eQuipped

Safety IQ eNewsletter

Introducing the Safety IQ eNewsletter

eQuipped is the official e-newsletter for the Safety IQ Pilot. Each issue will feature a Safety IQ Pilot Pharmacy, Safety IQ statistics, continuous quality improvement tips and tricks, and resources and information to keep you updated on all things Safety IQ! Enjoy the first issue of our quarterly publication!

Piloting Change: The Broadway Pharmacy Experience

Diligent pharmacy professionals, advanced technology, well-defined processes, and informed patients all have a role to play in medication safety. For pharmacy manager Floyd Lee, joining the Safety IQ Pilot is just one more way to not only ensure patient safety, but also to advance pharmacy practice.

"Reporting is anonymous, so don't be afraid to report something because in the end this is going to help us all," said Lee. "If there is a workflow issue or if DIN checks aren't being enforced it's something like that that could perhaps save a life."

Lee oversees a team of seven pharmacists and nine assistants, so communication and openness are key to pharmacy workflow and safety. Using the Safety IQ tools, Lee along with staff pharmacist Ashley Ewasiuk, noticed there were inconsistencies in staff understanding and implementation of pharmacy procedures.

"Things weren't always consistent about how we do things in the front vs. the backend of the pharmacy," said Ewasiuk.

"Reporting is anonymous, so don't be afraid to report something because in the end this is going to help us all."

From left to right: Floyd Lee, Broadway Pharmacy Manager, Ashely Ewasiuk, Staff Pharmacist, and Oumad Khalek, Dispensary Manager.

Talking more openly about errors since the start of Safety IQ has helped the entire team close those gaps and encourages everyone to participate in a cultural shift.

"At the start we had to address the culture," Ewasiuk said. "We had to address that this is not about shame and blame but it's more about enhancing safety."

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Incorporating Safety IQ into the pharmacy's workflow involved tailored training sessions, gentle reinforcement of the benefits of reporting, and figuring out what exactly, constitutes an error, said Ewasiuk. Over time, working with the tools helped shape their reporting practices.

"I just did a little tutorial with everyone in small groups of no more 2-3 and we walked through an example and discussed establishing what we wanted to report and what wasn't feasible to include," she said.

"We do live reporting," added Lee. "We've taken a little bit of time out of the day, but it's been relatively seamless."

"I think coming into this I was more worried about how much more work it was going to be," said Oumad Khalek, Broadway Pharmacy's dispensary manager. "In the end, it's as much or as little work as you want it to be. I think you have to look at the long game. You think about how much time you have to spend looking into the error and fix it vs. doing it right the first time."

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:

320 INCIDENTS REPORTED

- **222** NEAR MISS/MEDICATION DISCREPANCY (MEDICATION NOT DISPENSED)
- **90** NO HARM (MEDICATION DISPENSED - NO SYMPTOMS AND NO TREATMENT NEEDED)
- **7** MILD HARM (MEDICATION DISPENSED - NO TREATMENT OR MINOR TREATMENT NEEDED)
- **1** MODERATE HARM (MEDICATION DISPENSED - ADDITIONAL TREATMENT OR OPERATION NEEDED; CAUSED PERMANENT HARM OR LOSS OF FUNCTION)

Q & A: Errors on Prescriptions - To Report or not to Report?

A Safety IQ pharmacy questioned whether to report an error on a discharge prescription and likely other pharmacies may have the same question on prescription errors. In a community pharmacy, prescriptions are received from a variety of care settings (hospital, community, long term care, etc.) and a variety of practitioners (physicians, nurse practitioners, midwives, etc.). Each prescriber uses different methods of prescribing including written, electronic prescriptions and pre-printed orders such as for cataract surgery. With each care setting and prescribing mechanism, the potential for prescribing errors exists.

The Institute for Safe Medication Practices Canada (ISMP Canada) recommends that pharmacies report incidents and near misses related to the "Prescribing" stage. Because pharmacists and other health care providers reported prescribing stage errors, ISMP Canada was able to conduct a multi-incident analysis, identify root causes of these types of errors, and share recommendations for prevention. For more information on reporting and preventing prescribing stage incidents, please see ISMP Canada's poster and/or article.

As always, your pharmacy team can determine the circumstances for reporting a near miss and the amount of detail to include in CPhIR; however, more detail will result in better analysis. As with other near misses and medication incidents, additional information can be entered under the "Other Incident Info" section of CPhIR including which setting the prescription came from (e.g. hospital or community) and how it was presented to the pharmacy (e.g. handwritten, facsimile).

If you have any questions or suggestions for safety improvement in pharmacy practice, please share them with the Safety IQ team via email: SafetyIQ@cphm.ca. We will, in turn, share what we learn with the Safety IQ Pilot pharmacies.

Messages from ISMP Canada

ISMP Canada has been conducting analyses of the incidents that have been submitted over the past quarter, and we would like to thank everyone for their engagement in the Safety IQ Pilot.

