Practical examples - Addressing medication safety in transitions of care at the organizational level

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Addressing Medication Safety in Transitions of Care at the Organizational Level

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Challenges to ensuring medication safety at the organizational level (LMIC)

- Very little or no dialogue on medication safety
- Role of clinical pharmacists restricted to dispensing in the pharmacy store
- HCW are scared that if errors are reported it reflects poorly on them
- Complacency (no one will ask, so why change?)
- Not formally taught in courses
- Mere lip service paid to good practices

Challenges to patient safety during transitions of care at the organizational level (LMIC)

- Short staffed; staff not trained adequately
- Use of IT and IT tools are less
- Best Possible Medication History mostly never taken
- Medication reconciliation almost never happens
- Language issues create confusion
- Not recognized; not reported
When the two intersect the situation can be pretty bad

Poor medication safety environment
(unsafe medication practices and medication errors)

Poor / non-existent transitions of care protocols
What can be done at an organizational level?

- Make medication safety visible – create awareness, form a group in the hospital
- ‘Catch them young’ – include the topic in all training courses for healthcare workers
- Blame free reporting – focus is to learn from mistakes; no naming and shaming
- Include med safety issues as a part of the mortality & morbidity meetings
- Document change; Encourage research at all levels
What is being done at an organizational level?

- Use of WhatsApp to connect with the prescriber and check medication – video chat
- Online medication error reporting forms – monitored by the medication safety group
- Weekly feedback on medication errors given to nurses
- Encouraging use of generics, printed prescriptions when possible
- At discharge, the nurse makes sure the medications which were dispensed by the pharmacist are once again explained by her
Implementation Research Associates for Patient Safety (i-RAPS) is a framework to involve Institutions of National Importance in India on collaborative, implementation research in patient safety in order to implement evidence based outcomes for betterment of public health delivery in India.
Thank you