Safety.
Improvement.
Quality.

eQuipped

Safety IQ eNewsletter

eQuipped is the official e-newsletter for the College of Pharmacists of Manitoba's Safety IQ Program. Each issue will feature updates on Safety IQ, Safety IQ statistics from the pilot pharmacies, continuous quality improvement tips and tricks, and resources and information to keep you updated on all things Safety IQ! Please let us know if you have suggestions on information that you would like to see in eQuipped or have ideas or safety tips you would like to share.

In this Issue:

Safety IQ PD Event

The College of Pharmacists of Manitoba (College) is hosting A Safer Future: Preparing your Pharmacy for Safety IQ on Thursday, September 26. The event will be held in person at the Samuel Cohen Auditorium (351 Tache Avenue), and via webcast.

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The program will provide an introduction to the goals and requirements of Safety IQ for community pharmacies and to help pharmacy professionals begin some advance preparations. At this time, a date of provincial implementation of Safety IQ is still to be determined but could potentially launch in the second half of 2020.

The main learning objectives include:

- Describe the elements and value of the College's continuous quality improvement program - Safety IQ for community pharmacies in Manitoba
- Identify strategies to prepare for future implementation of Safety IQ within your community pharmacy
- Consider new resources and tools to evaluate and improve the safety culture in your pharmacy practice
- Reflect on the value of incident data and the use of analytical tools to improve patient safety in your pharmacy practice
- Implement new approaches to improve pharmacy-patient communication and disclosure of medication incidents in your pharmacy practice

Speakers include the following:

- A multidisciplinary team from CancerCare Manitoba, who will discuss disclosure
- A game day statistician from the Winnipeg Jets, who will relate the value of incident data and analysis for the purpose of improving patient safety in healthcare to the data and analysis collected and used by professional athletes

To register to attend the event in-person or via webcast, please call the College office at 204-233-1411 or email profdevelopment@cphm.ca by 4:30 today. Provide us with:

your full name
your licence number (if applicable)
whether you are participating in-person or via webcast

The event will also be available following this evening on the College's Previously Recorded Programs page.

Safety Measures

Data matters! Here are the medication incident and near miss statistics reported by the Safety IQ Pilot pharmacies to the Community Pharmacy Incident Reporting (CPhIR) program since September 2017:

909 INCIDENTS REPORTED

- 626 NEAR MISS/MEDICATION DISCREPANCY (MEDICATION NOT DISPENSED)
- 258 NO HARM (MEDICATION DISPENSED - NO SYMPTOMS AND NO TREATMENT NEEDED)
- 20 MILD HARM (MEDICATION DISPENSED - NO TREATMENT OR MINOR TREATMENT NEEDED)
- 5 MODERATE HARM (MEDICATION DISPENSED - ADDITIONAL TREATMENT OR OPERATION NEEDED; CAUSED PERMANENT HARM OR LOSS OF FUNCTION)

MOST FREQUENT INCIDENTS BY TYPE

INCORRECT DRUG	222
INCORRECT DOSE / FREQUENCY	212
INCORRECT STRENGTH / DOSE	112
INCORRECT QUANITY	77
INCORRECT PATIENT	75

DIsclosure of Medication Incidents: A Suggested Framework

Grant Fuller, PharmD Candidate[1,2]
Certina Ho, RPh, BScPhm, MISt, MEd, PhD [2,3]

[1] School of Pharmacy, University of Waterloo
[2] Institute for Safe Medication Practices Canada
[3] Leslie Dan Faculty of Pharmacy, University of Toronto

Case Example

Mr. Jones, a patient of your pharmacy, states that he has been feeling nauseated and has had a few episodes of diarrhea ever since he picked up his new prescription two days ago. Upon examining his pharmacy profile and the medication vial he has brought in, it becomes apparent that he has received another patient's metformin prescription by accident, instead of his intended medication, atorvastatin.

Introduction

Every patient has the right to be informed about their healthcare. This includes the right to be promptly notified when an incident associated with medication therapy has occurred. In fulfilling this commitment to their patients, as well as meeting their ethical and organizational obligations, practitioners need to understand when disclosure is appropriate or necessary and how to properly disclose medication incidents.

