Your Call to Make a Difference
By David U

Making system improvements for safer medication use in hospitals needs leadership from the top of the organization. We need hospital administrative staff to believe in, and support efforts for promotion of a culture of patient safety. Individual staff of every discipline is also in a position to make significant contributions to safety in the system as a whole. Front-line staff is relied upon to carry out and ensure implementation of hospital-wide strategies for medication safety. More importantly, it is often the front-line practitioners who are in a position to identify potential problems in the processes, procedures and practices related to medication use in hospitals. Outlined below are some brief descriptions of how individual practitioners can promote increased medication safety in our complex hospital systems.

1. **Focus on patient safety**. In carrying out duties to serve patients, keep patient safety as a top priority in your mind. Question yourself and your peers in order to continuously and critically evaluate the inherent safety of the procedures being carried out. Ask if "additional safety measures be built in"? Recognize that policies and procedures are designed to protect the majority of patients, the majority of the time. Challenge the current practice in *unique situations* when the usual course of action may have a negative and/or unsafe outcome to the patient. Take responsibility to suggest alternatives, or improvements to the current policies, procedures and practices and offer to assist management in developing revised policies for added safety.

2. **Take Steps to Overcome the Authority gradient**. All practitioners need to question any unsafe orders or procedures regardless of the rank and/or discipline of the individuals. For example, when an order written by a physician for a drug, dose, route, or frequency, is considered unsafe by a nurse or pharmacist, then the nurse or pharmacist should feel completely at ease to contact the physician about the possibility of changing the order. An open culture that supports the questioning and discussion of the risk/benefits for patients will ultimately prevent harm due to errors. All levels of the organization, including the medical staff and administrative staff need to support and promote such safety checks within the system.

3. **Discuss Medication Safety**. Adding "patient safety" as a regular agenda item for staff meetings can facilitate open discussions and learning from problems that have been encountered. In particular, discussion of medication errors and near-error events can help set the stage for prevention of recurrences. Any member of the interdisciplinary team can help to initiate discussions of error experiences for the purposes of identifying preventative strategies. Many hospitals have created interdisciplinary Safe Medication Practice committees with focussed mandates to specifically address medication safety issues and develop system safeguards against errors with medications. The reason for such committees is the recognition that the medication use system crosses the boundaries of departments and

involves many different disciplines, as well as the need to give priority to the issues.

4. **Follow medication safety procedures**. Example system strategies that hospitals have implemented for ensuring medication safety include: a second independent professional check for selected high alert drugs before preparation and administration; addition of warning labels to drugs with similar names or packaging; enforcing the use of standardized, pre-printed protocol order forms when applicable; enforcing the adherence to approved abbreviations when writing orders, etc. Understanding the rationale behind the procedures and providing ongoing education about the benefits will help ensure the procedures are consistently followed.

5. **Apply best practice and update knowledge skill sets.** Search out and implement the "Best Practices" that are evidence-based, or proven in practice. It is also our professional responsibility to ensure that our clinical knowledge is kept up to date. We need to continuously look for our own improvement opportunities.

6. **Reporting errors/near-misses**. Most hospitals have a medication error reporting system in place. It is up to the individual practitioner to report incidents and near misses. In many cases, it is only through these reported incidents and near misses that the hospital can learn and implement prevention strategies. You are also encouraged to confidentially report medication errors to ISMP Canada, an independent, non-profit organization, established to promote safe medication practices. ISMP Canada will investigate and analyze the reported events, and make recommendations for their prevention. Information is also disseminated to other hospitals in the form of Medication Safety Alert bulletins, and other publications, for the purpose of sharing the knowledge gained. See the ISMP Canada web site: www.ismp-canada.org .

7. **Educate patients on medication safety.** The patient is the last line of defense, and can be a very effective defense, against medication mishaps. Educate patients about what to expect. Encourage patients to be aware of all medications they are ordered and administered. Encourage patients to ask questions. We have previously published a special article on the "Patient's Role in Safe Medication Use" published in the December 2001 issue of Hospital News. The article is posted in our website (Publications section).

Patient safety is a shared responsibility. All levels of healthcare associations and organizations, and all walks of disciplines must take ownership to achieve the overall goal. This is your call to make a difference.

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