



Michael Tierney

Lessons from patient deaths

An Ontario pharmacist responds to Calgary's patient safety review

Five years ago, the Institute of Medicine in the United States published the landmark report *To Err is Human: Building a Safer Health System*.¹ Since that time, there have been numerous reports on the incidence and severity of unintended adverse events, as well as recommendations on how to prevent their occurrence. Our Canadian experience with adverse events in health care has been highlighted by two publications this year and, not surprisingly, we have learned that adverse events are an all-too-frequent occurrence in both hospitalized and ambulatory patients.^{2,3}

Their common themes are that:

- Adverse events occur too often in our health care system
- Up to half are preventable
- Medication-related events are a leading cause.

The epidemiology and statistical analyses of adverse events often fail to affect us on a personal level. However, the sober reality of these events was highlighted by two inci-

dents in Calgary last February and March, when the hospital pharmacy inadvertently substituted concentrated potassium chloride for sodium chloride in a dialysis solution, which killed two critically ill patients in that hospital.

The Calgary Hospital Region's response was swift and commendable. Notably, its review board's mandate was broad and included pharmacy services in general and the culture of patient safety within the institution.

Of the 66 recommendations included in the report, 31 pertain to pharmacy services. However, rather than being an indictment of the failures of personnel or the hospital and pharmacy services, the report provides the Calgary Health Region and other hospitals across the country with an opportunity to move forward to improve patient safety.

Easy, inexpensive

Will hospital pharmacy departments across the country seize this opportunity to implement changes to protect patient safety? Although many of the recommendations included in the report will be easy and inexpensive to address, there are several that will require additional staff, space, and equipment, and most of all, leadership that puts safety first (see excerpt at right).

As we all know, there are many financial pressures within our health care system and allocating resources to pharmacy initiatives to improve patient safety will have to compete with other areas where dollars are also needed to improve patient care.

The resources necessary for

Calgary External Patient Safety Review (excerpt)

'There seems to be relatively little discretionary spending provided in the CHR (Calgary Health Region) annual budget. Resources to fund expansion and ensure a growing population's access to health services have generally been found in internal economies rather than in new money allocations from government. CHR staff sense this and infer that using the few dollars available for discretionary spending to pay for capacity while threats to safety seem to be tolerated reflects the values of the organization. This logic (inferring values from the policies and decisions they experience) may not be valid but nevertheless informs the organization's beliefs and behaviour.'

See full report at:

www.crha-health.ab.ca/newslink/robson1.pdf

improved pharmacy services to enhance patient safety will not fall into our laps and will require leadership from within pharmacy to move this agenda forward. I would encourage all pharmacists to read the Calgary External Patient Safety Review with their own practice setting in mind and use the report and its recommendations to advocate for real change within their practice.

In addition to the specific recommendations included in the external

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EXEMPLARY CRISIS MANAGEMENT

Calgary Health Region:

- Notified patients' families as soon as possible
- Immediately began an internal review
- Notified peer hospitals to raise awareness of risk
- Initiated external review by three experts (including a pharmacist) within a month of the incident
- Released final report within four months of the error.⁴

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report on the Calgary incident, we can learn much from the approach taken. The prompt and honest disclosure of the error and the systematic, thoughtful, and multidisciplinary review should be an example to all, including individual practitioners and institutions, of the benefits of examining our errors and frailties with an open and constructive approach that focuses on what we can

do to improve our training, structures, and processes so that we can deliver better outcomes to our patients. ■

REFERENCES

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3. Forster AJ, Clark HD, Menard A, Dupuis N, Chernish R, Chandok N, et al. Adverse events among medical patients after discharge from hospital. *CMAJ* 2004;170:345-9.
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