eQuipped

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!

In this Issue:

Piloting Change:
The Ashern Pharmacy Experience

In the years since the 2014 proclamation of The Pharmaceutical Act in Manitoba, the scope of services provided by pharmacists has expanded. While this means pharmacists have increased Manitobans' access to quality healthcare, it also means that day-to-day pharmacy practice is more complex and demanding. At Ashern Pharmacy, Safety IQ is a steadying force that brings service and safety closer together in a relationship of efficiency and balance, said pharmacy manager, Doug Thidrickson.

"Safety IQ is a great tool to help prioritize the spots where the errors occur," said Thidrickson. "You can slow down at those spots to prevent errors. It's just taking it step-by-step and seeing where we can get the most improved safety for the time invested."

Safety IQ participants are required to invest time in completing the Medication Safety Self-Assessment (MSSA) created by ISMP Canada. Over approximately three hours, a pharmacy team systematically analyzes the quality of medication safety through the ten key elements outlined in the MSSA.

Completing an MSSA empowered the Ashern Pharmacy team to identify and address the most pressing safety issues in their practice.

From left to right (back row): Doreen Tober, Pharmacy Assistant; Melony Just, Pharmacy Assistant; Doug Thidrickson, Pharmacy Manager; Jaimin Patel, Pharmacist; and Bassem Khalil, Pharmacist.

From left to right (front row): Daniel Lowe, Pharmacy Assistant, and Jennifer Ross-Gutknecht, Pharmacy Assistant.

"On the MSSA we scored very low on the first item which is patient drop-off and assessment," said Thidrickson. "Since then, we've added a few features like asking for allergies every time a patient drops off a prescription and asking for two unique identifiers. Those things have helped tremendously."

While the MSSA is a one-time assessment, reporting medication incidents and near misses is an on-going task in Safety IQ pharmacies and has a greater impact on pharmacy workflow. At Ashern Pharmacy, the team approaches reporting with a two-pronged strategy: report in real-time and clearly define what needs to be reported.

"We enter [reports] right away when it happens, but sometimes we enter [reports] at the end of the day or we try do it within 3-4 days of when an error happens," said Ashern pharmacist, Jaimin Patel. "We try to do it as soon as possible so we remember everything about the error and then we discuss at meetings."

The person reporting enters at least the seven required fields and then exports the report to PDF before printing it and filing it in a binder. This binder serves to remind the team of open incidents and provides a discussion guide for continuous quality improvement meetings and initiatives.

While all medication incidents (errors that reach a patient) must be reported, what constitutes a near miss is defined by the pilot pharmacy teams. For Ashern, a near miss must pose an unknown or poorly understood patient safety risk.

"In terms of what we report I always tell my staff that we want to report things that are relevant," said Thidrickson. "Relevant meaning that there is an opportunity to assess how we failed and how we can protect patient safety."

"The value of reporting when a pill may have jumped into another blister pack slot maybe should not be prioritized because we're already aware that can happen and it might be better to put our efforts into more important areas."

Safety IQ has brought the Ashern Pharmacy team closer together in their mission to improve their safety culture, said Thidrickson.

"It may be coincidental, we've had a very consistent staff [since starting Safety IQ] whereas in past years we've had a lot of staff turnover," he said. "We have a more stable and cohesive team that's more focused on error prevention."

"Now that we have a systemic process and everybody is communicating and is aware of these errors occurring we're able to act on it as a group."

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:

418 INCIDENTS REPORTED

- **280** NEAR MISS/MEDICATION DISCREPANCY (MEDICATION NOT DISPENSED)
- **128** NO HARM (MEDICATION DISPENSED - NO SYMPTOMS AND NO TREATMENT NEEDED)
- **9** 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)

MOST FREQUENT INCIDENTS BY TYPE

INCORRECT DOSE / FREQUENCY	96
INCORRECT DRUG	88
OMITTED MEDICATION / DOSE	54
INCORRECT STRENGTH / DOSE	46
INCORRECT PATIENT	41

Q & A: Conducting CQI Meetings - How can our team enhance CQI Meetings?

