Relating 2007 National Patient Safety Goals to your practice, p.2

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Hospital pharmacies having trouble hiring experienced pharmacists

According to the latest annual staffing survey from the ASHP, pharmacy managers in hospital and health systems are having trouble filling positions with experienced frontline pharmacists. Among the other findings in the survey of pharmacy directors at 597 U.S. hospitals and health systems:

- 87% of respondents perceive a shortage of pharmacy managers.
- The average vacancy rate for pharmacists in 2006 was 7%.
- Almost 50% of respondents noted greater use of nontraditional staffing models, particularly in larger hospitals, including compressed work week (54%), team scheduling (48%), and job sharing (45%).


New publications

- USP30-NF25, a three-volume print format and enhanced online and CD features, is available to order in English (http://www.usp.org/products/USPNF) or Spanish (http://www.usp.org/products/USPNF/spanishEdition.html)

New resource for pharmacists

There’s a new section on The Joint Commission’s Web site that’s designed for pharmacists at http://www.jointcommission.org/Pharmacists/default.htm. It includes articles from Joint Commission Resources’ publications, reviews and updates on standards, FAQs, and safety and quality issues important to pharmacists.

Also new on the site is a revised list of look-alike/ sound-alike drugs. For the complete listing, including potential errors and consequences and specific safety strategies, visit http://www.jointcommission.org/NR/rdonlyres/C92AAB3F-A9BD-431C-8628-11DD2D1D53CC/o/Revised_LASA_list_200607.pdf.

The public trusts you

When asked to rate how trustworthy and ethical various professionals are, 73% of respondents to an annual Gallup poll indicated “very high” or “high” for druggists/pharmacists. Only nurses rated higher (84%). Car salesmen hit bottom at 7%.

Salary results in

The Fall 2006 National Pharmacy Compensation Survey report of 104 organizations includes these key results:

<table>
<thead>
<tr>
<th>Position title (Specialization: Hospital/Health care)</th>
<th>Hourly base pay*</th>
<th>Annual base pay**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy team manager</td>
<td>$53.85</td>
<td>$111.60</td>
</tr>
<tr>
<td>Staff pharmacist (retail,hospital, health care retail/satellite, mail-order/online); clinical pharmacist; nuclear pharmacist</td>
<td>$46.52</td>
<td>$96.80</td>
</tr>
<tr>
<td>Lead pharmacy tech, pharmacy tech</td>
<td>$14.18</td>
<td>$29.50</td>
</tr>
</tbody>
</table>

*Weighted mean
**Weighted mean in thousands


Watching the news

For updates on patient and medication safety, tune in free to the FDA Patient Safety News each month. This televised series for health care professionals is carried on satellite broadcast networks. It appears on many health care education networks and on the FDA Patient Safety News Web page, http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/index.cfm. Each monthly broadcast covers new medical products, FDA recalls and safety alerts, patient teaching, and error prevention. If you can’t watch the video, you can review the index and read information featured in current and previous programs.
While undergoing cerebral angiography, a 69-year-old patient was accidentally injected with an antiseptic skin prep solution, chlorhexidine, instead of a contrast medium. The clear chlorhexidine had been placed on the sterile field in an unlabeled basin identical to that used to hold the clear contrast medium. At the end of the procedure, the contrast medium should have been injected into the patient’s artery for radiographic visualization.

Instead, the chlorhexidine was drawn into the syringe and injected into the patient.

Chlorhexidine is highly toxic when injected intravascularly and the patient experienced acute, severe chemical injury to the blood vessels of her leg. Over the following 2 weeks, her condition deteriorated. She underwent a leg amputation, then suffered a stroke and multiple organ failure, which killed her.

As revealed when this incident was investigated, the hospital had recently switched antiseptics from a brown povidone-iodine solution to a clear chlorhexidine one. This decision ultimately resulted in a latent failure—two look-alike, clear solutions that were previously distinguished by color placed in unlabeled basins on the sterile field.1

To help organizations prevent medication errors like this, The Joint Commission established National Patient Safety Goals (NPSGs) and made them part of the accreditation requirements. NPSGs highlight problematic areas in health care and promote specific patient-safety improvements. The goals are derived from information on sentinel events reported to The Joint Commission and from recommendations made by the Sentinel Event Advisory Group that works with the commission to determine and create goals and related requirements.2 This article will discuss NPSGs that focus on the medication-use process and affect pharmacists working in acute care settings.

