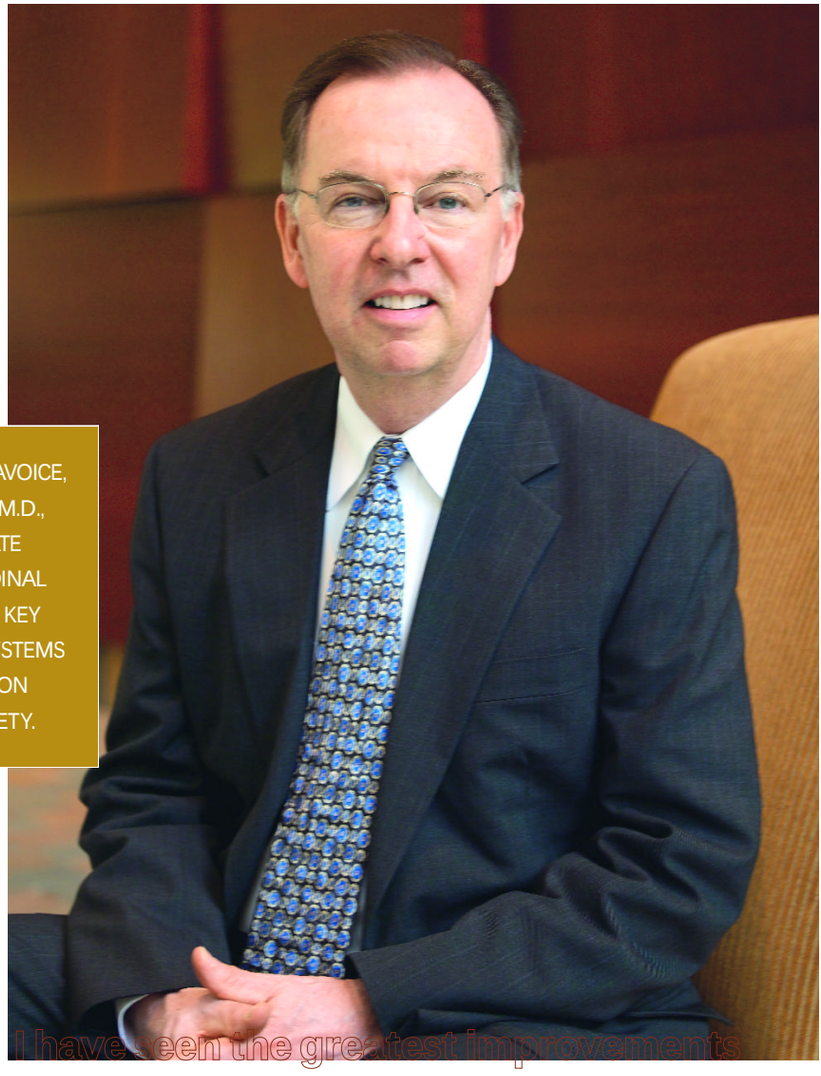
MEDICATION SAFETY

8 Focus

Long before the topic became part of a broader, national dialogue, **THE RESPONSIBILITY TO IMPROVE PATIENT SAFETY WAS TOP OF MIND WITH NEARLY EVERY PROFESSIONAL WITHIN THE VAST CHAIN OF HEALTHCARE.** But significant improvements are often difficult to achieve and elusive for health-care organizations. **IS THERE A SECRET FOR SUCCESS?**

IN AN EXCLUSIVE TO PHARMAVOICE, BRUCE MCWHINNEY, PHARM.D., SENIOR VP OF CORPORATE CLINICAL AFFAIRS AT CARDINAL HEALTH, DISCUSSES EIGHT KEY AREAS THAT HEALTHCARE SYSTEMS SHOULD CONCENTRATE ON TO IMPROVE PATIENT SAFETY.



I have seen the greatest improvements made by addressing the problem of **patient safety in a systematic way.**

Areas

As the nation's regulatory landscape continues to change, the future of patient safety is, by no means, predictable. And as each generation becomes better educated, patients will rightfully expect higher standards of quality and safety in healthcare.

According to Bruce McWhinney, Pharm.D., senior VP of corporate clinical affairs at Cardinal Health Inc., through action in eight focus areas, healthcare professionals can make significant advancements in patient safety, which ultimately lower costs and improve patient care.

"Some organizations target just one approach, such as the implementation of technology, which by itself may not achieve the desired improvements," he says. "From my own experience and from what I've learned working with other healthcare professionals over the past three decades, there are eight key areas on which healthcare systems should concentrate. Focus on these areas enables professionals to take a real-world approach and recognize the different dynamics that exist between people who prescribe medications and those who dispense and administer them."

1 LEADERSHIP AND CULTURE

Leadership in medication safety begins at the top of a healthcare system by creating a positive culture and driving it to all levels of an organization.