In addition to disclosure, there can be other challenges in responding to medication incidents. The Safety IQ patient safety initiative relies on practitioners to share details of medication incidents when they are

discovered. However, this requires an environment in which staff feel comfortable reporting medication incidents without undue consequences to their self-image, status, or career.[1] (For further information, refer to a previous article published in Vol. 4 of eQuipped Safety IQ eNewsletter: Psychological Safety: An Essential Constituent of Safety IQ.)

Very often, practitioners involved in medication incidents experience psychological and physical consequences which include extreme sadness, difficulty sleeping, and intrusive memories.[2] Recognizing these responses and the need to support practitioners are often overlooked in the aftermath of a medication incident. (For further information, refer to a previous article published in Vol. 2 of eQuipped Safety IQ eNewsletter: The Second Victim: Supporting Healthcare Providers Involved in Medication Incidents.)

To support practitioners, we have provided a framework for medication incident disclosure and applied it to the case example above. This framework has been adapted from the Canadian Patient Safety Institute (CPSI) Canadian Disclosure Guidelines and a previously published continuing education lesson for pharmacy technicians on How to Handle a Medication Error.[3,4] We also consulted the Canadian Medical Protective Association (CMPA) article, Disclosing harm from healthcare delivery: Open and honest communication with patients.[5] We would like to refer readers to these original resources for further information.

Suggested Disclosure Framework

Immediate Actions[3,4]

After a medication incident is discovered, there are immediate actions that must be taken before beginning the disclosure process:
Attend to the affected patient(s); ensure their care needs are met.
Take immediate measures to prevent similar safety risks from harming other patients or staff.

Is Disclosure of the Medication Incident Needed? [3,4]

After any immediate safety concerns are addressed, practitioners must decide whether disclosing the medication incident to the patient is appropriate or necessary.

Note: In accordance with the College of Pharmacists of Manitoba Practice Direction – Standards of Practice #9: Medication Incidents and Discrepancies or Near-Miss Events, any medication incident that reaches the patient must be disclosed to the patient and prescriber.

Apologies[3,4]

Apologies are crucial to the disclosure process and should be offered as they make patients feel validated and respected. Legislation exists in several provinces, including Manitoba (the Apology Act), to protect practitioners from legal liability due to apologizing.7 Features of an effective approach are presented below:
Communicate genuine sincerity about the medication incident.
Use a personal tone including terms such as “I” or “We.”
Use appropriate non-verbal gestures (body language, tone of voice, facial expressions).
Assure that harm did not result from anything the patient or family did or did not do.

Preparing the Disclosure[3,4]

After it has been determined that a disclosure is needed, consider the following when preparing the initial meeting:
Schedule an in-person disclosure meeting at the earliest practical opportunity. Select a time that is convenient for the patient and family and a place that is private and free of interruptions. Allow adequate time for a complete discussion about the incident.
The most responsible healthcare provider who is involved should facilitate the disclosure. All others who played a role in the incident should be prepared to discuss relevant events with the patient and family.
Anticipate emotions; both the patient and practitioners should have supports available at the disclosure

meeting if needed.
Assign a staff member as the primary contact for the patient and family throughout this process.

Disclosure[3,4]

The initial disclosure is a crucial step as it provides an opportunity for the patient and family to understand what the medication incident was and why/how it might have happened.
Focus on the events that led to the medication incident, using clear and understandable terminology. Avoid speculation and assigning blame.
Encourage the patient and family to discuss the incident from their point of view.
Discuss any changes to the ongoing care of the patient in consultation with the patient's primary healthcare provider.
Keep a record of the discussion. Allow the patient and family to review the documentation to ensure everyone agrees on the facts.

Continued Feedback[3,4]

The disclosure process requires continued dialogue with the patient and family rather than a single discussion.
After the initial disclosure meeting and when the medication incident has been fully reviewed and analyzed:
Communicate new findings about the incident to the patient and family members.
Reinforce, update, or correct information provided in previous meetings.
Discuss any improvements or changes made to prevent similar events from occurring.
Provide continued practical and emotional support to the patient and family.

