'An ounce of prevention is worth a pound of cure" – Benjamin Franklin'

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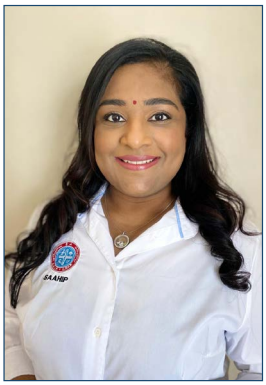

In my previous write-ups I reminded pharmacists of striving to do their best whilst performing their professional responsibilities, aiming to be ten-star pharmacists. We need to own our space and ensure that our role as the custodian of medicine is maintained. This sets us apart from the rest of the healthcare team but also ensures that we are valued for our contribution. As medicine experts, it is our responsibility to ensure that all medicine provided to the patient has the desired or intended effect and the therapeutic goal is achieved.

As my traditional role of pharmacist evolved into an administrative role of quality assurance and medical litigation manager at the beginning of 2025, I became more involved in patient safety and the culture of reporting these events throughout the facility, whilst also trying to improve patient safety systems and guidelines. Patient harm is a global priority and death due to patient harm is one of the top 10 causes of death and disability worldwide. Besides harm to the patients, compromised patient safety contributes to escalating hospital expenditure. Globally there is a patient safety action plan developed by the World Health Organisation 2021 – 2030 and the South African public sector has nationally implemented a patient safety guideline in 2022, which all government facilities need to adhere to.

Patient safety incidents (PSI) are defined as an unplanned or unintended event that did or has the potential to result in harm to the patient, while the patient is within the healthcare facility. These PSI events can be categorised as no harm, near misses or adverse/harmful events. There is a misconception that nurses or doctors are the only healthcare workers responsible for patient safety. The overall patient journey involves medication at some point and therefore patient safety is key when dealing with medication. The medication cycle within a hospital facility starts at procurement to the dispensing to the patient at the outpatient pharmacy or dispensing to the ward, which culminates in administering medication to the patient, by the nursing team. Medication errors can be made by anyone involved in the patient care process and we are all responsible for reporting these events. Medication errors may have dire consequences for the patient, and sometimes may lead to litigation cases, costing facilities and governments a lot of money.

The National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) in the United States defined a medication error as a preventable event that may result in inappropriate medication use or cause harm to a patient while the medication is under the control of a healthcare professional, patient, or consumer (2000). As the role of the pharmacist moves away from just dispensing in the pharmacy to more ward-based pharmacy practice, there is more patient interaction at the bed side. This interaction allows for more meaningful prescription assessments and medicine reconciliation which may allow the pharmacist to be best positioned to rationalise the prescription, advise on drug monitoring and to highlight potential or actual drug-drug or adverse reactions or PSIs. Pharmacists need to get into the culture of leaving the dispensaries and attending to patients at their bedsides. Pharmacists need to be more involved in ward rounds and reporting these PSI medication error related events, which will allow the facility to identify trends and types of these errors and allow for mitigation strategies to be implemented.

Medication errors are a type of PSI and have grave consequences. As pharmacists, we need to ensure that the patient's best interests stay at the forefront, by adhering to policies and guidelines and ensure that the 5 Rs are practised i.e. right patient, right drug, right dose, right time and right duration. As a pharmacist, you are the last line of defense to prevent a tragic event that may occur in the patient due to an adverse event. The NCCMERP highlighted that these med errors/PSIs may occur at any stage of the medication administration process i.e. prescribing, preparation, storage, administration and monitoring with the different types of errors including wrong patient, wrong drug, wrong time, wrong dose, wrong route, wrong dosage form, dose omission, wrong frequency, unprescribed drug, extra dose, incorrect labelling, etc.

Reports generated from these PSIs can be used to highlight trends and improve systems. The landscape of healthcare and pharmacy is continuously evolving, and these systems have been able to assist in minimising potential medication errors/PSIs. However human oversight and interaction is still needed and that is why pharmacists are best positioned to ensure that these PSIs are avoided. Pharmacists can offer evidence-based counselling to patients and may also equip the nursing team with skills on proper medication administration to patients in the ward. The hospital pharmacists may also develop training programmes for nurses on medication administration and how to avoid medication related PSIs. The overall PSI reports may be used to motivate for additional staff, improved patient outcomes, cost minimisation, reduced hospital expenditure and improvement of hospital policies and guidelines. I therefore urge us pharmacists to start being proactive and practice pharmacy preventatively rather than reactively. Focus on implementing proactive measures that will avoid PSIs, which ultimately will benefit the patient and have a positive impact on the health system.