

## Institute for Safe Medication Practices

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### ISMP Issues Recommendations on Resolving Conflicts When Safety Questions Arise

*Huntingdon Valley, Pa.*— Many harmful prescribing errors that reach patients share a surprisingly common factor: at least one person—a healthcare practitioner, patient, or family member—felt there was a problem with the order before the medication was dispensed and administered. All practitioners involved in the medication-use system have an obligation to protect patients from harm; ISMP has issued guidelines to help practitioners follow through and be persistent when the safety of a medication order needs to be questioned.

One reason that potentially unsafe medication orders are not questioned is intimidation. A 2003 ISMP survey on workplace intimidation showed 40% of the respondents had questions about the safety of an order in the past year, but chose to assume the order was correct rather than interact with a prescriber they perceived as intimidating. In some cases, concern about the safety of a medication order is brought to the attention of another practitioner, but the person raising the concern was easily convinced that the medication was safe as prescribed. In the 2003 survey, half of respondents said that when questioning the prescriber, they felt pressured to dispense or administer the drug despite their concerns.

The key to preventing these errors is a defined process that ensures drug therapy does not move forward until all parties are satisfied that safe resolution has occurred. This process needs to involve more than just referring problems up the chain of command—staff need clear guidance and support from organizational leaders on how to follow through when supervisors or prescribers do not agree with their expressed concerns. Following are ISMP guidelines to consider when developing or revising a process for handling conflicting opinions objectively and professionally.

#### **Conflict Resolution Guidelines**

**Gather information.** If a nurse or pharmacist suspects that an order is potentially harmful, he or she should pursue the matter until satisfied that it is safe or the order is changed. The issue should be researched and supporting factual information gathered before talking to the prescriber, so that concerns can be clearly communicated—this may involve reviewing the medical record, talking with the patient, using reputable drug information resources, and consulting other nurses, pharmacists, or physicians.

**Question the order.** Pharmacists and nurses should not be afraid to question an order and discuss it directly with the prescriber when they have reason to believe a patient is at risk or even just have a sense that something is wrong. Use of a standard communication strategy such as SBAR (situation, background, assessment, recommendation) or the Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) developed by the Agency for Healthcare Research and Quality and Department of Defense can help frame the discussion.

If applicable, the prescriber should be asked for documentation to support the order, since published information may have been misinterpreted or references containing misprints used. Statements such as “the protocol says to do it this way” or “that’s how they do it at X hospital” should never be accepted as proof. Practitioners should check with risk management regarding the best way to document safety concerns and the prescriber's response.

**Take the concern higher.** If the prescriber will not change the order and the practitioner is not satisfied no harm will occur, the prescriber should not be asked or allowed to personally administer the drug. Transferring responsibility to the prescriber for possible patient harm is not likely to legally or emotionally absolve the practitioner if patient harm were to occur. Instead, the prescriber’s chief resident, chief attending physician, department chair, or a specialist in the area of the ordered drug therapy should be contacted. If that person also believes the order may be unsafe, he or she should contact the prescriber.

**Refer to a peer-review group.** If concerns persist, the nurse or pharmacist should consider whether greater harm would result from administering the drug than from withholding it. Practitioners should refuse to dispense or administer a medication if they are reasonably sure that withholding it is the safest action. The issue should then be referred to a timely ad hoc group for peer review to determine the order’s safety.

**Call a rapid response team.** If patient wellbeing is likely to be compromised while peer review is undertaken, and the patient’s condition requires immediate attention, a rapid response team can be called if available. The team can assist with taking emergency action as needed until the conflict can be resolved. Upon admission, patients and family members also should be advised that they can call the rapid response team if they have time-sensitive concerns about medication use and believe their safety is in jeopardy.

**About ISMP:** The Institute for Safe Medication Practices (ISMP) is a 501c(3) nonprofit organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 30 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process.