SMART Medication Safety Agenda: A Tool for Continuous Quality Improvement Meetings

At least once every quarter, teams within each Safety IQ pharmacy including pharmacy managers, staff pharmacists, pharmacy technicians and pharmacy assistants are required to meet to discuss and analyze the previous quarter's medication incidents, and some strategies to prevent recurrence. Some Safety IQ pharmacies have expressed some difficulties with scheduling and conducting Continuous Quality Improvement (CQI) Meetings.

Along with the practice of documenting patient care activities, documenting discussions and ideas pertaining to quality improvement and medication safety are just as important.

To help keep the CQI meetings short and focused, ISMP Canada has developed the SMART (Specific, Measurable, Attainable, Relevant, and Time-Based) Medication Safety Agenda. ISMP Canada introduced the SMART Medication Safety Agenda with the goal of shared learnings and continuous quality improvement.

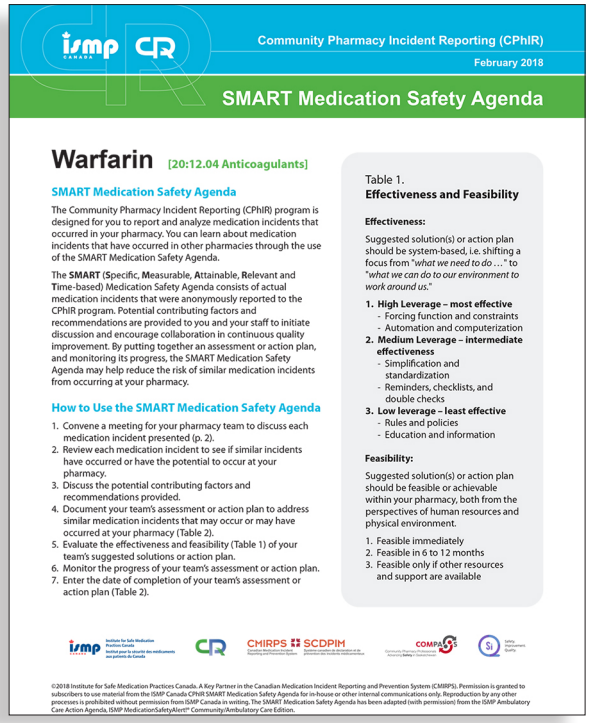
The SMART Medication Safety Agendas features anonymously reported medication incidents from across Canada through the Community Pharmacy Incident Reporting (CPhiR) program. Potential contributing factors and recommendations are provided in each issue for the team to discuss and encourage collaboration toward continuous quality improvement. By putting together an action plan and monitoring its progress, the SMART Medication Safety Agenda can help raise awareness regarding similar incidents at the pharmacy.

The Agenda will be published on a quarterly basis and each publication will focus on a unique type of medication error. The most current Agenda is about Warfarin. Your team can use the SMART Medication Safety Agenda to improve safety on Warfarin even if you have not reported a Warfarin-related error. Alternatively, your team can use the SMART Medication Safety Agenda as an outline to guide CQI discussions and initiatives on any incident or near miss that happened in your pharmacy.

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

For more tools and resources to support CQI meetings, please see the following Messages from ISMP Canada and the section of eQuipped on CQI Meeting Reminders.



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Community Pharmacy Incident Reporting (CPhiR)

February 2018

SMART Medication Safety Agenda

Warfarin [20:12.04 Anticoagulants]

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

Messages from ISMP Canada

Enhancing Patient Safety in Community Pharmacy Practice: Standardized Continuous Quality Improvement (CQI) Programs

Documenting discussions and ideas pertinent to quality improvement and medication safety is critical for the advancement of medication safety culture (Figure 1). The "Quality Improvement" tab within the Community Pharmacy Incident Reporting (CPhIR) program was created with this philosophy in mind – to encourage and enable open dialogue regarding medication incidents among staff and to provide a standardized and structured format to document these meetings. Please see the eQuipped section on Continuous Quality Improvement (CQI) Meetings for additional resources and instructions to access this tool on the CPhIR site.

In July 2017, ISMP Canada administered a Pre-Safety IQ study to pharmacy professionals in Manitoba to gain their insight into the benefits, barriers, perceptions, and experience of CQI programs. The study demonstrated that CQI programs are perceived as

- reliable platforms for pharmacy team communication;
- opportunities for participants to share their incidents in a blame-free environment;
- increasing awareness and caution regarding medication incidents that may occur during the medication-use process; and
- improving understanding of how modification of workflow and dispensing processes can help to mitigate potential errors.