**Goal 2: Improving communication**

As one of the original NPSGs, Goal 2 strives to improve the effectiveness of communication among caregivers. Requirement 2B advocates creating a standardized list of abbreviations, acronyms, symbols, and dose designations that organizations shouldn’t use.

Throughout the years, the Institute for Safe Medication Practices (ISMP) has warned about the dangers associated with using certain abbreviations when communicating medication information. For example, the abbreviation “U” for “units” has often been misread as a zero, resulting in tenfold overdoses of medications such as insulin.

The best way to avoid using dangerous abbreviations is establishing and enforcing policies for written and oral orders.3 Avoiding these dangerous abbreviations and

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**Abbreviations from the official “Do Not Use” list**

- **U** (unit)
- **IU** (International unit)
- **Q.D., QD, q.d., qd** (daily)
- **Q.O.D., QOD, q.o.d., qod** (every other day)
- **Trailing zero** (X.0 mg)*
- **Lack of leading zero** (.X mg)
- **MS**
- **MSO₄ and MgSO₄**

*Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
dose expressions in other communications—including computer-generated labels, medication administration records, labels for drug storage bins/shelves, preprinted orders and protocols, and computerized pharmacy and prescriber order entry programs—is equally important. However, many computer systems display drug doses using naked decimal points or a trailing zero and may use dangerous abbreviations, such as QD and U. So misinterpreting orders remains a very real possibility even with advanced technology solutions such as computerized physician order entry (CPOE).4

Goal 3: Safe medication use
National Patient Safety Goal 3 is directed at promoting the safe use of medications. Requirement 3B of this goal states that institutions must standardize and limit the number of drug concentrations used in their institution. This requirement has been a challenge for hospitals whose nursing and house staff use the Rule of 6 to calculate and prepare solutions that are dosed in microgram per kilogram per minute. The formula for the Rule of 6, as referenced in The Harriet Lane Handbook, is 6 multiplied by the patient’s weight (in kilograms) equals the amount of drug in milligrams that should be added to 100 mL of solution. The infusion volume in milliliters per hour then equals the microgram per kilogram per minute dose ordered, and results in multiple concentrations of medications to be infused in patient care areas. One of the problems with the Rule of 6 is that some nurses use the formula for intravenous (I.V.) admixture, a risky procedure that bypasses pharmacy preparation and subsequent double-check systems to verify accuracy. This method also adds a mathematical calculation, which is always error-prone if done manually.5 In 2004, ISMP reported on an infant who died as a result of a calculation error that occurred when a decimal point was misplaced. The dopamine infusion prepared was 10 times more concentrated than intended. With problems like these in mind, hospitals need to adopt standard concentrations for solutions, abandon use of the Rule of 6, and have the pharmacy prepare and dispense premixed I.V. solutions while on site.3

The second medication-related requirement of Goal 3, 3C, requires that facilities identify and annually review a list of look-alike/sound-alike drugs and take action to prevent mix-ups. The list must contain a minimum of 10 drug combinations.2 The Joint Commission has released an updated list of look-alike/sound-alike medications for 2006-2007 (available online at http://www.jointcommission.org/NR/rdonlyres/C92AAB3F-A9BD-431C-8628-11DD2D1D53CC/0/LASA.pdf). Various strategies can minimize the risk of look-alike/sound-alike errors. For example, determine which name pairs are problematic in your organization and don’t store these drugs alphabetically by name; arrange them out of alpha order or put one of them in an alternate location. Encourage prescribers to provide both the generic and brand names of drugs that are problematic and to write the medication’s purpose on the medication orders. This will help you screen for proper doses, duration, and appropriateness. Also, when taking oral orders, first write down the order, then clearly read back the name of the drug and the dosage ordered, and request or provide correct spelling of the medication name.9

