MEDICATION SAFETY UPDATE

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DISCLOSURE STATEMENT

Under guidelines established by the Accreditation Council for Pharmacy Education, disclosure must be made regarding financial relationships with commercial interests within the last 12 months.

I have no relevant financial relationships or affiliations with commercial interests to disclose.
LEARNING OBJECTIVES

At the completion of this activity, pharmacists will be able to:

- Discuss the prevalence and effects of medication errors in healthcare
- Describe approaches to improve medication safety within their medical facilities

PRE-ASSESSMENT QUESTION

1. JUST CULTURE describes a working environment that includes the following:
   a. Leadership that is accountable to create an environment supportive of error disclosure.
   b. Leadership that addresses organizational issues brought forward by staff that impede safe care.
   c. Staff that are accountable to share information and experiences encountered with errors and error-prone systems.
   d. All the above.
IS HEALTHCARE SAFE?

Some studies show medical errors as 3rd leading cause of death in US

This medical error data point won’t appear on WHO or CDC reports

MEDICATION SAFETY REVIEW

1999 – The Institute of Medicine - To Err is Human
  • 1 million injured and 98,000 deaths annually
  • Reduce medical errors by 50% within 5 years

2005 – The Agency for Healthcare Research and Quality
  • Set safety goals that included decreasing medication errors by 50% within 5 years

2010 – The Lucian Leape Institute
  • Identified need for a shift in cultural change
MEDICATION SAFETY REVIEW

2015 - The National Patient Safety Foundation
• LEADERS establish and sustain a safety culture
• Centralize and coordinate approaches to patient safety
• Common safety metrics showing meaningful outcomes
• Prioritize funding for research in patient safety
• Address safety across the entire care continuum
• Support the health care workforce
• Partner with patients/families for the safest care
• Ensure that technology is safe and optimized

BENCHMARKING ERROR RATES

National Coordinating Council for Medication Error Reporting and Prevention
• THERE IS NO ACCEPTABLE MEDICATION ERROR INCIDENCE RATE
• De-emphasize the number of medication errors reported
• Identify root causes and continually improve processes

The Institute for Safe Medication Practices (ISMP)
• Discourages benchmarking with medication error rates
BENCHMARKING ERROR RATES

Comparing medication error rates with other organizations is NOT RECOMMENDED due to differences in:

- REPORTING SYSTEMS
- CULTURE
- MEDICATION ERROR DEFINITION
- PATIENT POPULATION

RECOMMENDATIONS FOR MEDICATION ERRORS

JUST CULTURE

ERROR REPORTING

SYSTEM APPROACH
JUST CULTURE

• SHARED ACCOUNTABILITY
• LEADERSHIP SUPPORTS DISCLOSURE
• STAFF SHARES INFORMATION/EXPERIENCES
• SYSTEM APPROACH TO CREATE SAFE REPORTING ENVIRONMENT

JUST CULTURE

• Close the gap between leadership’s and staff’s perception of safety culture
• Leadership understands the perspective of the staff
• Staff understand efforts toward improvement
• CREATE SHARED COMMITMENT AND APPROACH TO PATIENT SAFETY
JUST CULTURE

- ENGAGED ORGANIZATIONS
  - Show a clearer understanding of the realities experienced by their nurses and providers

- OTHER ORGANIZATIONS
  - “We have no real problems here”

STAFF HESITANCY TO REPORT ERRORS

- UNWILLINGNESS TO ADMIT MISTAKE
- FEAR OF REPRECUSSIONS
- TAKES TOO MUCH TIME
- FORGET TO REPORT
- NOT EMPHASIZED BY LEADERSHIP
- FEEL LIKE NOTHING WILL BE DONE
ISMP RECOMMENDATIONS FOR ERROR REPORTING

• TRUSTWORTHINESS
• CONFIDENTIALITY
• CLARITY AND SIMPLICITY
• REWARDING
• CREDIBLE AND USEFUL
• REINFORCED IMPERATIVE

RESPONDING TO MEDICATION ERRORS

PERSON APPROACH
• Focuses on the errors of individuals

SYSTEM APPROACH
• Focuses on the processes that failed

HIGH RELIABILITY ORGANIZATIONS UTILIZE THE SYSTEM APPROACH
SYSTEM APPROACH

• Humans are FALLIBLE - Errors should be expected

• We can change the conditions under which humans work

• Question is not ‘who blundered?’, but should be ‘WHY DID THE SYSTEM FAIL?’

