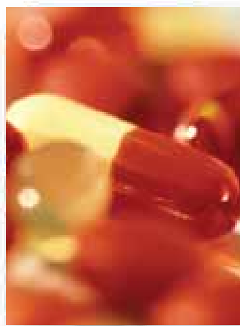

By Deb Saine, MS, RPh

Navigating the Seven Cs of a **Medication Safety Pharmacist**

Ahoy!

WANTED: Pharmacist to provide leadership in medication safety. •Identifies best practices. •Recommends process and system changes. •Ensures compliance with JCAHO, state board of pharmacy, legal, and other safety standards. •Develops policies and procedures. •Evaluates errors. •Participates on interdisciplinary teams: technology, pharmacotherapy, cost-reduction. •Collects data. •Analyzes trends. •Presents results and recommendations. •Completes research studies. •Reviews policies and printed/CPOE protocols. •Performs root cause and failure modes and effects analyses. •Manages medication error/adverse event reporting programs. •Offers educational sessions. •Precepts students and residents. •Monitors literature. •Coordinates safety-related activities of nursing, medicine, performance improvement, and ancillary areas with pharmacy.

THIS, OF COURSE, IS A FICTIONAL AD, BUT IT ENCOMPASSES ACTIVITIES THAT may be within the realm of a medication safety pharmacist. Read further to voyage into the "seven Cs" of a medication safety pharmacist.

The **concept** of a medication safety pharmacist is still evolving. Many health care organizations have responded to the publicized problem of medical errors by appointing a patient safety officer. The "safety officer" model has been around for a long time in other areas of health care operations. Moving this concept to patient care made sense, but what makes medication use stand out, and why is there a place for its own safety specialist? There is no denying it: the medication-use process is extremely complex. Flow charting the process often documents hundreds of steps. Its scope is wide: Medications "touch" almost all of our patients. Medication use involves a variety of disciplines that need to work as a team to accomplish a goal – a tall order when we are not trained as a team from the start. The harm resulting from a medication error can be devastating to patients and families. An event can be very expensive in terms of societal costs, loss of trust in health care systems and providers, and, of course, financially.

Rewind to about 12 years ago: The title "medication safety pharmacist" was scarce. A forum at a national meeting on medication safety attracted fewer than 40 attendees. Adherence to safety standards of care and monitoring programs for adverse events were often considered "administrative details," and not particularly exciting as a practice area for most pharmacists. Fast forward to the present: Medication safety has become one of the hottest topics in pharmacy, and med safety forums now boast attendance in the hundreds. What changed? Adverse events from medications surely did not become more frequent overnight. Consider these facts: Before 1962, the topic of medication errors was rarely discussed. The Institute for Safe Medication Practices (ISMP) was not established until 1994. The late '90s saw an increased number of articles published on medication error studies and individual case reviews. In November 1999, the Institute of Medicine (IOM) reported that medical errors kill 44,000 to 98,000 people in U.S. hospitals each year. A snowball effect ensued: Medication safety articles proliferated in public and professional domains; health care disciplines and organizations responded to the call; additional IOM reports followed. Medication errors remain in the limelight, and the safe use of medications continues to occupy our health systems. Enter the medication safety pharmacist.

The **configuration** of the medication safety pharmacist position varies. Positions may be integrated into the department structure as staff, specialist, manager, or a hybrid of these categories. Likewise, titles may incorporate terms such as coordinator, officer, director, or specialist, instead of "pharmacist," to reflect the scope of responsibilities Active participation in department leadership decisions – both operationally and strategically – is essential for optimal effectiveness. The medication safety position may also be external to the pharmacy department. An advantage to this structure is the ability to focus on medication use from a systems perspective, free of the departmental operations minutiae. It may be easier to build interdisciplinary synergies as part of a "neutral" home base. Whether on a full-time or part-time basis, it is important that this position is absolutely focused on medication safety activities. Secondary attention leads to secondary results. Independent of configuration, there are some desired accomplishments, activities, and skill sets common to all medication safety pharmacists.

