

# Medication Safety Issue Brief

## *A Fully Stocked Toolkit*

1

of 6 in a series

*Series II*

Choosing an effective mix of tools to measure medication errors is the focus of part one in a six-part series designed to help senior managers reduce preventable patient harm in their hospitals. This series of six issue briefs was developed by the American Hospital Association, the American Society of Health-System Pharmacists and *Hospitals & Health Networks* with the generous support of Aventis Pharmaceuticals. You may tear out this card for future reference. Additional copies of both an earlier series, published in 2001, and this series are available in PDF versions on the ASHP and *H&HN* Web sites ([www.ashp.org](http://www.ashp.org) and [www.hhnmag.com](http://www.hhnmag.com)). ASHP members can also call the ASHP's fax-on-demand service.

### • SUMMARY

Medication errors in hospitals have historically been reported intermittently and voluntarily by the staff members who make or witness them. Hospitals are supplementing that method with computers, chart reviews, observation studies and other ways to generate a more accurate picture of the kinds of mistakes that take place. The goal is to change systems to minimize mistakes. Like snapping a series of photos of a panoramic view, each method offers a different sampling of reality that can combine to present a wider perspective.

### • ISSUE BRIEF

When patient safety rocketed to the top of the nation's agenda in the late 1990s, it was fueled by the shocking number of errors reported to take place in hospitals, and by the number going unreported. Researchers found that just a small percentage of medication errors in hospitals were identified by incident reports under the usual method of measuring mistakes. The numbers are a matter of debate, but hospitals are looking for the best ways to identify and measure errors to improve safety. They have found that each method has strengths and weaknesses, but that a well-designed measurement toolkit may use each one at least occasionally.

**VOLUNTARY REPORTING.** It has been maligned for identifying less than 5 percent of errors, but voluntary reporting is still useful for measurement. That's because staffers involved can be quickly identified and interviewed about what went wrong. This method can be improved by convincing staff members they won't be penalized for reporting and that the information will be used to improve systems. "Once the staff sees their reports are used to implement improvements, reports go up," says Marjorie Phillips, a pharmacist and chair of the Medication Error Prevention Committee at the Medical College of Georgia Health System, Augusta.

**COMPUTERIZED ALERTS.** A simple laboratory or pharmacy computer system can search automatically for triggers if a medication error might have occurred; for instance, seeking out prescriptions for antidotes or for certain significant lab results. Such searches are quick and inexpensive, and can be followed up with a chart review. "You can do it in real time, which lets you find events before they actually get out of hand or result in a patient injury," says David Bates, M.D., medical director of clinical and quality analysis at Partners HealthCare System, Boston.



The Medication Safety Issue Briefs are a joint project of the American Hospital Association's Quality Agenda, the American Society of Health-System Pharmacists and *Hospitals & Health Networks*, and are made possible through the generous support of Aventis.



## ACTION *Agenda*

Here is a list of action items you can use to create a culture of safety within your organization:

- When measuring quality using error reporting, don't focus on reducing the number of errors because they will actually rise when reporting improves. Instead, work to reduce the number of harmful events resulting from errors.
- To win staff support, use the information they provide to fix problems, and let them know their reports lead to positive change.
- Don't wait until you have a complete electronic medical record—or even a pharmacy and lab system that connect—to use computers to help identify errors. Simple flags can be built into existing systems and run inexpensively.
- Voluntary reports may highlight a relatively small number of errors, but they are an important part of the mix. Reports from real staff members allow for in-depth discussion of what went wrong in the system.
- Consider sending executives on walkarounds on a monthly or weekly basis along with someone from the unit being visited.

### ADDITIONAL RESOURCES

- American Journal of Health-System Pharmacy, Dec. 1, 2002; series of articles based on presentations during the Measuring Medication Safety in Hospitals Conference, Tucson, Ariz., April 8-9, 2002.
- Gandhi TK, et. al., Identifying drug safety issues: from research to practice, International Journal for Quality in Health Care, 2000 (comparing pros and cons of measurement methods).
- *Hospitals & Health Networks*, "Medication Safety: A Framework for Change," April 2002; [www.hhnmag.com](http://www.hhnmag.com); click on Hot Topics button.

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**CHART REVIEW.** Chart review is a familiar technique in many hospitals, where it is used occasionally for specific research purposes. It can be helpful in detecting errors in drug ordering, but is too expensive and time-consuming a technique to identify errors daily.

**OBSERVATION.** This technique involves a trained observer watching staff administer medications and unobtrusively tracking errors. Researchers at Auburn University in Alabama are studying eight pilot hospitals to see if it could be a useful supplement to other error measurement methods. "It has a wonderful advantage in that there's a witness," says Kenneth Barker, director of the Center for Pharmacy Operations and Design at Auburn. "It does away with arguments over, 'Maybe that wasn't really an error.'"

**EXECUTIVE WALKROUNDS.** A relatively new idea developed by Allan Frankel at Partners HealthCare System, Boston, the walkround involves a regular visit to medical units by senior executives and vice presidents who are joined by a nurse or other available staff. They ask specific questions about adverse events or near-misses, and executives communicate to staff that it is a high priority to management.

Collecting numbers is important, but medication safety experts say it shouldn't be the main focus of a patient safety initiative. That's because a simple error rate can be misleading—it goes up when reporting improves, so a hospital appears to be making more mistakes when it simply gets better at identifying them. Instead, the focus should be on reducing harm to patients and improving the system.

### • CASE STUDY

**Cleveland Clinic:** Like many hospitals, Cleveland Clinic has created a nonpunitive atmosphere that guarantees those who bring problems to light will not be punished. But the hospital has gone a step further. Anyone who reports an error gets a thank-you card and a coupon for free pizza. Staff members appreciate the incentive and the recognition. "I've gotten thank-you cards back for the thank-you cards," says David Gragg, manager of pharmacy operations for the Cleveland Clinic. "We've had whole nursing units take up a project. They collect their coupons and have a staff party."

The reporting system, in place for about two years, also focuses on making the computer-based error reporting form easy to use. The software, designed in-house, requires as few inputs as possible. For instance, some fields, such as patient name, are automatically filled in. And medications can be chosen from a menu of drop-down items, so spelling mistakes and mix-ups are less likely.

Gragg says the changes to the reporting system have resulted in "significant" improvements in both the number of reports and their quality. However, he said the organization is trying to avoid tallying numbers of error reports for comparison because the figures can be misused and difficult to compare. Instead, he said, the hospital focuses on the results: an ongoing "to-do" list of system fixes carried out by a subgroup of the pharmacy and therapeutic committee. ●

