MEDICATION SAFETY

Starting in Medication Safety? Some hints for early career pharmacists

The 'why' drives what we do and don't do, and helps us stay agile

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"We have always done it that way"

"That wouldn't work here…"

When you start your medication safety journey, you will no doubt hear these phrases. You might even say them yourself. So, tune your medication safety brain to prompt for the more useful questions; "why *do* we do this?" or "why *don't* we do that?" If we have a *good* answer to the why, the system or process will stick. If not, we should explore whether there is any benefit to changing.

The true challenge in medication safety is realising that there is usually not one singular way to do something safely. A principle or rule could be in place, but how it is applied in the particular setting (hospital ward, dispensary, patient's home) should take into consideration **what** we are trying to achieve (or avoid) and a **pragmatic approach** to implement a change to enhance safety, without introducing new risks. When improvement implementation is done badly, the humans working in these systems may just revert to old practices or devise workarounds.

A good example is neuromuscular blocking agent recommendations. The VicTAG Safe Management of Neuromuscular Blocking Agents is a great, practical resource.[1] But let's look at a recommendation from the Institute for Safe Medication Practices, the Targeted Medication Safety Best Practices for Hospitals (Best Practices) states "[i]n patient care areas where they are needed (...) place neuromuscular blocking agents in a sealed box or, preferably, in a rapid sequence intubation kit".[2]

In terms of the Hierarchy of Effectiveness[3] these recommendations take the recommended multi-pronged approach i.e. restricted access via imprest = barrier (high leverage) and alerts/reminders (medium leverage). The Best Practices[2] describes the rationale of these recommendations, but not the *why's*; such as *why* a sealed box. When implementing these recommendations, it is tempting to take things quite literally, in order to 'tick the box' and move onto the next project. Let's ask the *why* to persuade others of the benefits of the intervention, and more importantly, to recognise any limitations. See the table below, which assesses the intervention to store neuromuscular blockers in a sealed box.

The *WHY?*	Benefits	Limitations
Keeps neuromuscular blockers separate from other medicines Reduces chance of selection error	Selection error risk reduced, especially in a busy ward environment	Staff may take off the lid or not re-seal the box after use
Ensures neuromuscular blockers are labelled differently to other medicines stored in the same location	A high-risk label can be attached to the box, to alert staff at the point of selection	Alert can be ignored
There is a barrier to access medicines i.e. must open a seal/lid. This is a cognitive reminder	Highlights that selection of neuromuscular blockers needs care. Are you sure you want to choose this?	Risk of not being able to access the medicine in a timely manner e.g. the lid may jam Could existing separate compartments of an anaesthetic trolley be considered sealed containers instead? If trolleys are already standardised, does that mitigate the risk of selection error? Still need to confirm the product details before administration

The message is: be careful applying blanket rules without asking the '*why*'. Articulate the *why* behind improvement initiatives and apply the safety principles behind them to suit your setting. Then embed these practices for clarity and accountability into governance processes, such as committee and stakeholder consensus, and policies/procedures.

Don't forget — challenge and review practices over time, to be sure they are enhancing and not obstructing medication safety.

References

1. VicTAG. Safe management of neuromuscular blocking agents. Melbourne: Victorian Therapeutics Advisory Group 2023. Available from <https://www.victag.org.au/programs/safe-management-of-neuromuscular-blocking-agents>. Accessed 17 August 2023.
2. Institute for Safe Medication Practices (ISMP). Targeted medication safety best practices for hospitals. Plymouth Meeting, PA: ISMP; 2022. Available from <https://www.ismp.org/guidelines/best-practices-hospitals?check_logged_in=1>. Accessed 17 August 2023.