Creating a nonpunitive culture that promotes discovery and discussion of errors and near misses must be a priority for senior executives.

"Years ago, I observed the CEO at one large academic medical center adopt safety as a personal mission," Dr. McWhinney says. "This CEO was visibly proactive about the issue to key stakeholders internally and externally, and, as a result, this focus on safety remains palpable even today."

He says the patient must always be central in a healthcare system, and communication of this idea must start at the top with the development of a strategic plan to make safety top of mind for all employees.

2 THE PLAN

A thoughtful plan enlists comprehensive data and information to establish priorities that are focused at strategic and tactical levels. But the process of developing such a plan should not bog down the organization; flexibility is essential.

"Consider that the state of California requires all hospitals to have a safety plan, but it does not require specific activities," he says. "No cookie-cutter approach exists to assess and understand the issues specific to each organization's facility. The important point is to have a plan with clearly defined priorities."

According to Dr. McWhinney, one large academic medical center in the Midwest conducted its own study to determine its greatest safety risks. The results differed from regularly cited published studies, and the organization consequently focused on bedside safety rather than the point of prescribing.

Dr. McWhinney says regardless of the key focus areas, every staff member must be held accountable for the plan in an environment that encourages colleagues to learn from each other and build on successes. Once the plan is deployed, it is essential to closely monitor results and remain persistent about its consistent implementation.

3 THE PROCESS

Safety improvements can often be made through simple process analysis and redesign.

"Think for a moment about the extensive checklists the aviation industry uses as part of every preflight procedure," Dr. McWhinney says. "Our healthcare systems could benefit from similar presurgery procedures."

Carefully examining processes when introducing new technologies can mean fewer steps are required in a process, making the system safer, more efficient, and less expensive. Dr. McWhinney cites barcode scanning of medications as a compelling example of process improvement; barcoding eliminates steps from the process and reduces pressures for those administering medications.

4 SYSTEMS VS. PEOPLE

Most safety and quality problems relate to systems problems, not people problems, he says. The human issue is largely one of a lack of information, education, and appropriate systems support.

"Whenever a person is involved in any application, room for error exists," Dr. McWhinney says. "The key is to design safety into the process, rather than as an afterthought. This is more difficult than it sounds because it requires existing processes to be challenged."

For example, Dr. McWhinney says, serious adverse consequences from incorrect medication administration were addressed in one health-system organization by simply removing a certain intravenous drug from the patient-care unit. This drug was placed in emergency boxes and relocated to the pharmacy where it now requires a pharmacist review before administration. He says contrary to initial concerns, patient care was not compromised through this change, and serious medication administration errors have been dramatically reduced.

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5 TECHNOLOGY

Technology decidedly represents part of any solution. It is important, however, Dr. McWhinney says, to thoroughly understand the human impact of technology, as well as factors such as education of users and the required changes in existing routines.

"For example, consider smart pumps, which require extensive education to use correctly for maximum return," he says. "Once a technology is installed and in use, monitoring should continue to gauge not only the technology's effectiveness, but also continue to solve the problem for which it was originally intended."

Finally, integration is key. Dr. McWhinney encourages the review of all solutions in the context of the need to integrate with other disparate systems and technologies.

6 METRICS AND FEEDBACK

Dr. McWhinney recommends that for any medication-safety initiative, meaningful metrics need to be created, and then these metrics need to be communicated regularly to stakeholders.

"From our discussions with healthcare leaders, a simple acronym, SPOC, describes the most important feedback for a safety initiative," he says.

SPOC is short for satisfaction (patient, physician, and employee), process improvement, outcomes (best if risk adjusted, clinical outcomes), and cost management.

"Once the metrics are gathered, companies need to analyze and use this information appropriately and act on the feedback," he says. "Most importantly, people should not be afraid to conclude that an approach is not working."

7 RECOGNITION AND REWARDS

For cultural success, there is the need to motivate, educate, and manage people who work on the front lines of the medication-use process.

"People want to do a good job and do not intentionally put patients in harm's way," he says. "Successful organizations celebrate advances in patient safety and recognize individuals who prevent problems, report problems before they cause harm, or who file medication error reports that result in a solution."

8 COSTS

In today's financially stressed organizations, addressing medication safety is sometimes judged as too costly.

"Failure to act, however, often proves even more costly as organizations face patient harm, damaged reputations, and eroded internal morale," Dr. McWhinney says. "The most successful organizations recognize that making changes to keep patients safer can be done without incurring major costs, or costs can be spread out through effective planning."

Key to this effort is defining a clear focus, with ranked priorities. By identifying the low-hanging fruit, Dr. McWhinney says healthcare systems can justify immediate capital costs and address needed areas, as well as plan ahead for lower priority expenditures.✦

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