Learning From Medication Errors
Promoting a Culture of Safety and Support in Your Practice

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Working to eliminate preventable medication errors is a worthwhile goal for any healthcare practice. However, in the fast-paced healthcare environment, with the numerous demands on doctors and the large volume of available medications, the possibility of eliminating all errors is unlikely. Thus, being prepared to handle errors and learn from them is a priority in creating a culture of safety that is continually evolving and improving.

Just as healthcare practices should have processes and procedures in place to guide medication safety, so too should they have adequate systems and processes for identifying, addressing, disclosing, and reporting medication errors, adverse drug events, and near misses — as well as ample opportunities for staff to learn from errors that occur both within the practice and in the healthcare community at large.

Identifying

Root cause analysis often is the first step in determining how and why a medication error occurred. The best way to initiate the analysis might be to examine the healthcare practice’s current policies and protocols. These guidelines should clearly define the appropriate actions for evaluating the events surrounding an error or near miss, such as saving materials or supplies that might help determine the cause of an error.

In addition, staff members who are involved in a medication mishap should help review and assess the incident and the circumstances involved, and management should seek their input on strategies for improving system- or process-related issues that may have contributed to the error.

The Institute for Safe Medication Practices (ISMP) also suggests that, when attempting to identify errors and their causes, healthcare practices might find it helpful to seek external feedback from local pharmacies and hospitals about any possible errors originating in the practice. This feedback can provide valuable information that will help improve internal processes.¹

Addressing

Following an analysis of the root cause of a medication error or near miss, designated staff members should recommend and implement any changes or additional steps to the practice’s procedures for prescribing, administering, storing, or dispensing medications.
Additionally, the practice should determine a viable way to communicate critical information about errors and near misses with staff, whether individually (e.g., in an alert sent to staff mailboxes) or as a group (e.g., in a staff meeting). Timely and proactive communication will encourage staff members to participate in medication safety initiatives and feel comfortable making recommendations and asking questions.

**Disclosing**

Perhaps one of the most difficult aspects of managing medication errors is disclosing the error to the affected patient and, if applicable, his or her caregivers. Despite the difficulty, patients should be informed of errors, regardless of whether they result in harm.

To assist with this process, healthcare practices should have policies in place that guide disclosure activities and provide specific strategies for disclosing medication errors, such as who will be present, what wording is appropriate, and how follow up will occur. Any disclosure activities need to be documented in the patient’s record; only factual — not speculative — information should be included.

Additionally, clinicians and staff members who are involved in serious medication errors should be offered counseling services and emotional support from colleagues to help address feelings of guilt, sadness, stress, or anger. Often referred to as the “second victims” of medical errors, as many as half of all clinicians might be involved in serious adverse events at least once during their careers.²

A culture of safety not only encourages adequate systems and processes, but also a network of support for patients and staff.

**Reporting**

Reporting medication errors — both within a practice and to external entities — can provide valuable data for assessing and improving medication safety. Mandatory requirements for error and adverse event reporting vary by state. Confidential and voluntary error-reporting programs, such as the FDA’s MedWatch and the ISMP’s Medication Errors Reporting Program, also collect data and disseminate information about the causes of medication errors.

Practice guidelines and policies should clearly establish what types of events and incidents should be reported. Further, a functional system should be in place for documenting medication errors and near misses. The system should capture the information necessary to adequately assess and study each error or event.
Practice management and leadership can facilitate these efforts by encouraging staff to report incidents (even if the errors were caught or corrected) and commending staff whose actions bring these issues to light. The ISMP explains that “a non-punitive approach” to error reporting will help determine the causes and appropriate responses.3

**Learning**

Learning from medication errors that occur in the practice and in other practices and organizations is one of the best ways to prevent repeat occurrences. In a culture of safety, all errors should be viewed as learning opportunities, and information gathered from error analyses should be used to improve medication safety processes.

To support continued learning, staff need ongoing training on the causes and prevention of medication errors, as well as on new medications, technologies, and devices. Staff also should be thoroughly trained in office policies and procedures related to identifying, addressing, disclosing, and reporting medication errors.

Routine evaluations of a healthcare practice’s care processes and medication safety initiatives will present an opportunity for staff to demonstrate competency in safety procedures and strategize how best to develop new initiatives or improve existing protocols.

Additionally, healthcare practices can utilize their electronic health record systems to support efforts to better understand and reduce medication errors. For more information, see MedPro Group’s guideline titled *Using an Electronic Health Record System as a Quality Improvement Tool.*

**Conclusion**

When a medication error or near miss occurs, determining the “how” and “why” of the situation is necessary to identify gaps in process, strategize improvements, and reduce the future risk of liability.

Equally important is fostering an environment that adequately supports effective systems and processes, encourages staff participation and compliance, and nurtures staff learning and development.

A culture of safety will inspire staff to learn from medication errors, freely recommend changes, and share accountability for medication safety within the practice.
Endnotes