Key messages:

- The information included within the "Incident Description" field has been very rich and informative, especially for analysis
- While entering a medication incident, please consider checking off relevant contributing factors within the "Contributing Factors" section of the incident reporting form. This information provides additional insight for analysis, which is helpful for pharmacy staff members to analyze and discuss during quarterly meetings
- Upon completion of an incident report, please remember to "Close and Submit" the incident. ISMP Canada only receives "Closed Incidents"; "Open Incidents" are only saved locally within the pharmacy's CPhIR account, and are not sent to ISMP Canada

Reminders

Medication Incident and Near Miss Reporting

Amidst the hustle-bustle of winter holidays and the flu season, pharmacy staff can be hard-pressed to remember medication incident and near miss reporting to the Community Pharmacy Incident Reporting (CPhIR) program. Sometimes it is also difficult to decide what might constitute a near miss that is worth reporting; however, near miss reporting, even when the near miss seems inconsequential, is invaluable data for safety analysis and improvement.

If you are having issues finding something to report, then report anything that constitutes a near miss, such as mislabeling a pill bottle before it's filled or given to a patient. This will give your staff practice using the CPhiR tools and figuring how they fit into your pharmacy's workflow. Near miss reporting is as valuable as incident reporting when it comes to improving patient safety.

If your pharmacy staff are having difficulty reporting to CPhIR 'in-the-moment' you can try printing the off-line forms and using a paper system until you have time to enter the information online. Have a stack of report forms readily available to staff to fill out manually until business slows down or someone has time to enter the reports into CPhIR. If your pharmacy has yet to report an incident or near-miss to CPhIR, please begin to do so now.

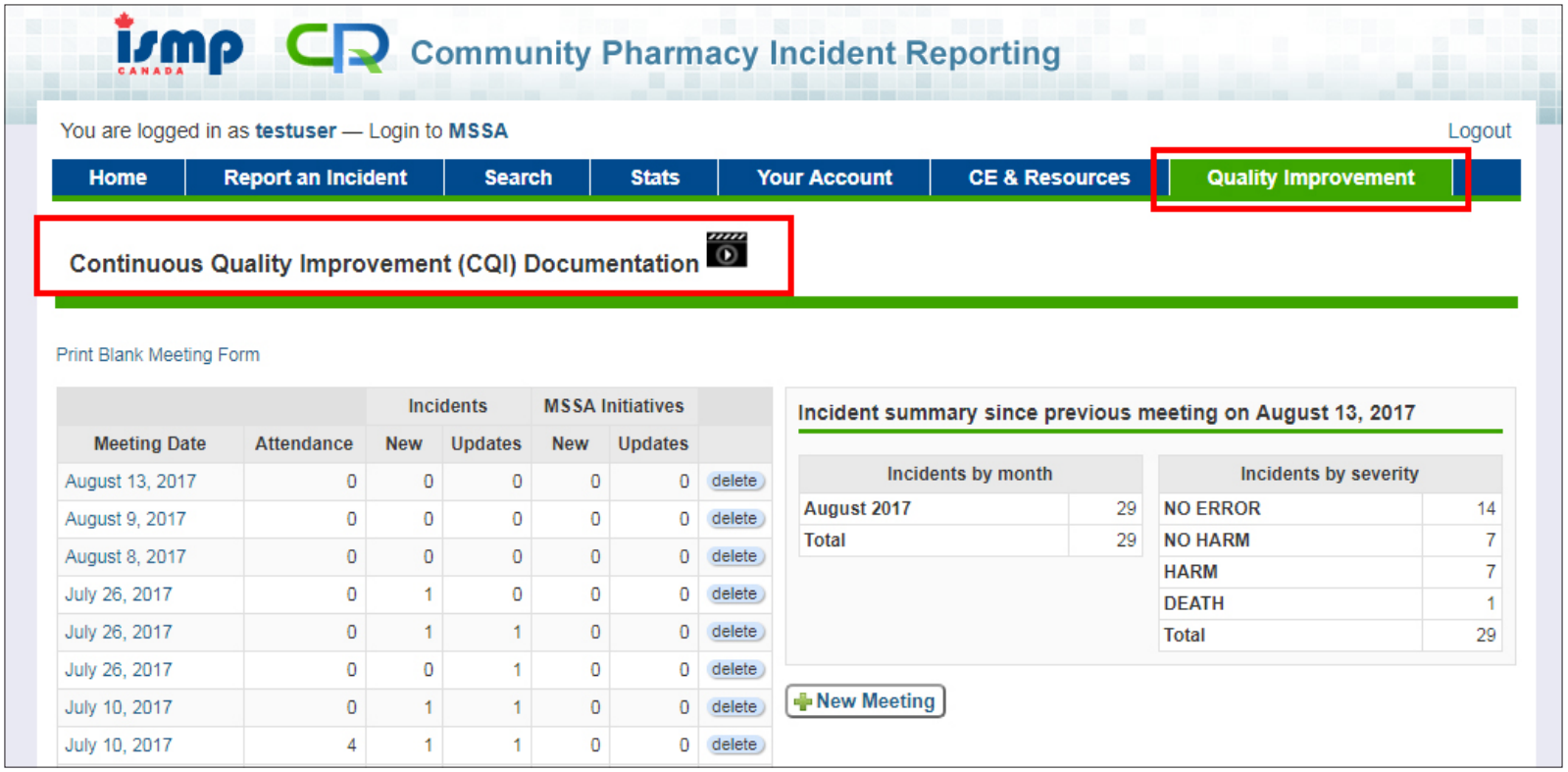
Continuous Quality Improvement Meetings

Quarterly Continuous Quality Improvement (CQI) Meetings allow pharmacy staff and managers to discuss medication incidents and near misses and their plans for improvement. The Safety IQ Training Manual features several resources to support your CQI Meetings including:

