The Ohio Society of Health-System Pharmacists
Position Statement on Reporting Medical Errors and Adoption of a Just Culture

The Ohio Society of Health-System Pharmacists supports an error reporting system with the following characteristics:

1. Standardized mandatory reporting of medical errors that cause death or "serious harm,"
    a. "Serious harm" is defined as errors that lead to long-term or irreversible harm.
2. Reporting system incorporates an intuitive design, improved usability, and compatibility with other reporting systems,
3. An independent state agency would analyze and evaluate reported errors, ensure compliance with the reporting system, and participate in best practice recommendations /quality improvement initiatives,
4. The system has a defined process to review and evaluate the success of best practice recommendations and quality improvement initiatives,
5. Legally protect the confidentiality of patients, health care workers, and information submitted; explicit incorporation of the peer review and incident and risk management report privileges afforded health care entities under Ohio law,
6. The act and follow-up of reporting is non-punitive,
7. Promote "culture of safety" focusing on systems not individuals,
8. Provide support to voluntary reporting systems

Additionally, OSHP believes pharmacists should exert leadership in establishing a **just culture** in their workplaces and a non-punitive systems approach to addressing medication errors while supporting a non-threatening reporting environment to encourage pharmacy staff and others to report actual and potential medication errors in a timely manner.

- **Medication error**: "Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care provider, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use." (National Coordinating Council on Medication Error Reporting and Prevention)

Pharmacists should provide leadership in supporting a single, comprehensive, hospital- or health system- specific medication error reporting program that (1) fosters a confidential, nonthreatening, and just environment for the submission of medication error reports; (2) receives and analyzes these confidential reports to identify system-based causes of medication errors or potential errors; and (3) recommends and disseminates error prevention strategies. Furthermore, pharmacists should provide leadership in encouraging the participation of all stakeholders in the reporting of medication errors to this program.

OSHP believes when errors occur there should be a clear and transparent process for evaluating the errors and separating events arising from flawed system design or inadvertent human error from those caused by reckless behavior, defined as a behavioral choice to consciously disregard what is known to be a substantial or

unjustifiable risk. Only when there is clear reckless or malevolent behavior should a punitive system be employed.

Additionally, OSHP endorses the broader guidance statements and guidelines provided by ASHP to address issues of medication errors and adoption of just culture:

- ASHP Statement of Reporting Medical Errors (Medication Misadventures-*Statements*, p 244)
- ASHP Guidelines on Preventing Medication Errors in Hospitals (Medication Misadventures-*Guidelines*, p.252-60)

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