Problematic look-alike and sound-alike drug names

ephedrine – epinephrine
hydrocodone – oxycodone
hydromorphone injection – morphine injection
hydroxyzine – hydralazine
MS Contin – OxyContin
OxyContin – oxycodone
tramadol – trazadone

Don’t mix up these opioids

Over the years, ISMP has received many reports of confusion between HYDROMorphine and morphine, some of which have described fatalities. In fact, mix-ups between these drugs are among the most common and serious look-alike errors that can occur involving high-alert drugs. Some practitioners mistakenly believe that HYDROMorphine is the generic name for morphine. However, these products aren’t interchangeable; 1.5 mg of I.V. HYDROMorphine is equianalgesic to 10 mg of I.V. morphine.8 One such mix-up involved a 32-year-old woman who was admitted to a hospital with abdominal pain. For her pain, she was ordered 1 mg of I.V. HYDROMorphine every 2 hours as needed. Throughout the evening, the patient continued to complain of pain, and her dose of I.V. HYDROMorphine was increased to 2-4 mg every 2 hours as needed. After two doses of 4 mg, the patient continued to report a pain rating of 10 on a 1-10 rating scale. The physician, thinking 1 mg of morphine was equal to 1 mg of HYDROmorphine, ordered 4-6 mg of I.V. morphine every 2 hours. After two doses of 6 mg I.V. morphine, the patient experienced respiratory arrest. She recovered but required ventilator support for 24 hours.
The final requirement of this goal, 3D, calls for the labeling of all medications, medication containers (such as syringes, medicine cups, basins), and other solutions both on and off the sterile field. Unlabeled medications and solutions have caused many errors, some with tragic outcomes, such as the report described at the beginning of this article.

To facilitate labeling, consider purchasing sterile markers, blank labels, and preprinted labels that can be opened onto the sterile field during procedures to mark bowls of solutions and syringes. If drug or solution names are similar, use tall man lettering on the labels to differentiate them or highlight/circle the distinguishing information of the label. Also, individually verify each medication and complete its preparation for administration, delivery to the sterile field, and labeling on the field before you prepare another medication for use.1

**Goal 8: Medication reconciliation**

In 2005, Goal 8 was introduced directing accredited organizations to completely reconcile medications across the continuum of care—in other words, to develop a process for “medication reconciliation.” This process entails creating a complete list of the patient’s current medications upon entry to the health care organization. This list is to be used by clinicians when ordering new medications and when re-ordering a medication if a patient is admitted to a facility. Clinicians compare any medications ordered for that patient to those on the list and resolve any discrepancies. When the patient’s level of care changes (for example, when he transfers from a surgical unit to the intensive care unit) or upon discharge or transfer to another facility, his profile and new list of medications is reconciled and sent to his next provider of health care services.10

The medication reconciliation process isn’t new; the practice of collecting a medication list from a patient has been a standard of practice for years. Unfortunately, it hasn’t prevented errors that have occurred because of failed communication during transition points in the continuum of care. Here’s an example: ISMP learned of an error in which Pamelor (nortriptyline) was prescribed for a newly admitted patient. While clarifying another order with the pharmacist several days later, a pharmacist learned that the patient had been taking Panlor (acetaminophen, caffeine, dihydrocodeine) at home, not Pamelor. Error reports like this one serve as a compelling reason for establishing this NPSG to help prevent similar errors.

Most practitioners agree with the value of medication reconciliation, but they’re also frustrated by the difficulties they face implementing the processes in their facility. In a recent ISMP survey of over 1,400 health care practitioners, 91% of respondents were familiar with the medication reconciliation NPSG, but only 75% had attended staff-development sessions about the process. In addition, many of the respondents were unsure of the time in which medications must be reconciled. Thirty-six percent of nurses were unsure of the required time frame, as were 63% of practitioners working in outpatient/office settings. Respondents in the survey indicated that teamwork among disciplines and clearly defined protocols are important factors for a successful medication reconciliation process. The most significant barriers encountered by all respondents included unreliable reports from patients and lack of physician leadership.12

**NPSGs requiring pharmacy’s involvement**

Although some goals, such as those discussed above, are specifically directed at improving medication safety, other NPSGs apply to the medication use process and require participation of the pharmacy department.

