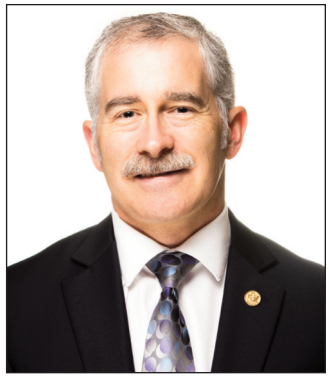
To Err Is Human, …

Douglas Doucette

The issue of medication errors has been receiving much attention lately. At a recent pharmacy conference, Melissa Sheldrick shared the heartbreaking story of her son's death from an unintended overdose of baclofen involving the family's pharmacy. Melissa has become a leading advocate for patient safety, and I encourage you to read about her courageous efforts to prevent medication errors (https://pharmacyconnection.ca/interview-melissa-sheldrick-winter-2018/). This past summer, Canadian media reported on a medication error involving 3 oncology drugs that were potentially underdosed as a result of IV administration procedures (https://www.theglobeandmail.com/canada/article-hundreds-of-cancer-patients-received-partial-doses-of-medication/). Numerous hospitals and cancer centres detected the error, undertaking widespread notification of patients and families, responding to their concerns about the potential risks, and providing assurances that the issue had been resolved for future patients (https://www.theglobeandmail.com/canada/article-manitoba-will-now-inform-cancer-patients-of-partial-doses-as-quebec/).

Research shows that medication errors and serious adverse drug reactions are a leading cause of harm worldwide. The Canadian Institute for Health Information recently reported that harm occurred for 1 of every 18 hospitalizations in Canada, with many of these incidents involving medications (https://www.cihi.ca/sites/default/files/document/cihi_cpsi_hospital_harm_en.pdf). To counter this statistic, the Canadian Society of Hospital Pharmacists (CSHP) is committed to advancing medication safety practices, as evidenced by frequent collaborations with other organizations and agencies. For example, developed in conjunction with the Institute for Safe Medication Practices Canada, the CSHP's *Medication Incidents: Guidelines on Reporting and Prevention* (available through https://www.cshp.ca/medication-incidents) provide best-practice information for organizational programs to report and help prevent medication incidents, and enhance quality of patient care. Similarly, CSHP collaborated with the Canadian Patient Safety Institute and others to develop *5 Questions to Ask About Your Medications*, a tool to help patients and caregivers talk about medications and improve communications with healthcare providers (http://www.patientsafetyinstitute.ca/en/toolsResources/5-Questions-to-Ask-about-your-Medications/Pages/default.aspx).



The CSHP's recent survey of its Excellence program (available from https://www.cshp.ca/what-we-heard) showed that 68% of management level respondents were involved in evaluating the impact of risk reduction strategies for the medication system within their organization. This finding indicates that knowledge is being translated into practice, but one-third of respondents still have room to improve. In direct patient care, such strategies may involve paying more attention to decisions at transitions of care and promoting initiatives such as deprescribing and stewardship of antimicrobials, opioids, and other medication classes. The same survey showed that patients want to learn more about the uses, benefits, and side effects of their medications. Front-line clinicians can help to reduce the risk of medication errors and related harm through patient encounters, seeking to understand patients' beliefs and behaviours about medications and health conditions, providing education, and sharing goals and plans with other healthcare providers.

Over the years, CSHP has shown strong advocacy for patient safety and the reduction of preventable medication harm. At the same time, you, as individual practitioners, have a vital role in detecting and reporting errors. Reflect on your own level of awareness for error detection and the strategies available in your department or institution for reporting or preventing medication errors. How would you and your team respond to a medication error involving your patient, whether or not harm was evident? How would you support the patient and family, and those healthcare providers involved? Thinking about these issues ahead of time will help in efforts to prevent and address medication errors.

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