Conflict of Interest

- No conflicts to disclose

Learning Objectives

- Describe the concept of continuous quality improvement within the health care field and pharmacy profession
- Outline the elements and value of the Safety IQ program
- Define safety culture and its importance in continuous quality improvement within pharmacy
- Employ some initial strategies for your pharmacy to prepare for Safety IQ
What is Continuous Quality Improvement (CQI)?

- "What are we doing now and how can we do better?"
- Ongoing approach to problem-solving and harm prevention
- Continuously reassessing to see if improvements are effective

Safety IQ = Standardized Continuous Quality Improvement Program

- Beyond simply fulfilling the College’s or pharmacy’s liability requirements
- Establish a culture of safety to encourage reporting
- Analyze incidents using a system-based approach vs person based approach
- Proactively looking for areas to improve safety in pharmacy practice

Standardized – each pharmacy may use a different system but each will have similar elements or criteria and documentation

Safety IQ is a standardized CQI program

What is the Value of CQI?
CQI Movement in Canada

<table>
<thead>
<tr>
<th>Provinces with established CQI programs or requirements</th>
<th>Provinces/Territories researching for future CQI program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saskatchewan (2017)</td>
<td>Alberta</td>
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<tr>
<td>Ontario (2019)</td>
<td>Quebec</td>
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<tr>
<td>New Brunswick (2019)</td>
<td>Prince Edward Island</td>
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<tr>
<td>Manitoba (2020)</td>
<td>Newfoundland</td>
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<td></td>
<td>Nunavut</td>
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<td>NorthWest Territories</td>
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<td>Yukon</td>
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Safety IQ Pilot

- 20 volunteer community pharmacies - September 2017 – September 2018
- Enhance CQI program in community pharmacy by developing a standardized process and identifying barriers and enablers that may influence reporting

Safety IQ Tools

- Community Pharmacy Incident Reporting (CPhIR)
  - Anonymous incident and near miss reporting to ISMP Canada
  - Contribute to aggregate data for ISMP analysis and shared learning
  - Determine contributing factors and develop & implement changes

- Safety Self-Assessment
  - Proactive approach to risk assessment
  - Evaluation of different areas of pharmacy practice
  - Determine areas to focus improvements

- CQI Meetings and Documentation
  - Pharmacy staff as a team discuss:
    - Medication incidents and near misses
    - Improvement plans
    - SSA initiatives
    - Safety education
Safety IQ Pilot

- June 2018 – evaluation of pilot by SafetyNET-Rx research team to provide assessment and recommendations to Council
- October 2018 – Council approved provincial implementation of Safety IQ and created an Advisory Committee to work on the plan for implementation

Timeline for provincial implementation – 2020

Safety IQ Advisory Committee

- Consider the current requirements of pilot and make any updates for provincial program
- All incident report data must be exported to the national incident data repository – ISMP Canada
- Review and update Incident and Discrepancy Practice Direction
- Pharmacies to choose a reporting platform provider
- Develop criteria for platform providers to meet

Differences in Safety IQ Then and Now

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Pilot</th>
<th>Provincial Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Platform</td>
<td>ISMP – CPhI-NR</td>
<td>Pharmacy chooses a College approved platform</td>
</tr>
<tr>
<td>Safety Self-Assessment</td>
<td>Annually</td>
<td>Within first year then every 3 years or sooner</td>
</tr>
<tr>
<td>CQI meetings</td>
<td>Quarterly</td>
<td>Annual formal meeting Informal meetings as needed</td>
</tr>
<tr>
<td>Documentation</td>
<td>Meetings and Improvement plans</td>
<td>Meetings and Improvement plans</td>
</tr>
</tbody>
</table>


“At a minimum, reporting can help identify hazards and risks, and provide information as to where the system is breaking down.”

