

**Improving Medication Errors in the Kuwaiti Government Hospitals through Training and  
Clinical Vigilance: Patient Safety Culture**

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Three tenets of a patient safety culture are important in reducing medication errors. They include the non-punitive response to medication errors and staffing and communication openness (Alqattan et al., 2018). Teamwork is another key tenet of patient culture, which influences the occurrence of such mistakes (Alqattan et al., 2018). Generally, medical researchers suggest that countries that have a poor safety culture have a high incidence of medication errors compared to those that highly regard safety as a key tenet of their operational processes (Alqattan et al., 2018).

A culture of patient safety could address the management of human and systemic weaknesses in the provision of healthcare services, which cause medication errors in the first place (Ghobashi et al., 2014). Several researchers, such as Alsaleh et al. (2018), have highlighted the importance of organisational culture in the improvement of safety standards in the healthcare setting. Therefore, the focus on a safety culture is not new to the medical field. Indeed, as far back as 1999, the Institute of Medicine recommended that institutional cultures should be re-examined for purposes of advancing medical efficacy (Alsaleh et al., 2018). Broadly, the safety culture represents the group and individual perceptions of medical professions regarding medication errors (based on their attitudes and values towards the problem). In line with this view, the occurrence of medication errors has been associated with human factors, such as the lack of vigilance and laziness (Yousef & Yousef, 2017).

Human errors that cause problems in medication plans can be either intended or unintended (Cousins, 2018). Intended actions include basic error types such as violations and mistakes, while unintended actions often amount to slip-ups and lapses in the judgement of a

healthcare service professional. These lapses in judgement often lead to the improper administration of medicine (Cousins, 2018). The same lapses could lead to skill-based errors or memory failures (on the part of medical professionals), while slip-ups are associated with skill-based errors that stem from the failure of healthcare professionals to be attentive in their work (Chalasanani et al., 2018). Comparatively, violations made by health workers are linked to routine reasons and actions, which are often associated with the reckless and malicious behaviours of healthcare service professionals (Cousins, 2018).

The above-mentioned insights show that most medication errors are products of active failures by healthcare service professionals to be attentive to their work. However, latent conditions in the healthcare environment also contribute to some of these mistakes (Cousins, 2018). Therefore, errors that emerge from the administration of medicines are products of human factors and systemic weaknesses in the provision of healthcare services (Yousef & Yousef, 2017).

To address the rising incidence of medication errors in some healthcare facilities and to minimise the undetected nature of their effects on patients, suggestions have been made to increase clinical vigilance (Yousef & Yousef, 2017). For example, some medical administrators have suggested that employing a ward-based clinical pharmacist to detect medication errors and re-evaluating systemic errors to decrease the susceptibility of organisations to such mistakes are strategies that healthcare facilities should consider using to minimise the incidence of such mistakes (Elden & Ismail, 2015).

In line with this view, a patient safety culture is critical to the improvement of patient safety standards (Ghobashi et al., 2014). From the impact of culture on safety, some researchers have recommended the need to integrate a safety culture in organisational policies (Ghobashi et

al., 2014). Particularly, they have emphasised the need to review the bioethical component of medical errors to achieve this goal. At the same time, they have suggested the need to review training procedures for health workers and emphasised the importance of creating a strong team attitude to support skilful organisational learning (Ghobashi et al., 2014).

The need to review safety cultures in hospitals (as a strategy of managing medication errors) has been supported by several global healthcare organisations such as the World Health Organization (WHO) and the National Patient Safety Foundation (NPSF) (Ali et al., 2018; Elmontsri et al., 2017). Other global institutions that hold the same position include the Joint Commission International (JCI) and the Institute for Healthcare Improvement (IHI) (Ali et al., 2018).

Systematic crosschecking of treatment plans by an emergency physician in a critical care environment has been associated with a reduction in medication errors (Freund et al., 2015). In other words, such errors are projected to decline if more physicians are assigned the responsibility of crosschecking medical operations across different care settings (Freund et al., 2015). Some observers have proposed the need to educate patients about medications as a strategy to minimise associated errors because many of them are unaware of the implications or effects of such medicines on their bodies (Zaree et al., 2017). For example, it is proposed that patients should be educated about the colour and names of their drugs so that they report anomalies if they occur. Educating them about the drugs they take should also enable them to understand what the medicines are meant to do and their possible side effects. By doing so, they would better understand the need to alert their doctors about changes in the administration of their medication.

The need to review patient safety standards as one of the ways of managing medication errors is also touted as a strategy for addressing medication errors (World Health Organization [WHO], 2016). Stated differently, healthcare administrators have been encouraged to adopt a wide range of actions that should involve performance improvements and environmental safety risk awareness to address this problem (WHO, 2016). These recommendations emphasise the proper use of medicine and the promotion of equipment safety as auxiliary techniques for minimising incidents of medication errors.

Recommendations also exist to enhance health system's performance to protect patients from experiencing medication errors (Cousins, 2018). For example, member countries of the European Union have been encouraged to adopt this recommendation to minimise the possibility of healthcare practitioners making mistakes that would lead to medication errors (Cousins, 2018). Nonetheless, the necessity to promote patient safety is highlighted not only as a technique for reducing the incidents of medication errors but also a fundamental principle that guides the operational procedures of many healthcare facilities. All member states of the European Union have also been encouraged to pay close attention to the need to establish a culture of patient safety and strengthen evidence-based practices to manage such errors (Cousins, 2018). Improved monitoring and using advanced medical equipment and technology have also been proposed as possible strategies to mitigate the issue (Cousins, 2018).

In line with the above recommendations, proposals have also been made for the global healthcare sector to learn from other industries, which have a high safety standard, such as the airline, nuclear, and oil and gas sectors (Cousins, 2018). The use of common risk reduction measures and auditing are other solutions that medical practitioners have pursued in the past to minimise the incidence of medication errors (Ayani et al., 2016). Broadly, Alsaleh et al. (2018)

say that medical errors are preventable and pharmacists could curb most of them if they were more vigilant in their work. This proposal is also linked with recommendations made to pharmacists to play a more active role in the improvement of patient safety standards and quality of care (Ayani et al., 2016).

The need to train healthcare professionals about the management of medication errors by providing them with a guide that stipulates how to report medication errors is also another strategy that some healthcare organisations have embraced to manage the problem (Johnson et al., 2014). Such proposals are confined within the larger scope of promoting ethically responsible medical care practices (Johnson et al., 2014). Several researchers, including Zaghloul et al. (2016) support this view. Their goal is to reduce apprehension among physicians when a medication error occurs (Zaghloul et al., 2016). In other words, the minimisation of medication errors depends on their effective reporting and the need to learn from them. This is why accidents, near misses, and adverse events are often recorded and evaluated to minimise their probability of occurring again (Mohanty et al., 2018).

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