For instance, Goal 1 aims to improve the accuracy of patient identification. The intent of the goal is to reliably identify a patient as the person for whom a service or treatment is intended and to match the service or treatment to him.13

The most common scenario of a patient-identification error is when a nurse walks into a patient’s room and administers medications intended for Patient A to Patient B. However, identification errors can originate during any phase in the medication use process. For example, pharmacists select the correct patient profile in the pharmacy computer system by entering either the patient’s name or identification number. But poor visibility of the patient’s name and number on paper order copies (often via addressograph imprint), compounded by look-alike last names, has occasionally resulted in entering orders into the wrong patient profile.

A pharmacist reported a similar error to ISMP with a different twist. To enter a new order for a patient we’ll call Franklin Hope, a pharmacist tried to access the profile using the identification number. However, the number was hard to read, and he couldn’t locate the profile. He then entered the patient’s name, Franklin Hope, and a profile appeared on the screen. While entering the order, the pharmacist happened to notice that the patient was female, not male. He soon realized that he’d been entering the order into Hope Franklin’s profile, not Franklin Hope’s!14

To help prevent patient identification errors, pharmacists and pharmacy technicians should compare the patient’s name and identification number on the computer profile to that on the order when entering medication or-
ders. Enlarging the size of the patient’s name on the screen also can improve the accuracy of CPOE. Replacing addressograph imprints with laser-printed identification stickers to improve clarity is another option.¹

Even if problems aren’t obvious in your facility today, every facility can anticipate and focus on problems by complying with NPSGs, discussing errors that have happened at other facilities, and incorporating the risk-reduction strategies presented in this article. ■

REFERENCES

Kelly Stanforth is safe medication management fellow and Matthew Grissinger is a medication safety analyst at the Institute for Safe Medication Practices, Huntingdon Valley, Pa.
Medication safety by the numbers

At St. John’s Regional Medical Center, a hybrid medication distribution model adds up to safer care at lower cost.

By Jack W. Udell, PharmD, RPh, ABE

SPURRED BY QUALITY, regulatory compliance, and financial pressures, administrators at U.S. hospitals rightly are focusing more attention on the impact of medication management on patient care. There’s also a growing emphasis on freeing pharmacists from dispensing duties in the central pharmacy and moving them into consulting roles with patients, physicians, and nurses, where they can positively influence prescribing patterns.1,2

At St. John’s Regional Medical Center in Joplin, Mo., a 367-bed community hospital, we’re ahead of the curve in many medication management respects, thanks in large part to technology we adopted. Just 6 years ago, our medication distribution system was incredibly labor intensive, requiring 16 pharmacists and 15 technicians to manually dispense about 1,600 doses per day. We had a very time-consuming daily cart fill process that consumed about 13.5 full-time equivalent (FTE) staff. We used a pneumatic tube system that delivered all orders that were “first dose,” “now,” and “stat” to the nursing floor, and we did all filling by hand. Each day, we had scores of returned medications and dozens of missing medications. Constantly filling orders and fielding phone calls from nurses, we were too busy to have a clinical program. Clearly, we needed to make a change.

Pharmacy models to choose from

The American Society of Health-System Pharmacists 2006 National Survey of Pharmacy Practice in Hospital Settings3 defined two models for distributing drugs—centralized manual distribution, in which medications are manually distributed from central pharmacy to nursing units, and decentralized distribution, in which nurses retrieve 85% to 95% of patient medications from medication cabinets on patient floors, which pharmacy staff manually replenish.

But I suggest a third model—hybrid distribution. Using automation technology, such as robotics or carousel technology, central pharmacy provides 85% to 95% of medications to nurses in bar-coded, patient-specific form. Nurses retrieve opioids, p.r.n. medications, and some first doses from a vastly reduced medication cabinet footprint.

After reviewing the literature, examining data, attending conferences and seminars, consulting with peers, conducting site visits, and completing a thorough business case analysis, we concluded that hybrid distribution, with its bar-coding foundation and inherent safety and productivity benefits, was clearly what we wanted to develop.

