CHAPTER 5

Medication Safety Essentials for the Clinical Coordinator

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KEY TERMS

Employee Assistance Program (EAP)—A service offered by most employers to assist employees in times of need with counseling or other support.

Failure Mode and Effects Analysis (FMEA)—A problem-solving tool used to analyze a process or system to identify possible modes of failure and potential consequences before the failures occur.

Just Culture—A culture that recognizes the contribution of systems in error, focuses on behavioral choices and accountability, and distinguishes between acceptable and unacceptable behavior as well as between unsafe acts and the blatant disregard of safety procedures with which most peers would comply. Just culture is one component of an overarching safety culture.

Mistake-Proofing or Poka-Yoke—A device or method that prevents people from making mistakes or implementation of fail-safe mechanisms to prevent errors from occurring with a process (e.g., an ATM that gives the debit card back before the cash so that the card is not forgotten).

Near Miss—An error process that is stopped or interrupted either by chance or through a check-and-balance in the medication-use process, such as recognition of the problem and intervention by an experienced practitioner before it reaches the patient. Other similar terms include close call and good catch.

PDSA (plan, do, study, act)—A quality improvement methodology involving plan-do-study-act steps for planning, implementing, evaluating, and changing a process or system.

Root Cause Analysis—A systematic process utilized to determine the primary cause of system failures that has already occurred. The goal is to define the root causes and develop an action plan to prevent recurrence or mitigate a future event.

Second Victim—A healthcare provider involved in an unanticipated adverse patient event, medical error, and/or a patient-related injury who becomes victimized in the sense that the provider is traumatized by the event. Frequently,

second victims feel personally responsible for the unexpected patient outcomes and doubt their clinical skills and knowledge base.

Introduction

As a clinical coordinator, it is important to have a solid understanding of the pharmacy department's role in medication safety. If the department has a medication safety officer (MSO), it is also important to know how to interact with the MSO; if there is no MSO, you will need to be the medication safety leader and know how to lead these efforts. This chapter will outline the critical information about being an effective leader in medication safety whether you are complementing someone else's efforts or leading the efforts.

Medication safety is important to incorporate into everything that you do as a clinical coordinator. If you make decisions and lead with the patient at the center, this will help you make sound decisions and remove emotion from discussions. This chapter provides a high-level overview of medication safety for the clinical coordinator. For more detailed information about medication safety, I recommend Larson and Saine's *Medication Safety Officer's Handbook*.[1]

Medication safety-related errors will happen in the organization, and you need to know how to address these from a clinical coordinator's perspective. Sometimes you will be asked to be the expert to explain the medication's clinical aspects; sometimes you will have a staff member involved and need to learn what happened from them; and sometimes you will be the expert for the pharmacy medication management processes. You may be asked for this information via email, sidebar in the hallway, or in a more formal setting such as a **failure mode and effects analysis** (FMEA), **root cause analysis** (RCA), or during the medication safety committee meeting. Whatever the situation, it is important to make sure you have all the facts and always look for the story behind the story. It can be tempting to just ask a few questions and make a conclusion, but you need to keep digging and ask probing questions. One good technique is to continue to ask "why" several times until the root cause or the underlying reason is discovered. It is important to ask objectively and tactfully. Try not to lead the employee to the answer you want them to give, but instead let them talk and share what they know.

Talking with Staff and a Culture of Safety

Addressing medication errors with the staff can be challenging and should be approached thoughtfully. You will need to ask staff members for their recollection of what happened. Remember, they may be worried about getting in trouble or need help remembering what happened. Have discussions in a private area rather than in the middle of the patient care unit or where others are around. You can go to their work area rather than calling staff members to your office, which might place them on the defensive because they may be scared or concerned about the discussion's outcome. Having a good culture of safety at your organization will help to facilitate this conversation. In a strong culture of safety, employees know that medication errors may happen as a result of a system failure or due to something more pervasive than an individual's mistake. If your organization does not have a strong culture of safety, I recommend investigating **just culture**.[2] A just culture supports a learning organization focused on improving processes and systems to develop a safer environment for employees and patients.

To promote a culture in which we learn from our mistakes, organizations must re-evaluate how their disciplinary system fits into the equation. Disciplining employees in response to honest mistakes does little to improve overall system safety. In a just culture, it is important to determine if the error was human error, negligent conduct, reckless conduct, or an intentional violation of the rules.[3] Once this determination is made, it is possible to hold the employee accountable for his or her actions, to help coach and console, and, most importantly, to review the system that led to the error so as to prevent future occurrences. By understanding the reason behind the error, you can build trust with your staff members. They will see that they will not be penalized for something beyond their control, but if they knowingly violate rules, they will be held accountable. Tell