- Sample Quarterly Meeting Agenda
- Quarterly Meeting Report and Action Plan Forms
- CQI Summarization Document
- Suggested Protocol for Handling Medication Incidents and Near Misses

The deadline to complete and document four CQI Meetings is September 18, 2018

You can document your CQI Meetings and improvement plans by logging in to CPhIR at www.cphir.ca using your pharmacy's unique user name and password and clicking on the 'Quality Improvement' tab as seen below.



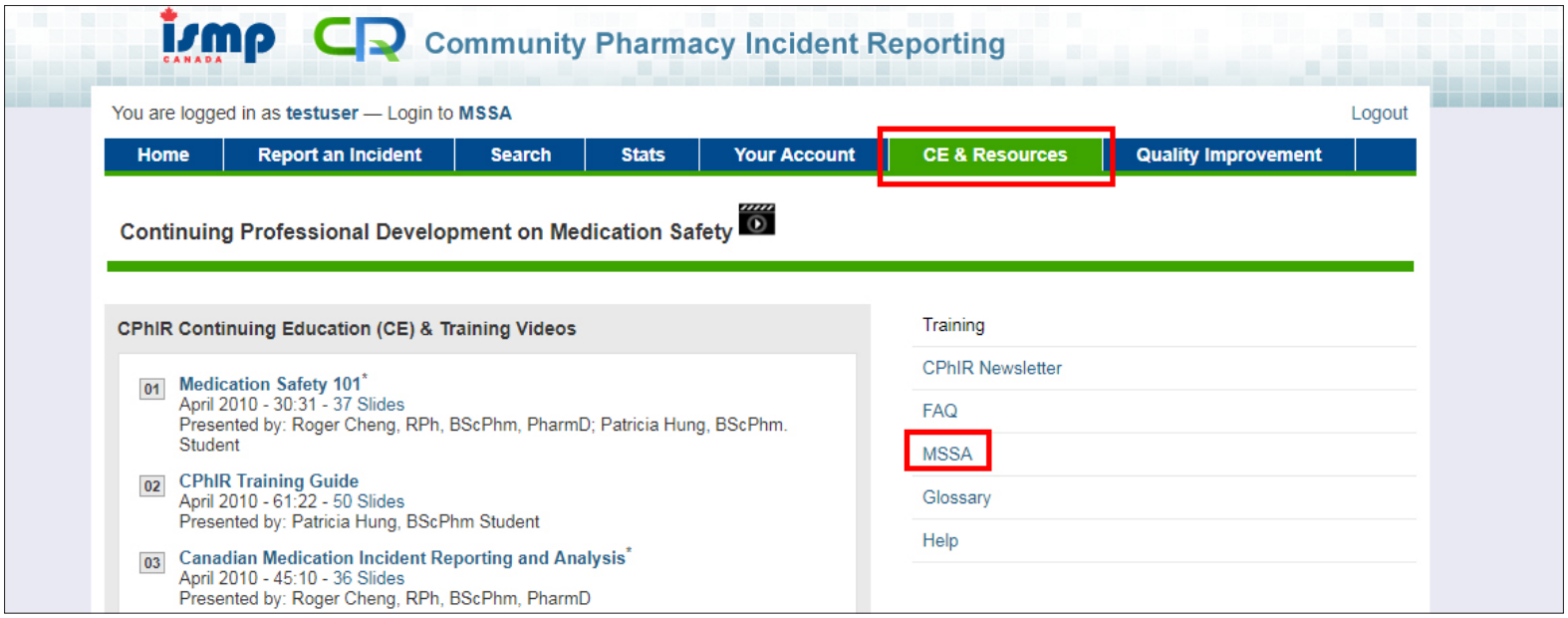
Medication Safety Self-Assessment

The Medication Safety Self-Assessment (MSSA) is a proactive tool to assess the safety of current medication practice in your pharmacy and identify opportunities for improvement. The MSSA is a required component of the Safety IQ Pilot.

The deadline to complete your MSSA is March 18, 2018.

If your pharmacy has yet to complete or start your MSSA, please begin to do so now.

To access the online version, log in to CPhIR at www.cphir.ca using your pharmacy's unique user name and password. Under "Your Account," you will find a link to the 'MSSA Instructional Guide' and the 'MSSA Handbook.' You can document your MSSA in CPhIR by clicking on the 'CE and Resources' tab and then on the 'MSSA' tab as shown below:



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.