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A LEGAL PERSPECTIVE ON

MEDICATION INCIDENTS: HOW TO MINIMIZE PREVENTABLE ERRORS

Medication incidents happen. Unfortunately they represent a fact of life in virtually every health care institution. Medication errors involve a variety of health professions, from the physicians who prescribe medication, to pharmacists who have responsibility for dispensing it, to nursing staff who administer it. Determining the causes for medication errors and the means of minimizing these errors is a difficult task. This requires a careful review of policies and systems.

It is a fact of life. Most nurses and physicians will be involved in a medication error at some point in their careers. Medication errors usually do not involve any lack of competence on the part of the health care practitioner. Nevertheless, the pressures of daily practice or a moment of inattention may result in a patient not receiving the required medication in a timely manner. Health practitioners who are involved in a medication incident may learn the important lesson that they are not immune from this type of error. This, in turn, can have a positive impact to ensure that this type of incident does not recur.

Consequences of Medication Error

Medication errors usually don't lead to any permanent health problem. Unfortunately, in a small percentage of cases medication errors result in serious injury or death.

For health practitioners who are involved in a serious medication incident resulting in patient injury or death, the impact on their professional life can be devastating. In addition to the emotional impact of having to come to grips with a serious incident, a civil claim for damages will follow. The incident could also result in discipline in the employment setting or, if a physician is involved, could result in a review of privileges to practice in a particular institution. There is also the potential for a regulatory college to become involved and to impose discipline which could limit an individual's right to practice in the future.

Ways to Minimize Problems

It is unrealistic to expect that medication incidents will ever disappear entirely. However, there are certainly steps which individuals and institutions can take to reduce the likelihood of a serious medication incident occurring:

1. Every health practitioner should recognize his or her own personal responsibility and accountability to the patient for the services provided. Every health practitioner is responsible for understanding and maintaining on a current basis the basic principles relating to the prescription and administration of medication. These basic principles are normally taught as part of the professional training of a health professional.

2. A health practitioner is also expected to understand and abide by guidelines which are issued by the relevant regulatory body. For example, the College of Nurses has issued guidelines to its members dealing with the administration of medication.

3. Institutions will usually have protocols for medication administration which will supplement the basic principles which are taught in school and the guidelines issued by the relevant regulatory body. These protocols typically describe in detail how medications are to be prescribed, dispensed and administered within a particular institution. Institutions need to develop uniform policies and processes for administering medications. If different departments of the same institution have different systems or protocols, there is a possibility that, as staff move from one department to another, there will be confusion and uncertainty over the protocols which need to be followed.

4. Hospitals should develop appropriate documentation and review mechanisms for medication incidents. The reporting of medication incidents needs to be encouraged with an emphasis on identifying trends which may indicate the need for changes in protocol or improved education for staff. Hospital protocols should ensure that the human errors are caught before a serious incident occurs. There is a delicate balance which hospitals need to consider in developing an effective incident reporting system. On the one hand, it is desirable to encourage reporting of medication incidents. Staff may be reluctant to report incidents in which they are involved if they perceive they will be subject to discipline at a

later time. On the other hand, however, institutions may need to reserve the right to impose discipline in appropriate cases.

5. Health care institutions also need to identify medications which have the greatest potential for serious injury. Special precautions need to be taken in connection with these medications.

6. Health care institutions need to be prepared to deal with serious medication incidents when they occur. Publicity surrounding these incidents can undermine the public's confidence in the institution. It is important to have appropriate support mechanisms in place for staff who are involved, recognizing that the emotional impact from these types of incidents can be substantial and can have a very negative impact on morale.

An important development in attempting to reduce medication errors in Canada has been the creation of the Institute for Safe Medication Practices Canada. This is an independent Canadian non-profit agency established for the collection and analysis of medication error reports and the development of recommendations for the enhancement of patient safety. The goals of the Institute include the review of medication errors which are submitted to it, as well as publishing information to the healthcare community to promote safe medication use. Since its creation the Institute has played an important role in advocating for changes which minimize preventable medication errors.
It is important in this era of change within the healthcare system to remember that the expectations of patients in the system remain high. Patients are not willing the accept the inevitability of medication errors resulting in significant injury. These incidents are for the most part preventable. All healthcare providers and institutions should review at regular intervals their practices in connection with the administration of medications.

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