

# Medication Safety Issue Brief

## *Creating an Alert and Active Team*

2

of 6 in a series

Series II

Putting together an effective medication-use safety team is the focus of part two in a six-part series designed to help senior management reduce medication errors 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 this series and an earlier series, published in 2001, are available as a PDF 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

Whenever an issue comes along that calls for creating yet another hospital committee, many executives understandably roll their eyes. But medication safety belongs at the top of a hospital's priority list. The challenge is to arrange the committee so that it uses input from throughout the hospital without making the effort so unwieldy that it prevents swift, regular action. Different hospitals have found their own ways to achieve that balance.

### • ISSUE BRIEF

The medication-use process is complex. Making the process safer is a top priority not just for hospital pharmacies but for everyone in the hospital. A key starting point is putting together a team that both represents everyone involved—from nursing to pharmacy to information technology—and is lean, focused and authorized to take action.

The American Society of Health-System Pharmacists conducted a systematic task analysis of the ideal medication-use safety team. The project began as an inventory of the duties of a hospital medication safety leader, but the study group found that there was too much work for one individual. The panel identified 33 job responsibilities and 84 different tasks needed to mount an effective defense against drug-related errors. "No way can one person have all the responsibility," says Kasey Thompson, director of the ASHP's Center on Patient Safety. "You'd be setting up the person to fail." The panel identified who needs to sit on a hospitalwide medication-use safety team: a nurse, a pharmacist and a physician, all of whom understand the organization's medication-use system. The team also should include others who interact with medication processes. Adding representatives from throughout the hospital is vital, Thompson says. As hospital administrators have learned with past initiatives, attempts at change are easily shot down by any department or group that feels left out of the process. Also, management must grant the team the authority to make decisions and carry them out. "The safety team is the leadership," Thompson says. "Plus, you've got to have your entire staff on board. That starts at the top."

While the ASHP research offers a model for medication-use safety, there is an array of ways that real hospitals are carrying out those basic principles. Arrangements vary based on a hospital's size and management philosophy. Some leaders are shy about setting up new committees that could eat up staffers' time unnecessarily, so they create teams that can take action on a continual basis. Others have a variety of groups dealing with patient safety, sharing ideas and innovations informally. There are also different ways to set up a medication-use safety



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## ACTION *Agenda*

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

- Consider placing a hospital executive on a medication safety panel to keep management informed and remind staffers of safety's importance to the administration.
- Ensure that a medication safety group has representation from throughout the hospital.
- If a medication safety committee begins to stagnate, take steps to reorganize it so more action is being taken, possibly with subgroups or teams that are assigned to specific tasks.
- Identify candidates to sit on safety teams by paying attention to those staff members who seem the most enthused about reporting process problems in their areas and seeking solutions.
- Be sure staff members chosen to serve on a medication safety team are ready to take action in the areas they represent.
- Medication safety is not just a pharmacy issue, but it can be viewed that way by other departments. Take care in describing medication safety issues to avoid the constant use of the term "pharmacy."

### ADDITIONAL RESOURCES

- The Medication-Use-System Safety Strategy, Introduction and Task Analysis, a project of the American Society of Health-System Pharmacists Center on Patient Safety; available online at [www.ashp.org/patient-safety/MS3-1.pdf](http://www.ashp.org/patient-safety/MS3-1.pdf).
- Silverman J, et al. Multifaceted Approach to Reducing Preventable Adverse Drug Events, *American Journal of Health-System Pharmacy*, May 2003; available online at [www.medscape.com/viewarticle/452567\\_1](http://www.medscape.com/viewarticle/452567_1).

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team—some are subpanels of a bigger patient safety group, something the Joint Commission on Accreditation of Healthcare Organizations expects. Others report to an existing quality or pharmacy and therapeutics committee.

### ● CASE STUDIES

**Missouri Baptist Medical Center, St. Louis** (an independent 489-bed hospital): The hospital has a medication safety group that reports to both a patient safety council and to the pharmacy and therapeutics committee. The team is led by a critical care physician, who works with Nancy Kimmel, a pharmacist and patient safety specialist for the hospital. The 15-member team includes representatives from risk management, education, human resources, information services and several nursing units. The group meets monthly and deals with such issues as high-risk drugs and processes, regulatory compliance, best practices and new literature, and reviews new automation. It also maintains subgroups to focus on topics such as dangerous abbreviations, patient identifiers and insulin. By maintaining a focus on specific projects the team keeps meetings action-oriented, Kimmel says. It also helps that someone from administration sits in on meetings. "Their time is minimal but it's been a big help for us to get our program going more quickly," she says.

**The Johns Hopkins Hospital, Baltimore** (an urban academic medical center): Johns Hopkins has a layered approach to safety, with several groups that touch on the issue and share ideas via staffers who sit on multiple committees. These include a patient safety committee that oversees general safety issues with representatives from throughout the hospital, an administration-sponsored group called Innovations, a performance improvement council, and a subcommittee of the pharmacy and therapeutics committee that reviews adverse drug events and medication errors for potential system changes. "The idea of a team suggests that it's one group doing it," says Bob Feroli, assistant director of pharmacy for the hospital. "That limits the scope too much. It's important to get it widespread and get to the grass roots."

**Fairview Health Services, Minneapolis** (a seven-hospital system): While each hospital has its own group of patient safety champions, the system also has a medication safety panel that acts as a monthly forum to share ideas and resources. The panel, chaired by Steven Meisel, the system's director of medication safety, includes representatives from each hospital: a pharmacist, a nurse and the medication safety leader. The group reviews internal sentinel events and errors along with alerts from the Institute for Safe Medication Practices, and discusses projects at each hospital. Meisel is adamant that the group not become yet another drag on its members' schedules. He's not even sure a medication safety group at the hospital level is a good idea. "A group means you have to have meetings," he says. "They're deciding their agenda, reviewing reports and not doing much else. You have to have a forum for discussions because somebody has to set the agenda. But you're better served by having two or three individuals who have safety as their job taking the agenda and going out and doing it." ●

