

Your call to make a difference

By David U

Making system improvements for safer medication use in hospitals requires leadership from the top of the organization. We need hospital administrative staff to believe in and support efforts for the promotion of a culture of patient safety. Individual staff in 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 processes, procedures and practices related to medication use in hospitals. Outlined below are some brief descriptions of how individual practitioners can promote medication safety in our complex hospital systems.

1. Focus on patient safety. When providing care for patients, directly or indirectly, make patient safety a top priority. Question yourself and your peers in order to continuously and critically evaluate the inherent safety of procedures. Ask, "Should additional safety measures be built into the system?" 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 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 questioning and discussion of the risk/benefits for patients will ultimately prevent or mitigate 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 at staff meetings can facilitate open discussions and learning from problems that have been encountered. In particular, discussion of medication errors and near-miss events can help set the stage for prevention of recurrences. Any member of the interdisciplinary team can help to initiate discussion of error experiences for the purposes of identifying preventative strategies. Many hospitals have created interdisciplinary Safe Medication Practice Committees with focused mandates to specifically address medication safety issues and develop system safeguards against errors with medications. The existence of such committees is evidence of the recognition that the medication use system crosses the boundaries of departments and involves many different disciplines, as well as of the need to give priority to these issues.

4. Follow medication safety procedures. Examples of 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; and enforcing adherence to approved abbreviations for written orders. Understanding the rationale behind the medication safety procedures and providing ongoing education about their benefits will help ensure that procedures are consistently followed.

5. Apply best practice and update knowledge skill sets. Search out and implement best practices that are evidence-based, i.e., proven in practice. Health care professionals have a professional responsibility to ensure that their clinical knowledge is kept up-to-date. We

need to continuously look for our own improvement opportunities.

6. Reporting errors and 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 reports that the hospital can learn and implement prevention strategies. You are also encouraged to confidentially report medication errors to the Institute for Safe Medication Practices Canada (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 disseminated to other hospitals in the form of Medication Safety 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 when they take their medications. Encourage them to be aware of all the medications they receive and to ask questions. (A previously published article on the Patient's Role in Safe Medication Use, was published in the December 2001 issue of Hospital News. The article is posted on our website (See Publications section).)

Patient safety is a shared responsibility. All levels of health care, including associations, administrators, and all disciplines, must take ownership to achieve the common goal of patient safety. This is your call to make a difference.

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