SYSTEM APPROACH

DEFENSES, BARRIERS, AND SAFEGUARDS

• Technology systems, people, procedures, and administrative controls

DEFENSES CAN HAVE WEAKNESSES

• Active Failures
• Latent Conditions
SYSTEM APPROACH: SWISS CHEESE MODEL

- Creates resilient systems capable of containing the damaging effects of errors
- Equips organizations to anticipate errors and mistakes

EVERY MED ERROR IS AN OPPORTUNITY TO LEARN
POST-ASSESSMENT QUESTION
1. JUST CULTURE describes a working environment that includes the following:
   a. Leadership that is accountable to create an environment supportive of error disclosure.
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   c. Staff that are accountable to share information and experiences encountered with errors and error-prone systems.
   d. All the above.
SUMMARY

• **JUST CULTURE**
  • Shared commitment and approach to patient safety

• **ERROR REPORTING**
  • Effective in identifying weaknesses in medication use system

• **SYSTEM APPROACH**
  • Improve the system that failed, don’t blame the individual

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Medication Safety Update

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Talihina, OK

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Learning Objective

At the completion of this activity, pharmacists will be able to:

• Review recent national medication safety recommendations and application of these principles.

Pre-assessment Question

• Which of the following is not one of ISMP’s 2018-19 Targeted Medication Safety Best Practices?
  A. Improper use of antidotes or reversal agents
  B. Use of meperidine for pain
  C. Inappropriate use of fentanyl patches
  D. Remove IV promethazine from formulary
Medication Safety Organizations

• Two types:
  1. Guideline Organizations
  2. Regulatory Organizations

1. Guideline Organizations

• Institute for Safe Medication Practices (ISMP)
• American Society for Health-System Pharmacists (ASHP)
• Institute for Healthcare Improvement (IHI)
• National Patient Safety Foundation (NPSF)
2. Regulatory Organizations

- Centers for Medicare and Medicaid Services (CMS)
- The Joint Commission (TJC)
- Det Norske Veritas (DNV)

Recent Medication Safety Recommendations

1. White paper – Medication Safety Officer
2. ASHP Guidelines on Preventing Medication Errors in Hospitals
3. Targeted Medication Safety Best Practice for Hospitals, 2018-19
1. White paper – Medication Safety Officer

The Medication Safety Officer optimizes medication safety work through the following roles:

CHAMPION: The visible campaigner and authoritative resource on medication safety.

EVIDENCE AND KNOWLEDGE STEWARD: The centralized expert on organizational medication safety–related evidence, information, and knowledge.

STRATEGIST/ADVOCATE: The voice establishing medication safety as a core value for both individuals and the organization.

FACILITATOR: The team leader leveraging scientific strategies to embed safety and sustain improvements at the local and organizational level.

CROSS-DISCIPLINE LEADER: The connector spanning boundaries to work across professional silos and hierarchy and engaging all in medication safety efforts.

DATA OPTIMIZER: The conduit for coordinating investigations of medication error reporting data to ensure efforts result in tangible improvements.


“Dedicated safety personnel are needed to establish safety-related goals, policies and practices, and to ensure that organizational standards on agency-wide issues are disseminated and understood by all employees””[pg9]

“Employing the Medication Safety Officer at least 20 hours a week showed significant improvement (in a national medication safety assessment score) between 2000 and 2011 (12% to 40% [233% increase]).””[pg1]
Recent Medication Safety Recommendations

1. White paper – Medication Safety Officer
2. ASHP Guidelines on Preventing Medication Errors in Hospitals
3. Targeted Medication Safety Best Practice for Hospitals, 2018-19

2. Guidelines on Preventing Errors in Hospitals

https://academic.oup.com/ajhp/article/75/19/1493/5139896?_ga=2.93777305.52267983.1548517218-1117004719.1486341787
Recent Medication Safety Recommendations

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2. ASHP Guidelines on Preventing Medication Errors in Hospitals
3. Targeted Medication Safety Best Practice for Hospitals, 2018-19
3. Targeted Medication Safety Best Practices

• Updated every two years or as needed
• Based on national medication error reports
• Specific to medication safety issues that continue to cause fatal and harmful errors
• Targeted towards hospital settings but some of the practices are applicable to other healthcare settings

2018-19 Targeted Medication Safety Best Practices
Examples

- Unintended IV administration or oral medications
- Infusion-related errors when administering high-alert IV medications
- Delay in administration or improper use of antidotes, reversal agents, and rescue agents
- Inappropriate use of fentanyl patches
- Serious tissue injuries from IV promethazine use
Helpful Medication Safety Trainings

• ISMP Medication Safety Intensive
• ASHP/ISMP Medication Safety Certificate Program
• Medication Safety Officer Society (MSOS) Member Briefings
Post-assessment Question

• Which of the following is not one of ISMP’s 2018-19 Targeted Medication Safety Best Practices?
A. Improper use of antidotes or reversal agents
B. Use of meperidine for pain
C. Inappropriate use of fentanyl patches
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Conclusion

• ISMP recommends dedicating a full time staff member to improving system medication-use safety
• ASHP guidelines provide recommendations and best practices for preventing harm from medication errors in the health-system setting
• Targeted Medication Safety Best Practices are published every 2 years as needed and are based on national medication error reports

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