Case Example – Application

Immediate Actions[3,4]

Ensure that Mr. Jones is not experiencing any symptoms of potentially dangerous hypoglycemia (e.g. confusion, dizziness, vision changes) due to the inadvertent administration of metformin. Follow up on the management of his nausea and diarrhea in consultation with his primary healthcare provider. Secure the metformin prescription and provide Mr. Jones with his correct medication, atorvastatin. Make sure to inform the prescriber. Ensure a new metformin prescription was prepared for the intended patient.

Is Disclosure of the Medication Incident Needed? [3,4]

Mr. Jones has experienced nausea and a few episodes of diarrhea due to this incident. Since this medication has reached the patient, disclosure is needed. Disclosure is necessary as it helps Mr. Jones understand that a medication incident occurred and what circumstances might have contributed to this event.

Apologies[3,4]

A suggested initial apology can be: "I am very sorry about this, Mr. Jones. It appears you received the wrong medication. I want to emphasize that none of this is your fault and we will work with you to figure out why/how this happened."

Preparing the Disclosure[3,4]

The pharmacy should make every effort to schedule an in-person disclosure meeting with Mr. Jones as soon as possible. The pharmacy manager will facilitate communication with Mr. Jones and oversee the disclosure process as the pharmacy manager is the most responsible healthcare provider involved in the patient's care in this case. The staff member who gave the medication to Mr. Jones at pick-up should also be prepared to discuss the incident with him.

A possible arrangement would be: The disclosure meeting is scheduled next Sunday when the pharmacy is

closed to allow for privacy and the time needed for a thorough discussion. Mr. Jones is advised that he may bring his family for support if desired.

Disclosure[3,4]

Here is a potential disclosure: "Mr. Jones, I want to take some time to discuss the events that have led up to you receiving the wrong medication. When you picked up the prescription, we neglected to ask you for an additional patient identifier or information besides your name, such as your address or date of birth. You share a very similar name to one of our other patients. These factors contributed to you receiving the wrong prescription. I have contacted your family physician who agrees that no changes to your current care are needed. Again, we are very sorry about what happened. Would you like to share your thoughts on this incident with us?"

Continued Feedback[3,4]

While reviewing and analyzing the medication incident, the pharmacy team discovered that Mr. Jones had refused counselling when he picked up his medication as he was in a rush. As a result of this incident, the pharmacy has changed its processes related to prescription pick-up. All staff will request secondary patient identifiers upon prescription pick-up and counselling will be given for all prescriptions (new prescriptions and refills). These process improvements and workflow changes will be shared with Mr. Jones along with any new findings the pharmacy discovers.

Conclusion

When a medication incident occurs, the ensuing process – from reporting and disclosure to the point where eventual system improvements are implemented – can be complicated. Having both a framework and the knowledge to appropriately disclose medication incidents are important, however, they represent just one step in addressing the challenges of medication incident reporting and learning. Improving how we deal with medication incidents will take continued effort on the part of organizations, teams and individual practitioners.

References

1. Edmondson AC, Lei Z. Psychological safety: The history, renaissance, and future of an interpersonal construct. Annu Rev Organ Psychol Organ Behav 2014; 1: 23-43.

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3. Disclosure Working Group. Canadian disclosure guidelines: being open and honest with patients and families. Edmonton, AB: Canadian Patient Safety Institute; 2011. Available from: https://www.patientsafetyinstitute.ca/en/toolsResources/disclosure/Pages/default.aspx

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5. Canadian Medical Protective Association. Disclosing harm from healthcare delivery: Open and honest communication with patients. 2017. Available from: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2015/disclosing-harm-from-healthcare-delivery-open-and-honest-communication-with-patients

6. Legislative Assembly of Manitoba. The Apology Act. 2007. Available from: https://www.cphm.ca/uploaded/38/web/documents/TheApologyAct.pdf

Lessons Learned from Seven Years of Medication Incident Reporting

Researchers conducted analysis of medication incident reports in Nova Scotia. They focused on incidents between October 2010 and June 2017. The resulting study shares valuable lessons from these incidents.

This pattern of reporting, analyzing, and sharing learnings is at the core of the Safety IQ cycle. It demonstrates the positive potential continuous quality improvement programs, like Safety IQ, possess. Analysis of medication incidents closes the loop between reporting incidents and improving practice, as it helps us learn from each other and apply those lessons to improve the processes in our pharmacies.

