescribed and over-the-counter medications, and document the patient's adherence.		
I review and document the patient's medication history as an essential component of the medical history for all patient encounters.		
I monitor the FDA website and drug labels for alerts and "box warnings".		
I review current allergy information, including descriptions of reactions, when ordering medications.		
I exercise caution when prescribing anticoagulants, antibiotics and psychoactive mediations, as well as other known toxicity-prone drugs.		
I avoid verbal orders, except in emergencies. In the case of a rare verbal order, I ensure that the clinical staff have verified the order using the "read-back" method and have documented the order appropriately.		
I remain current in my knowledge of new and specialty medications, including but not limited to their pharmacology, side effects and drug-drug interactions and consult with a pharmacist, as needed		
I ensure that any delegated care related to prescribing is within the scope of practice of the individual.		
I acknowledge CPOE alerts and disable the override function for high-risk alerts.		
I use standard order sets, when available, to minimize incorrect or incomplete prescribing and regularly inspect order sets to confirm accuracy.		

Safe Prescribing Self-Assessment Topic	Yes/No	Actions Needed to Reduce Risk
I review previous medication orders alongside new orders and care plans, and resolve any discrepancies each time a patient moves from one care setting to another.		
I educate patients/caregivers about their medication regime and the importance of maintaining an accurate medication list.		
I document efforts to obtain a current and accurate medication list during the medication reconciliation discussion with the patient, including the source of the information, and consider individual patient factors, such as advanced age, health literacy, language differences, hearing or cognitive impairments.		
I engage in quality improvement activities to track medication prescribing errors and utilize this information to develop error prevention initiatives.		
I adhere to all state/federal regulations and guidelines for prescribing controlled substances. I review safe storage and disposal protocols with patients receiving opioids.		
I review the current FDA-approved label for drugs and devices – including box warnings, contraindications, drug-drug interactions and adverse effects- prior to prescribing off-label medications and confirm that the proposed off-label use is considered an acceptable medical practice.		
I conduct a comprehensive patient history and physical prior to prescribing off-label medications in order to identify underlying conditions or patient risk factors that would contraindicate prescribing the off-label drug.		
I obtain the patient's written consent when prescribing off-label medications after discussing the following, which are documented in the informed consent form: - Details regarding the proposed off-label use and the use for which the medication received FDA approval, - Known risks, complications, side effects ,contraindications and potential unknown risks related to off-label use; - The fact that all of the risks associated with the off-label use may not be known.		

Disclaimer

This resource serves as a reference for healthcare organizations seeking to evaluate risk exposures associated with medication prescribing and management. The content is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your organization and risks may be different from those addressed herein, and you may wish to modify the activities and questions noted herein to suit your individual organizational practice and patient needs. The information contained herein is not intended to establish any standard of care, or address the circumstances of any specific healthcare organization. It is not intended to serve as legal advice appropriate for any particular factual situations, or to provide an acknowledgement that any given factual situation is covered under any CNA insurance policy. The material presented is not intended to constitute a binding contract. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.



This information was excerpted from NSO and CNA's full report, *Nurse Practitioner Liability Claim Report: 5th Edition*. www.nso.com/NPclaimreport

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This information is designed to help nurses evaluate risk control exposures associated with their current practice. It is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

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