Role of the Hospital Risk Manager in the Prevention and Reduction of Medication Error
by Michele Brennan, MN RN

The Whitehorse General Hospital (WGH) is a 49 bed northern acute care hospital providing medical, surgical, pediatric, mental health, labor and delivery and Emergency room services to the Yukon, northern BC and Alaska. The WGH is the regional center for the Yukon and is connected with rural nursing stations through air and ground ambulance services. The WGH has one FTE position for Quality Improvement and Risk Management. There are distinct advantages in this dual role as quality improvement and risk management is essentially two sides of the same coin.
The review, analysis and trending of patient occurrences and risk events led to the development of several safety improvements e.g. Fall Assessment and Intervention Program.

In recent years, there has been a paradigm shift in the general understanding and management of medication errors largely due to the " To Err is Human" report (IOM,1999) and the rise of health care consumerism. The WGH, like many institutions, is attempting to reframe the issue of medication safety and make it an improvement initiative. While medication error rates used to be considered a measure of patient safety, it is now recognized that providing quality care is the best measure of patient safety.

Whether in a primary or dual role, the risk manager (RM) has a central role to play in the prevention and management of medication errors, both internally and externally. It is essential that the RM participate in the development, implementation and evaluation of patient safety improvement initiatives.

Emphasizing a non-punitive and open environment
The RM can facilitate the creation of an open and non-punitive environment to encourage error reporting. This philosophy needs to be implemented from the top down. The WGH CEO has been very proactive and has made a strong commitment to preventing and reducing patient error of any kind. There is a real emphasis being placed on establishing a culture of safety as well as quality and the RM is in a key position to support and facilitate this. The RM serves as a liaison in communicating this philosophy between senior management and employees. The WGH QI/RM has made multiple presentations to many groups including the Board of Trustees, employees, QI teams etc regarding medication safety trends and issues, . The excellent 8-minute video " Beyond Blame" has been shown within the WGH and is available for review at any time.

Sensitizing and Educating Employees
There is a vast amount of new literature and knowledge being generated in the area of patient safety . The RM must be well informed regarding national patient safety trends, issues and initiatives and communicate this information to busy clinicians, teams etc. The WGH QI/RM has a regular column in the weekly hospital newsletter to discuss and inform employees re quality and risk issues, including recent Canadian initiatives in the area of medication safety.

Review of Medication Occurrence Reports
Although the WGH would like to have the resources to review all patient charts to identify potential and actual medication errors, it, like most hospitals, relies on self-reporting of error through occurrence reporting. While benchmarking of medication errors is fraught with difficulties, review of occurrence reports is useful in providing an opportunity to learn from

mistakes (U, 2000). There is as much to learn from" near misses" as from actual occurrences. There is a real advantage in having the RM serve as the focal point for the collection, analysis and communication of information regarding potential and actual medication errors through occurrence reporting.

Establishing Policies and Procedures

There are multiple opportunities to develop new policies and procedures in the area of patient safety. The RM has a strategic role in ensuring that the Hospital has and is seen to have an open and transparent reporting system for medication error. The WGH QI/RM developed and implemented a new policy and process for review of sentinel events, i.e., serious errors and near misses. The new process has been useful in approaching error from a systems perspective as well as anchoring change within the quality improvement framework. Discussions have begun to develop a policy on appropriate disclosure of patient errors, including medication error. The RM provides advice, information and support to physicians and other health care professionals regarding how best to communicate a serious medication occurrence to patients and/or families.

Leadership

The RM serves as change agent and patient advocate in the broadest sense. The WGH QI/RM initiated a new multidisciplinary Medication Safety Committee reporting to the senior Quality Improvement team. The Committee includes the RM, two physicians, two pharmacists, four front line nurses, a nurse manager and an information system analyst. The Medication Safety Committee is in the process of completing the Hospital Medication Safety Self-Assessment (ISMP-Canada, 2001) which provides a systems perspective to assess current medication practices in 10 broad areas encompassing a total of 195 characteristics. Upon completion of the self-assessment, the areas noted for improvement will be prioritized and action plans developed.

The RM plays a strategic leadership and advocacy role beyond the organization and is in a key position to share medication safety strategies with other facilities and jurisdictions. Communication among risk management professionals, organizations and government is essential to ensure that accountability frameworks are developed at the organizational, provincial/territorial and national levels. The RM should advocate for new public policy and regulation regarding the reporting and communication of medication errors.

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References

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