In presenting our case to hospital administration, we projected that our new, hybrid distribution system would reduce dispensing errors and increase pharmacists’ intervention. We projected a cost of $1.2 million over 6 years but we also anticipated saving the hospital $400,000 in the first year alone. In reality, we surpassed that first-year savings target by $28,000, and we’ve continued to see increased benefits every year since. To quantify our savings, our accounting department looked at the type of interventions our pharmacists make and put a dollar value on them, based on the literature. For example, dollar values were established for initiating a more cost-effective therapy or dosing a drug based on renal function; in addition, preventing a major adverse drug reaction was given a higher dollar value than preventing a minor one.

Dispensing to 99.9% accuracy

We redesigned our pharmacy team processes around a bar-code-based, hybrid distribution system. In the central pharmacy, we introduced ROBOT-Rx, McKesson’s robotic dispensing system, to automate the storage, dispensing, returning, restocking, and crediting of bar-coded medications. To prepare all of our medications in bar-coded, unit-dose form, we instituted McKesson’s PakPlus-Rx packaging service, which also serves as an inherent quality check, helping prevent dispensing errors. Our PakPlus-Rx technicians apply bar codes to all of our medications at a rate of about 600 unit doses per hour. All doses must pass through a five-point check before entering inventory.

Automating our systems saved us a lot of time and directly correlated to improved medication safety. It let us reengineer our processes and redeploy pharmacy staff to roles where they can interact with clinicians and directly
impact the quality of patient care.

From day one, ROBOT-Rx, operated by pharmacy technicians, has automated the dispensing of nearly 94% of unit-dose solid medications and single-dose vials. Overall, daily cart fill time has declined from 13.5 FTE hours to 3 FTE hours, including manual picks. The robot also dispenses between 65% and 75% of first doses.

The robot dispenses to 99.9% accuracy. In fact, the Missouri Board of Pharmacy, like those in about 24 other states, has granted a waiver for a full pharmacist quality check for those facilities using ROBOT-Rx. Even so, our pharmacists perform a 5% random check. Our robot has never picked a wrong dose, a wrong strength, or a wrong medication; the only errors occur when it’s dropped a dose before putting it into a cassette or when it grabbed two packages instead of one. These problems occur only rarely. Except for intravenous (I.V.) medications, opioids, and some oral liquids, all medications are dispensed from the central pharmacy in bar-coded form in containers personalized for each patient. Missing medication rates are down 75% over the past 5 years, expired medications have been reduced, and we reduced our cart fill dispensing error rate from 2.5% to less than 0.1%.

These results, along with improved turnaround times, have greatly improved nursing satisfaction and boosted pharmacy’s standing throughout the hospital. Nurses are confident that they’re getting the right medications in the right dose for a specific patient in a timely manner. And they like having a pharmacist on the floor to resolve any questions about drugs—and give them more time for patient care.

We still have room in our hybrid distribution model for medication cabinets, although we have a much smaller cabinet footprint than other hospitals our size. We have 29 medication cabinets located on the nursing units. Nurses use these for some first doses, as well as for opioids, p.r.n. medications, and floorstock items.

More recently, we added two MedCarousel units to central pharmacy. Their bar-code technology and pick-to-light feature, which directs technicians and pharmacists to the appropriate location, help reduce the risk of medication picking and restocking errors. We use the carousels to fill cabinets, for manual picks for cart fill and first doses, and for inventory control.

All automation systems are interfaced so that if an item isn’t stocked in the robot, it automatically queues up the carousel. This makes managing systems, running reports, and evaluating system effectiveness easier.

**Pharmacists taking on clinical roles**

Without a doubt, the most dramatic outcome enabled by our hybrid medication dispensing system—and the area most beneficial to our patients and the hospital—is our re-designed clinical pharmacy practice. Automation let us redeploy our pharmacists from dispensing activities to clinical roles. For most of our staff pharmacists, this was the first time they were part of a clinical care team. So, to start, we conducted extensive training on our outcome goals, including clinical assessments; economic evaluations; and humanistic outcomes such as patient satisfaction, adverse drug reactions, and quality of life. We had staff pharmacists shadow the hospital’s clinical pharmacists.

