MEDICATION SAFETY

World Patient Safety Day 2022: Medication without Harm

Powerful impact by using patient stories for medication safety

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Medication without harm is the theme for the World Health Organization's Patient Safety Day in 2022. With medications the most common intervention in healthcare, it is not unexpected that medication errors do occur and occasionally with disastrous outcomes. In Australia, we are fortunate that these events are extensively reviewed so that systems and processes can be rigorously examined. Patients and families have the opportunity to provide input into these reviews and they overwhelmingly report the main objective for them is to ensure other patients or families don't experience the same error they did.

Medication safety pharmacists and pharmacy technicians play a significant role in reducing the risk of medication errors and medications causing harm. Whether it's benchmarking, investigating errors, reviewing new products, educating staff, developing new procedures, or implementing revised processes. The main objective of all these activities is to reduce medication errors.

However, conveying messages to busy, overwhelmed, and exhausted healthcare staff is challenging. Yet another memo, email or procedure to read, online training package to complete, or education session to attend. The reasons why a change is required often becomes lost in medication safety initiatives because the attention moves to the implementation and then the auditing: ensuring every ward has the ENFit syringes; segregated storage for neuromuscular blocking agents; checking compliance rates for training; and so on. Similarly, when reviewing reported medication errors, the focus is the numbers and trends, and not about the patients.

Have you considered how the powerful words from patients, carers, and families can assist in conveying medication safety messages? Or how the 'story' of the error can add impact, cementing the message and increasing the possibility of recall when staff are presented with a similar situation?

What was the experience for a patient when:

- a wrong medicine was administered because the medication names sounded similar
- a parent is informed that a medicine that should be given orally was given directly into their child's bloodstream
- a patient is informed that the clot in their leg could have been prevented if only a medication had not been omitted?

If including the patient story is new to you, reflect and consider the following. Ensuring you maintain confidentiality, start including a snippet of patient information into your team huddles. Add an agenda item to your meetings as a prompt to all attendees to have a story ready to share. Quote the patient directly if you can. Start

with the patient story as the ‘why’ when implementing a change. Engage with your quality unit and consumer representatives. Embrace feedback, both compliments and complaints, and consider how you can use these stories.

Circle back to the ‘why’ to remind colleagues about why we put medication safety initiatives in place by sharing the patient stories again and again, not only to refresh the knowledge for existing staff but to educate new employees.

Patient stories about how a medication error affected them are powerful and their impact is not to be underestimated as we all strive to achieve medication use without harm.