



HUGH B. MACLEOD

Getting Serious About Medication Safety



If we want to accelerate change in medication management and improve quality and patient safety outcomes on a large scale, we have to do things differently. Cultural and behavioural changes are required. Perhaps most importantly, we need leaders and champions to carry changes in practice forward to make medication safety a priority.

A key medication safety issue is how to get the right parties to understand where we are and what we must collectively do to change behaviour. How do we get people to reflect in a way that will enable them to outgrow the constraints of the current approach to medication safety?

It may not always be easy to confront historic, systemic, or behavioural barriers to change.

To change behaviour and regenerate hope and confidence in the health care system, leaders, (both formal and informal) need to learn how to integrate three things:

1. *Creating*: We must nurture innovation that will bring about a well-connected and properly aligned medication safety and medication management system.
2. *Preserving*: We should leverage, sustain, and spread processes that already work.
3. *Discarding*: We need to abandon old patterns, structures, and processes that do not work.

When these approaches are not integrated, we are at risk of living with gaps in medication safety.

However, we should recognize that the solutions to our overall quality and patient safety challenges are within the system. Health care providers carry the seeds of redesign, but there are often intellectual, emotional, and systemic barriers to their planting (MacLeod, 2012).

How can we as leaders tap into and create a culture that encourages intellect, passion, commitment, and experience? How can we lead this development at all levels of the health care delivery system to make real medication safety changes that satisfy health care consumers' needs and expectations?

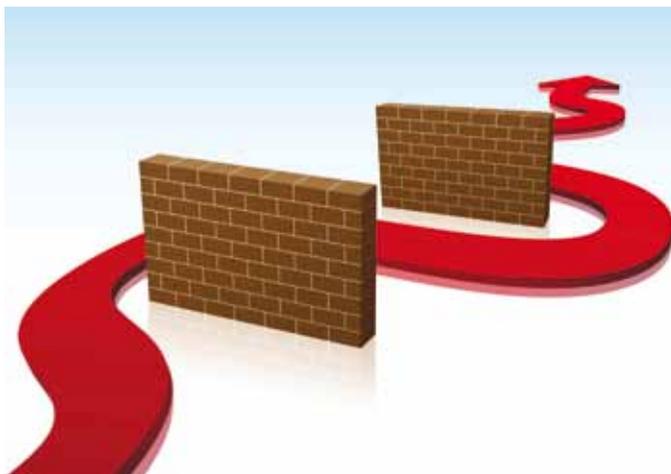
We need to learn to stop worshipping the current system; it is merely an evolving tool.

Tom Van Dawark, the former Board Chair of Virginia Mason, made this observation in response to a recent *Healthcare Quarterly* opinion piece Steven Lewis and I wrote titled, "Asking the Unaskable-Thinking the Unthinkable" (2012).

"What I continue to find fascinating, as well as extremely frustrating, is that the 'wicked' questions you pose for health care are not considered wicked at all in most industries outside health care, even those in high-consequence environments. Shortly after assuming the role of CEO in Foss Maritime many years ago, the company was sold to a group of private investors and my new board chair had but one question when we first met; 'Would my children and grand-children be safe if they worked for our company?' Imagine how we could move the safety and quality indicators in health care if trustees asked their CEO about the safety of families and loved ones as patients in their organization."

If we want to accelerate change and improve quality and patient safety outcomes on a large scale, we have to do things differently. We, means all of us. We all have either the legal or moral authority to promote quality and patient safety; some have both. Collectively, we have the power to make health care accountable to the patient, resident, or client.

It may not always be easy to confront the historical, systemic, or behavioural barriers to change. It will take courage to abandon old patterns, structures, and processes that are incompatible with a patient-centered approach. That said, here is my summary of what we need to do, and why:





1. We must get serious about medication safety.

- Almost everyone in the health care system is taking medication(s).
- The cost of readmissions related to medications is prohibitive. “More than 180,000 Canadians had unplanned readmission to acute care within 30 days of discharge in 2010, costing an estimated \$1.8 billion and accounting for 11% of all acute hospital costs. The rate for readmissions for medical patients was 13.3%.” (CIHI, 2012)
- Error prevention strategies for high-alert drugs (e.g., insulin, opioids) are not yet fully implemented across Canada.

2. Medication Safety should be about healthy relationships and interactions.

- Medication safety is often about interactions between people and technology.
- Medication safety outcomes are the result of interactions between providers and their patients, clients, or residents.

- Medication safety in delivery is largely about the way providers interact with each other, their organization’s processes, and technology.

3. Cultural and behavioral changes are required.

- As staffing strategies change, we need to have conversations about health care professionals’ level of medication knowledge.
- We must do a better job of educating health care consumers about their medications.
- Carrying a personal medication list needs to become a common practice — like wearing a seat belt.
- Great work is happening in pockets across the country. We need to work together to capture best practices and disseminate them using aggressive knowledge transfer strategies.

4. We need to focus.

- There are multiple players in the quality and patient safety agenda; this can be confusing and can feel crowded when we try to involve everyone.

- Duplication exists; it should not.
- There is misplaced competition (both passive and aggressive) among health care service providers.
- Policies and operational directions can be erratic.

5. We need to consider the patient perspective.

- There is tremendous power in technology such as cell phones, apps, and social media.
- Important demographic shifts are happening.
- Issues around home care (e.g., ethics and risks) are increasingly important as a result of these demographic shifts.

6. We need to support our work force.

- The impact of absenteeism and presenteeism (attending work while physically or mentally ill) is dramatic.

- Our limited capacity to take on new priorities while dealing with previous priorities should be acknowledged and managed.
- The importance of ‘human factor design work’* cannot be underestimated.

7. We need:

- **LEADERSHIP** ... to understand that culture (at the organizational and unit levels) is incredibly strong and can act as a barrier to new strategies.
- **LEADERSHIP** ... to understand that entitlement, expectations, and emotions sometimes trump evidence.
- **LEADERSHIP** ... from governments, boards, and those at the senior executive level who can help tear down silos, so all the relevant stakeholders can work together on medication safety.

We have libraries and databases filled with advanced health care research. We have board rooms filled with transformative ideas. We have conferences filled with brilliant minds, and the list goes on. We should be able to make our way through implementing new medication safety strategies, and I’m convinced that together, we will! Q

Hugh B. MacLeod has been the CEO of the Canadian Patient Safety Institute since 2010. He also served as Ontario’s Associate Deputy Minister, Executive Lead, Premier’s Health Results Team. In this position, he was responsible for a provincial surgical wait time strategy, a provincial primary care strategy, and the creation of the Local Health Integration Networks. Hugh also held a number of positions in British Columbia, including Senior Vice-President of Vancouver Coastal Health and Senior Vice-President of the Health Employers Association of British Columbia.



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* This is a multidisciplinary approach to designing service delivery systems in which people work, given their overall capabilities.