We established clear protocols for ensuring effective drug therapy. We covered such responsibilities as changing or clarifying medication orders, eliminating therapeutic duplications, evaluating drug–drug interactions, and avoiding adverse drug events. We also included participating in formulary conversions, recommending medications, providing pharmacokinetic consults, making therapeutic substitutions, and reporting medication error and drug levels. Next, we set forth rigorous documentation requirements, gained independent cost validation through our finance department, and committed to frequent analysis for continuous improvement.

Staff pharmacists embraced their new responsibilities. Today, we have three clinical pharmacists, each spending 40-plus hours per week on the nursing units. Combined, they perform more than 3,200 patient-pharmacist interventions each year. By decentralizing our staff and increasing other clinical activities, our department documented a total of 10,249 accepted interventions during 2006. Job satisfaction and retention improved immediately and have held strong in the past 5 years. One pharmacist has returned to college to earn his PharmD degree and is now responsible for our critical care area. Furthermore, the impact made by our patient-pharmacist interventions has prompted physicians, nurses, and others on the patient care teams to ask us to increase our clinical presence. None of this would have been possible without the hybrid distribution system.

**The bottom line: Saving money**

Here are three potential financial disadvantages with the decentralized model.

1. It stores up to 95% of medications in cabinets, so, for example, a 400-bed hospital would need 25 to 30 additional cabinets, costing as much as $125,000 per year. That 40% larger cabinet footprint provides poor asset productivity and no return on investment. Furthermore, to fill those cabinets, hospitals have to increase their annual drug expenditures.

2. It relies on expensive nurse labor for medication retrieval, which costs more and takes nurses away from pa-
Patient care activities—up to 45 minutes per nurse, per shift.

3. It keeps pharmacists in the pharmacy, performing order entry, quality checks, and other dispensing duties. Because bar coding isn’t required, the decentralized model doesn’t adequately position hospitals for these initiatives.

In conclusion, automation has decreased our medication waste and given us much better control over our inventory; we’ve had an 8% increase in drug expense per dose dispensed, despite double-digit inflation on most prescription drugs. Through pharmacy interventions, we reported cost savings to our hospital of $75,000 per month during 2006, proving a direct correlation between pharmacist involvement and dollar savings. Most important, patient care has improved as pharmacists are more involved in clinical care. These cumulative savings in terms of improved efficiencies, redirected capital assets, and savings gained through improved patient safety enabled us to realize a documented return on our hybrid system investment in less than 3 years. Today, our pharmacy workflow revolves around our automation systems.

At St. John’s, like other hospital pharmacies, workload increases are a way of life. Between 2002 and 2006, we saw a 15% jump in the number of doses dispensed. Increased regulatory requirements now consume much more of our time. However, our automation systems have the capacity to easily handle this extra workload without impacting FTEs. Clearly, our hybrid distribution model has been highly successful. The numbers speak for themselves.

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REFERENCES
Understanding the responsibilities and risks of moving into management

Moving into management is a great way to advance your career, but it’s not without risk. If you decide to take the next step in your career, make sure you understand what new responsibilities it will entail. Review the job description and required qualifications for the management position. Determine whether your skills can support these new duties.

Also, make sure your training and education prepare you for the job. You may need some inservice training or want to take some managerial training courses on your own time to fill in gaps in your background. Remember, performing tasks that are beyond your scope of practice or your job responsibilities can pose a liability risk.

If you’ll be supervising others, get familiar with the competencies and assigned duties of all staff members. To help protect them from liability, review their job descriptions and what procedures their licenses let them do. Consider making necessary changes to protect you, the staff, and the facility from a lawsuit.

Both you and your staff should be familiar with the chain of command and where you fit into it. If problems occur or questions arise, you should know where to turn.

Finally, know your facility’s policies and procedures and be aware that violating them can have consequences. Get familiar with your state’s employment and practice laws, as well as your employer’s policies. If you’ll have hiring and firing authority, for example, you’ll have to understand how to properly maintain employee files and what you can and can’t say when interviewing potential staff or terminating a subordinate.

What if you’re asked to be an expert witness?

An expert witness helps jurors determine if a defendant maintained the standard of care or acted in the same way a reasonable and prudent health care professional with a similar background would have acted in similar circumstances. Before you agree to testify as an expert witness in a malpractice case, make sure you understand what’s expected of you.