The study's authors analyzed several factors, including type of incident and patient outcome. They discovered high-risk processes in pharmacies, gaps in communication, and preventable adverse drug reactions. You can access the study here. A summary of the study can also be found here.

If you have more interest in this study, ISMP Canada is presenting a webinar on this topic on September 26, 2019 at 2 p.m.

Details
Topic: Lessons Learned from Medication Incidents by Community Pharmacies in Nova Scotia: A 7-Year Study
Date: Sep 26, 2019 (Thursday)
Time: 3 pm to 4 pm EST
Webinar: Online via GoToWebinar
RSVP: https://attendee.gotowebinar.com/register/7913881577074909452

SMART Medication Safety Agenda

The Institute for Safe Medication Practices Canada (ISMP Canada) has introduced the SMART Medication Safety Agenda to share learnings on common medication incidents reported to them from across Canada through the Community Pharmacy Incident Reporting (CPhIR) program. This data forms the foundation for continuous quality improvement (CQI) resources like SMART Medication Safety Agenda to support pharmacy practice enhancements for patient safety.

The SMART Medication Safety Agenda encourages pharmacy teams to discuss and collaborate on CQI.

The following YouTube video (4:16 Minutes) is a step-by-step guide for pharmacy professionals to learn how to use the SMART Medication Safety Agenda:

https://youtu.be/zFTwL-mt0Xw

The latest SMART Medication Safety Agenda is on Hospital DIscharge. Previous Agendas can be viewed on the Safety IQ homepage under Resources.


Community Pharmacy Incident Reporting (CPhIR)
May 2019
SMART Medication Safety Agenda

Hospital Discharge

SMART Medication Safety Agenda

The Community Pharmacy Incident Reporting (CPhIR) program is designed for you to report and analyze medication incidents that occurred in your pharmacy. You can learn about medication incidents that have occurred in other pharmacies through the use of the SMART Medication Safety Agenda.

The **SMART** (**S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime-based) Medication Safety Agenda consists of actual medication incidents that were anonymously reported to the CPhIR program. Potential contributing factors and recommendations are provided to you and your staff to initiate discussion and encourage collaboration in continuous quality improvement. By putting together an assessment or action plan, and monitoring its progress, the SMART Medication Safety Agenda may help reduce the risk of similar medication incidents from occurring at your pharmacy.

How to Use the SMART Medication Safety Agenda

1. Convene a meeting for your pharmacy team to discuss each medication incident presented (p. 2).
2. Review each medication incident to see if similar incidents have occurred or have the potential to occur at your pharmacy.
3. Discuss the potential contributing factors and recommendations provided.
4. Document your team's assessment or action plan to address similar medication incidents that may occur or may have occurred at your pharmacy (Table 2).
5. Evaluate the effectiveness and feasibility (Table 1) of your team's suggested solutions or action plan.
6. Monitor the progress of your team's assessment or action plan.
7. Enter the date of completion of your team's assessment or action plan (Table 2).

Table 1.
Effectiveness and Feasibility

Effectiveness:

Suggested solution(s) or action plan should be system-based, i.e. shifting a focus from "*what we need to do …*" to "*what we can do to our environment to work around us.*"

1. **High Leverage – most effective**
   - Forcing function and constraints
   - Automation and computerization
2. **Medium Leverage – intermediate effectiveness**
   - Simplification and standardization
   - Reminders, checklists, and double checks
3. **Low leverage – least effective**
   - Rules and policies
   - Education and information

Feasibility:

Suggested solution(s) or action plan should be feasible or achievable within your pharmacy, both from the perspectives of human resources and physical environment.

1. Feasible immediately
2. Feasible in 6 to 12 months
3. Feasible only if other resources and support are available

Contacts

College of Pharmacists of Manitoba:

P: 204-233-1411
F: 204-237-3468
E: safetyiq@cphm.ca

Medication Safety Self-Assessment (MSSA):

Institute for Safe Medication Practices Canada (ISMP Canada)
mssa@ismp-canada.org

Community Pharmacy Incident Reporting (CPhIR):

Institute for Safe Medication Practices Canada (ISMP Canada)
cphir@ismp-canada.org

Our mission is to protect the health and well-being of the public by ensuring and promoting safe, patient-centred, and progressive pharmacy practice in collaboration with other health-care providers.