

MEDICATION SAFETY

Starting in Medication Safety? Some hints for early career pharmacists

Don't jump into change without fully exploring all approaches



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Regardless of whether you are an early career pharmacist or the medication safety lead, all pharmacists are often asked to provide input into medication errors and to suggest or endorse mitigating strategies to prevent recurrence. Medication errors are often associated with heightened emotion, particularly when they result in adverse outcomes. Very understandably, as health care workers we are there to improve patient outcomes, not to cause harm.

There is often a sense of urgency to respond to an incident and consider changes to minimise the risk. However, sometimes initial thoughts for a solution can inadvertently create more risk.

An example I have encountered from more than one health service, and with the same solution proposed, involves incorrect intravenous potassium dispensing. There is considerable variance in how potassium is presented within the pharmacy dispensing system, with concentrated ampoules and many different premix bag combinations. The stories are different, but the outcome the same with concentrated potassium finding its way onto the ward, despite policy directing otherwise.

Think carefully before implementing change

The same solution is often suggested: the dispensing system should have the same naming convention for all intravenous potassium. In theory, this is a sound proposal and may prevent errors with product selection from the pharmacy dispensing system. Unfortunately, the manufacturers of intravenous potassium products don't all have the same naming convention!

So, what happens when the pharmacist or technician is trying to find the product on the shelf? Or for the store person unpacking stock where the box says one thing and the pharmacy shelf label says another? Or when the nurse is going to administer? Will differences between the pharmacy label and product label create unnecessary confusion and delay while clarification is sought?

This example emphasises the importance of consideration of all craft groups involved in the medication process. The pharmacist dispensing, the store person unpacking the stock in the pharmacy, the technician providing the ward imprest, and the nurse, midwife, or doctor administering to the patient.

When considering interventions in response to a medication error, it is important that all the factors contributing to the event are considered. Medication errors usually result from more than one failure, remember that Swiss cheese model!

When looking for solutions, forcing functions and barriers are far more effective than warnings, policy, and education. But remember, don't jump into implementing changes before exploring the impact of those changes on all those involved in getting the right medicine, to the right patient, at the right time.