If you decide that you may want to offer your services, ask yourself these questions:

- Am I qualified?
- Do I feel comfortable with the attorney handling the case?
- Am I sure I have no conflicts of interest—such as having worked previously with the defendant—that would make me a less-than-ideal witness?
- Am I well versed in my specialty’s standards of care?

If you answered “yes” to these questions, you may be well suited to be an expert witness. You’d be asked to review copies of medical records and other documents relevant to the case and provide an opinion about if and how a standard of care was met, as well as other related matters. If your opinion supports the attorney’s position, you’d most likely be asked to testify.

If you do serve as an expert witness, practice your testimony with the attorney before getting on the witness stand. Avoid looking too rehearsed, which could jeopardize your credibility. Answer questions objectively, honestly, and succinctly. Don’t volunteer information or provide testimony outside your area of expertise. Speak firmly, try to use language that laypeople in the courtroom will understand, and explain any clinical or technical terms. Above all, make sure your professional liability insurance includes a consulting services endorsement, which provides protection if your testimony results in a claim being brought against you.

Harmful errors: How will your facility respond?

If you don’t have a plan, here’s where to start.

TO HELP GUIDE the most appropriate response to a harmful error, all practice sites should have a well-designed plan that’s fully supported by the organization, including the board of trustees, executive leaders, professional staff, risk managers and attorneys, human resources and staff development personnel, public relations staff, and middle managers. The plan should address the following:

• **Internal notification.** Who needs to be notified about the event internally, such as the physician, manager, senior leaders, board of trustees, risk management, patient safety officer, director of pharmacy (for a drug-related event), and professional staff? Who provides that notification? How should staff report a harmful event to risk management? What’s the timeline for notification of the event? How will affected staff be notified about the event? How are staff and the board updated about the investigation and action plan? How will internal public relations activities be conducted so that appropriate staff know the story and how it’s being addressed?

• **External notification.** As required, who’ll notify external organizations, such as the department of health and the state reporting program, about the event? Who will the organization voluntarily notify, such as The Joint Commission, U.S. Pharmacopeia—Institute for Safe Medication Practices (USP-ISMP) Medication Errors Reporting Program, and product or device manufacturers, so others can take precautions to prevent similar errors? How should information about the causes of the event be handled according to state peer review statutes? How will the organization accommodate visits from regulatory or investigatory bodies?

• **Disclosure.** What specifically should be disclosed to patients and families? Examples to consider include the circumstances of the event, consequences to the patient, treatment given, plans for investigation, system-based causes, improvement efforts, other parties informed about the event, and contact information for support and counseling from the organization and from external sources. Who should disclose the information? How should the disclosure happen and who should be present? Who’ll be the contact person for follow-up or to answer the patient’s or family’s questions? How is just compensation for injuries determined and offered to the patient or family? Who should inquire about the patient’s or family’s desires about the level of disclosure to the public, and how will that information be communicated to all who need to know?

• **Treatment of staff.** How will staff involved in the event be evaluated and treated? How will system-wide accountability be assessed? What support and psychological counseling will be offered to those involved and affected?

• **Interaction with patients.** How should staff—both those involved and those not involved in the event—interact with patients and families who’ve been victims of a harmful error? How should staff interact with other patients who’ve heard about the event?

• **Media inquiries.** With inquiries from the news media, how can the organization provide useful and accurate information to the public without breaching patient confidentiality? Who’ll provide ongoing feedback to the community? How should staff respond to unsolicited media questions?

• **Investigation.** What procedures must be undertaken to safeguard documents and involved containers and equipment for further investigation? How should the immediate internal review and investigation of an event be carried out? How should a more detailed event analysis occur? What criteria will be used to determine whether an independent review of the event by outside experts should be carried out? How will the results of the investigation be communicated to the patient or family, applicable staff, the board, and the public, if appropriate?

• **Improvement.** What process(es) will be used to ensure that appropriate immediate and long-term preventative actions are taken, such as ongoing evaluation of action plan implementation, policy development, and measurement to determine positive or negative change?
