Making the Medication System Safer: Learning from Each Other
By Robin Ensom

Providence Health Care is the largest Catholic based health-care organization in Canada. Located in Vancouver, it includes eight patient care sites ranging from acute care teaching (St. Paul's Hospital) to rehabilitation and residential care (Holy Family Hospital). While the dynamics of care delivery varies considerably, the challenge of creating safer medication systems is universal. Recognizing that there was substantial opportunity for improvement, Providence Health Care committed to participate in the Institute for Healthcare Improvement's collaborative entitled: Quantum Leaps in Patient Safety: Redesigning Culture and Processes in the Medication System.

Bedside Issue Identification
One of the initiatives that we have undertaken (as a part of the collaborative), is an activity called "safety huddles". Two or three times a week, front-line staff assembles for a five-minute debriefing on medication safety issues. Issues are brought forward in response to two simple questions:

1. Are there any concerns about patient safety with medications today?
2. Were there any medication "near misses" today?

Systems Solutions
In very short order, a very long list of issues was compiled. Sometimes, a local solution (e.g. purchase of calculators for each medication cart to assist in medication calculations) could be implemented quickly. However, more often the issues had broader implications. Formatting of medication administration records and access to information when it is needed were two common issues. Let's look at a couple of specific issues in more detail:

> *Reconciliation of brand vs. generic name of medications* -- Like many organizations, our policies require adherence to use of the generic name in order to minimize confusion. However, I am sure that we are not the only organization in which physicians continue to order medications by brand name and nurses continue to refer to medications in the same way. We could hide behind a well-intentioned policy, or systematically deal with the confusion issue. We chose to enhance the medication administration record by more regularly including "(brand name or equivalent)" in addition to the standard inclusion of the generic name. The generic name continues to be the standard, but the nurse comparing the physician's order to the medication administration record is more likely to accurately match them, and therefore less likely to make a medication error.
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> *Nonformulary medication information* -- The use of nonformulary medications is a reality of current acute care. However, lack of staff familiarity with these medications increases the potential for medication errors. Currently, the onus to find and familiarize themselves with the necessary information is on each individual involved in the care of the patient. However, a system could be developed whereby the pharmacist who first deals with this order obtains a

printed copy of basic information about the medication. This information could be forwarded to the patient care area along with the supply of medication (to be included as a part of the active chart). While we have not yet initiated this, it seems that it would be a more efficient approach to insuring patient safety and leaving it to each individual.

The point of these examples is to demonstrate that system approaches are more likely to succeed than depending on professional judgment and hypervigilance.

Shared Learning

Finally, we are delighted to be able to share our learning with the 49 other organizations enrolled in this Institute for Healthcare Improvement collaborative. It is also encouraging to note that two other local organizations have invited us to share the benefit of our participation in the collaborative with them directly. Together, we will make the medication systems safer.

Robin Ensom is Director of Pharmaceutical Services at Providence Health Care in Vancouver.