Establishing and/or maintaining a **culture** in which medication safety thrives is fundamental to a medication safety pharmacist's activities. One must understand the problems to avoid them. Those involved in the medication-use process know it best; they are also in the prime position to identify its shortcomings. For the medication safety pharmacist to be successful, this information must be readily shared through established reporting programs, forums, one-to-one communication, teams, etc. Fear of reporting must be replaced with a desire to communicate. Building or maintaining that comfort is an overarching goal of a medication safety program. Creating a "just culture" is critical to success. Such a culture goes beyond eliminating "name and blame;" it is achieved when frontline personnel readily disclose errors, while sustaining professional accountability. A just culture recognizes that competent individuals make mistakes and should not be held accountable for system failings over which they have no control, but also has zero tolerance for reckless behavior. A just culture requires a continuous process of assessment – implementing changes when necessary – and maintenance.

A **collaborative** approach is essential to error reduction and prevention. The medication safety pharmacist should develop excellent working relationships with personnel from the departments of performance/quality improvement, risk management, nursing, education, medical affairs, information technology, and administration, along with individuals from the direct patient care workforce. Consider the example of improving PCA safety: Data obtained in collaboration with performance improvement will often be the catalyst for action plans. This may involve establishing standard concentrations, requiring the cooperation of physicians, nurses, pharmacists, and pain management team members. If the purchase of new pumps is recommended, the medication safety pharmacist will engage finance, nursing, pharmacy, materials management, and administration. A change in nursing practice (i.e. adding the step of independent verification) requires work with nursing and educators. The development of standard order sets connects prescribers, nursing, pharmacy, and others. Documentation changes may necessitate partnership with medical records and information technology. The target population is specific not only to the problem, but the solution strategy as well. Existing teams and

committee processes should be used whenever possible. Leading a medication safety team with members from medicine, pharmacy, nursing, risk management, performance improvement, and information technology has been a successful strategy for the medication safety pharmacist's collaborative approach. Medication safety pharmacists forming a new team should consider representation of all involved disciplines and departments. Ad hoc members may be used as necessary.

We have discussed some of the role's central functions, and now let us examine the day-to-day tasks of the medication safety pharmacist. In an informal survey of hospital-based medication safety pharmacists, the single activity that accounted for the majority of their time was investigating and reviewing reports of medication errors. Awarded second place was working with other health professionals on error-related issues and educating staff about errors. A not-so-distant third involved planning and implementing activities related to JCAHO or other medication safety-related standards. It was noted that increasing the awareness of medication errors was a prerequisite to other advancements in medication safety. Because the nature of their work is often linked to influencing behavioral changes, a medication safety pharmacist's "underground" efforts are often unrecognized. Such pharmacists have described their work as "being a catalyst for improvement" or "helping others see which issues are important to fix."

The **competencies** required of a successful medication safety pharmacist are similar to those needed of excellent leaders. This should come as no surprise, since the expectations are for this person to lead initiatives in medication safety. Strong communication skills, both written and oral, are required. Active listening is critical – the medication safety pharmacist must seek to understand before determining solutions. He/she should be knowledgeable about principles of medication safety, human factors, safety standards and regulations, performance improvement, systems analysis, and data evaluation. A passion for medication safety is a bonus; I am told it is not easy to hide, and it conveys the magnitude of the importance of medication safety to patient care. Creativity is a worthy skill for the medication safety pharmacist. It can be applied to problem solving, dealing with "difficult" situations, and daily communications. While safety is a serious matter, using humor, when appropriate, can be a winning approach, as message retention is often improved, and staff may even look forward to your next missive.

When asked for their favorite piece of advice for pharmacists who want to become more actively involved in medication safety, the following **citations** from medication safety pharmacists provide some insight into this exciting role: "Take a new perspective." "Be an advocate for the patient." "Share successes and failures." "Stay open to suggestions." "Be involved." "Use a systems-based approach." "Safety encompasses everything." "Safety touches all aspects of the pharmacist's role." A pharmacy career in medication safety enhances your view of the health care environment and can be most rewarding.

Your **challenge**: Continue the journey, and consider how you might incorporate a medication safety pharmacist into your medication safety plan. As J. Lyle Bootman, cochair of the IOM Panel said, "I'm hoping the pharmacy profession rises to the occasion and takes a leadership role." Happy sailing on your passage into the world of the medication safety pharmacist. ■

Deb Saine, MS, RPh, medication safety coordinator at Winchester Medical Center in Winchester, Virginia, has worked in medication safety for the past 15 years. The chair of ASHP's Section Advisory Group on Medication Safety, she received her BS in pharmacy from the University of Toledo and an MS in management from Antioch University.

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