Is your medication management workflow a help... or a *hindrance*?

The pressure is on surgical centers as patient volumes continue to increase in outpatient settings. Processes and resources are strained because complex and diverse procedures are shifting out of the hospital into your facilities—all while you're trying to keep costs under control.

In the face of so many challenges, it's easy to overlook functions that aren't causing you immediate and obvious headaches but are actually fueling problems. *And this can be the case with medication management*.

In the US, drug shortages result in nearly **$230M in additional costs annually.**[1]

10%-15% of healthcare professionals will misuse drugs and alcohol.[2]

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Use this checklist to identify potential risks in your medication management workflow.

Traditional approaches	Potential risks
Manual steps reliant upon on collective knowledge and muscle memory	*Manual-intensive workflows can be inefficient and lead to waste*
Workflows requiring multi-tasking amongst staff	*Despite your staff's best intentions, there's the constant risk of dispensing and administering an incorrect medication—particularly when they are stressed*
Staff frequently staying after hours to complete documentation or resolve discrepancies	*Keys and passwords can be easily compromised*
Using cabinets or "tackle boxes" to store and access new med orders or emergency meds	*Easy access to poorly secured controlled medications opens the potential for drug diversion that can result in investigations and fines*
Reliance on keys and passwords to secure meds	

While these methods of medication management may be working today, they are no longer scalable and can potentially impact patient care.

Successful facilities are now recognizing that they must look at the medication management process as a complete system, rather than disconnected transactional segments. When you do this, using automation, it can help you achieve a more standardized medication management workflow.

Of the medication safety-related events analyzed in an ECRI Institute PSO report, **67% fell into the category of "wrong" errors.**[3]

Ready to see what this could look like at your ASC? LEARN MORE NOW

References:

1 Urahn SK, Coukell A, Jungman E, Snyder E, Bournas JE, Kourti T, et al., Drug Shortages: a report from the Pew Charitable Trusts and the International Society for Pharmaceutical Engineering. Annals of Internal Medicine. 2017.

2 ASHP Guidelines on Preventing Controlled Substance Diversion 2022, pg 2.

3 ECRI Institute PSO Deep Dive™: Safe Ambulatory Care report. 2019.

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