Reference: WHO Draft Guidelines For Adverse Event Reporting And Learning Systems
http://apps.who.int/iris/bitstream/10665/69797/1/WHO-EIP-SPO-QPS-05.3-eng.pdf

Incident and Near Miss Reporting
- All medication incidents
- Near misses that could possibly cause harm or are repeated
- No patient identifiers or names of pharmacy staff are reported to the national database
- College does not have direct access to incident reports

National Incident Database
- Reporting platforms Export anonymized data to National Incident Database
- Medication Incident More roles in reporting
- Shared learnings from national data
- Provides pharmacies with data summary reports

Pharmacy A
Pharmacy B
Pharmacy C

Reporting Platform X
Reporting Platform Y

Shared learnings from national data
Safety IQ Reporting Statistics

Accumulative Reporting Statistics
- 909 medication incidents reported (as of Sept 1, 2019)
- 626 incidents were near misses
- 283 incidents reached the patient
- 258 incidents caused no harm
- 20 incidents caused mild harm
- 5 incidents caused moderate harm

Top categories of incidents
- Incorrect drug
- Incorrect dose/frequency
- Incorrect strength/concentration

What is a near miss? Why report them?

“Technically, the biggest “safety system” in healthcare is the minds and hearts of the workers who keep intercepting the flaws in the system and prevent patients from being hurt. They are the safety net, not the cause of the injury.”

Don Berwick
To Err is Human: Building a Safer Health System

What near misses have to be reported?
- A near miss that:
  - May have caused patient harm if it had reached patient
  - Occur repeatedly and may indicate a gap in systems or procedures
  - Provide an opportunity to learn

Pharmacy managers and staff can discuss and determine which near misses would provide an opportunity to improve.

Use professional judgment
**Safety IQ Cycle - Analyze**

**Reactive**
- Analysis of your own pharmacy’s incident and near miss reports using tools in the reporting platform
- Considering contributing factors
- Developing changes in systems or processes to prevent recurrence
- Goal: improvement not identifying who is at fault

**Proactive**
- Safety self-assessments (SSAs)
  - “What are we doing now?”
  - “How can we do better?”
- SSAs empower pharmacy teams to determine areas of strength and areas for improvement
- Subsequent safety self-assessments reveal the extent to which action plans caused improvement
- Reviewing data reports for your pharmacy to consider trends

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**Safety IQ Cycle - Share Learning**

Every staff member has a role in Safety IQ and the safety of the pharmacy.

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**Medication Safety Education already available to share**

SMART Medication Safety Agenda

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Safety IQ Cycle - Document

Document staff meetings and discussions in response to:
• Medication incidents
• SSA improvement initiatives
• Staff education

Keep track of the effectiveness of improvement plans – what is working and what doesn’t?

Safety IQ - Benefits and Challenges

Benefits
• Increased discussions of medication incidents
• More openness and less blame in incident discussions
• Ongoing assessment of risks and striving for improvement
• Increased awareness of individual actions and factors that may lead to incidents or near misses

Challenges
• Dual reporting
• Time to report
• Designating staff to report
• Number of near misses to report
• Training and engaging all staff to report

Safety Culture

US Institute of Medicine – “the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm.”
Community Pharmacy Safety Culture Toolkit

Goals
- Support community pharmacy teams to shift from a blame-and-shame to a just-and-safe culture
- Provide resources on safety culture to promote open discussion and communication of medication errors and near misses in order to make system-based changes
- Improve patient safety

Community Pharmacy Safety Culture Toolkit

► Defining and measuring safety culture
► Leadership
► Teamwork and communication
► Transparency
► Psychological safety
► Accountability
► Communication and Disclosure with Patients

How to Use the CPSC Toolkit
- Changing a culture involves many small changes over time
- Find what works for your pharmacy and start small
- Choose areas of improvement that are most pressing
- It is not a one-time change but rather an ongoing process
- Encourage all employees to engage with safety initiatives
What can my pharmacy and I do now to get ready for Safety IQ?

- Become familiar with the updated practice direction and guidance document
- Talk to your staff and colleagues about Safety IQ and the changes coming
- Review current procedures when an incident occurs – do we look at what happened and consider possible contributing factors and make changes in processes
- What is the culture of your pharmacy regarding medication incidents
  - Do staff feel isolated?
  - Is the incident discussed openly without blame or shame?
  - Do staff come forward with suggestions to improve safety?

What can my pharmacy and I do now to get ready for Safety IQ?

- Consider a process for reporting that would work in your pharmacy –
  - Who reports,
  - When do you report – when it happens or later in the day, and
- What near misses do you think should be reported.
  - Would the patient be harmed?
  - Are they repeated?
  - Could we learn and make changes from a near miss to prevent a future incident?
- Begin reviewing and sharing learning already available through ISMP and the eQuipped newsletter

Safety IQ Information Resources