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## BOOK REVIEW

# Principles and practices to identify and prevent medication errors

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## Medication Safety: A Guide for Health Care Facilities

Henri Manasse Jr. and Kasey Thompson

Publisher: American Society of Health-System Pharmacists, Bethesda, MD; 380 pages: \$69.

**C**omprehensive and authoritative, *Medication Safety: A Guide for Health Care Facilities* is an overview of principles and practices associated with the prevention and identification of medication errors.

The text includes thought-provoking analyses of public policies and other efforts related to improving medication safety in the United States. Many of the concepts and philosophies can be applied to the larger issue of patient safety in health care facilities. Perhaps most importantly, the book addresses a major system in health care and takes the reader through the entire process of patient safety.

Chapters are authored by 30 practitioners listing extensive experience in detecting and preventing medication errors.

Introductory chapters provide an excellent overview of the importance of medication safety and provide a plethora of data and literature citations that would enhance any presentation on patient and medication safety.

The opening chapter addresses the role that medication use safety has played in relation to American public policy in order to facilitate meaningful policy discussion, planning and action. It is pointed out, as stated in the IOM report "To Err Is Human," that American health care is not really a system but a "set of interdependent elements interacting to achieve a common aim" with very few systematic connections to facilitate communication, teamwork or safety. Stakeholders are asked to clear their minds of any preconceived notions about how things have traditionally been done and think creatively on how people and technology can work in concert to ensure that systems are fundamentally safe.

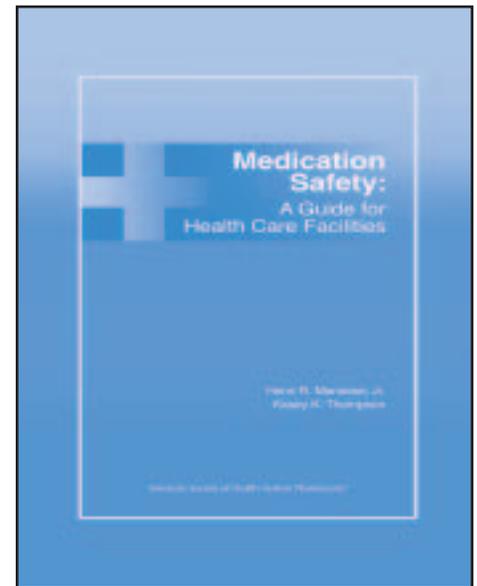
The first section concludes with the role of leadership in patient safety and how organizations can establish a blueprint for building a culture of safety. In doing so, in an era where health care resources are finite, we need to ensure that those who are responsible for making decisions about the size of our investments utilize an analytic framework that considers both the costs and the consequences of those investments.

The second section of chapters provides insight and a roadmap into the role of the medication safety team and tools in bringing about organizational culture changes. Non-health

care examples such as airplane failures and the 1999 Texas A&M bonfire accident provide parallel insight into why events that have succeeded repeatedly appear to randomly fail. Insight into non-health care examples is a useful tool in sharing with medication safety teams to illustrate that other industries face similar challenges and changes have occurred to prevent these events in the future.

Anyone working directly within an organization to build a safer medication use system must read the chapter on information technology. Strategies for the integration of automatic systems' clinical workflows and for the optimization of interactions between health practitioners and patients are outlined, and the importance to patient safety is described. Also included is a review of current and future information technologies such as computerized physician order entry (CPOE) systems, automated dispensing technology and bar-coded medication administration systems. As health systems face increased use of technology and increased financial commitments to maintain technology at cutting-edge levels, this chapter traces the safe use of technology in the medication use process.

With the current nursing and pharmacist shortage, the involvement of other health care providers in the medication use process is more commonplace. However, the transfer of responsibilities should be taken with a proactive approach to minimizing errors. Two chapters



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provide valuable insight into the application of human factors engineering in process and equipment design as well as the process changes inherent in safe supply-chain management.

The final chapters provide philosophical springboards for discussions including, "Medication-Safety Self-Assessments," "Characteristics of High Reliability Organizations," "International Perspective on Patient Safety," "The Science of Patient-Safety Research" and "The Role of the Patient and Family in Preventing Medication Errors."

### Book details fundamental changes

Who could benefit from this book? Every health system risk manager should influence the safety of the medication use process and provide guidance when new processes, new personnel skill levels and new automation are considered. Lawyers who advise institutions will find this book an invaluable resource in providing background materials for the current status of medication safety in health care. Individuals who control information technology decisions pertaining to medication prescribing, dispensing, administration and monitoring will also find this a valuable resource in evaluating future purchases and implementing safe and effective systems.

This book details fundamental changes that are needed in health care as a whole. Efforts to effect improvements in the cultures of individual departments and services such as medication use, can serve as highly productive and potentially influential examples to the broader health care system to drive the fundamental changes that must occur over time.

*Reviewed by Curtis L. Nolen, MPA, FASHRM, director of risk management, Division of Mental Retardation Services (DMRS), State of Tennessee.*



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