Figure 1: The four pillars in CQI: Reporting, Analysis, Solution Development, and Implementation of an Effective and Feasible Action Plan

The benefits of CQI are apparent not only from the perspective of front-line pharmacy professionals, but also from a management perspective as well. CQI stimulates transparency and communication between management and staff and builds a foundation for a systematic approach from which management can evaluate and improve pharmacy workflow processes and patient outcomes.

Ultimately, the CQI program provides pharmacy professionals with the necessary tools to identify sources of inefficiency and sub-optimal quality of care in their pharmacies, and the tactical know-how to effectively eliminate these pitfalls before they ever come close to endangering a patient.

Culture *Shift*

The Second Victim:

Supporting Healthcare Providers Involved in Medication Incidents

A medication or medical error can place a patient at the centre of a health emergency that ripples outward to encompass friends and family, care-givers and healthcare providers. Patients and their loved-ones are the focus of any medication or medical error, but the effects can also be devastating to the healthcare providers involved in the error. When we discover and address medication or medical errors we should think in terms of primary and secondary victims—the 'first victims' are the patient and their loved ones, and the 'second victims'[i] are the healthcare professionals involved in the error.

The profound effects and impact of errors to the first victim and their family are of utmost importance, consideration, and priority. Take care of them first, but don't lose sight of the second victim.

In the aftermath of an error, the second victim experiences emotional distress at the harm caused to their patient. Second victims feel as though they have failed the patient, and start to second guess their clinical skills, knowledge, and career choice[ii,iii].

It is estimated that almost 50 per cent of all healthcare providers are a second victim at least once in their professional career[iv]. Frequently, these individuals feel isolated and personally responsible for the patient outcome, and experience emotions such as anxiety, grief, depression, withdrawal or agitation, and self-doubt[v, vi]. The emotional burden to the second victim can last for a long time, ranging from several days to several weeks; a few go on to suffer long-term consequences similar to post-traumatic stress disorder.

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i Marmon LM, Heiss K. Improving surgeon wellness: The second victim syndrome and quality of care. Semin Pediatr Surg. 2015; 24(6):315-318. doi: 10.1053/j.sempedsurg.2015.08.011

ii Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Health Care 2009; 18: 325 0 300

iii Scott, S.D., et al. (2010) Caring for our own: deploying a systemwide second victim rapid response team. Joint Commission Journal on Quality and Patient Safety, 36, 233–240.

iv Edrees, HH., Paine, LA., Feroli, ER., Wu, AW., 2011. Health care workers as second victims of medical errors. Polskie Archiwum Medycyny Wewnętrznej 121, 101-108

v Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Health Care 2009; 18: 325 0 300

vi Wu A, Steckelberg R. Medical error, incident investigation and the second victim: doing better but feeling worse? BMJ Qual Saf. 2012; 21(4): 267 – 270

Second victims need our compassion and support.

In To err is human: Building a safer health system, Don Berwick argues that "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."

In keeping with this philosophy, second victims should be part of the discussion, and provided with emotional first aid, counselling, and education to help them recover in the aftermath of the error.

To learn more about what you can do to support second victims, please review the ISMP Canada presentation which includes information on identifying second victims, stages of recovery, barriers to support, and the structures that can promote healing:

https://youtu.be/bz1MKJ0Z0dQ

In ISMP Canada's "The Second Victim: Sharing the Journey toward Healing," you can read a first-hand account of a pharmacist who was involved in the death of his patient and how he coped in the aftermath of this fatal medication error.

Reminders

Important Deadlines

Medication Safety Self Assessment (MSSA)
Safety IQ Pilot pharmacies must complete their MSSA and submit it to ISMP Canada by March 18, 2018. Please review the section on MSSA for more information.

Continuous Quality Improvement (CQI) Meetings
Safety IQ Pilot Pharmacies must complete and document at least four CQI Meetings by September 18, 2018. Please review the section on CQI Meetings for more information.

Medication Incident and Near Miss Reporting

For a variety of reasons, workflow issues, high prescription volumes, etc., it can be difficult for a pharmacy team to report medication incidents and near misses. Some Safety IQ pharmacies are challenged with deciding 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.

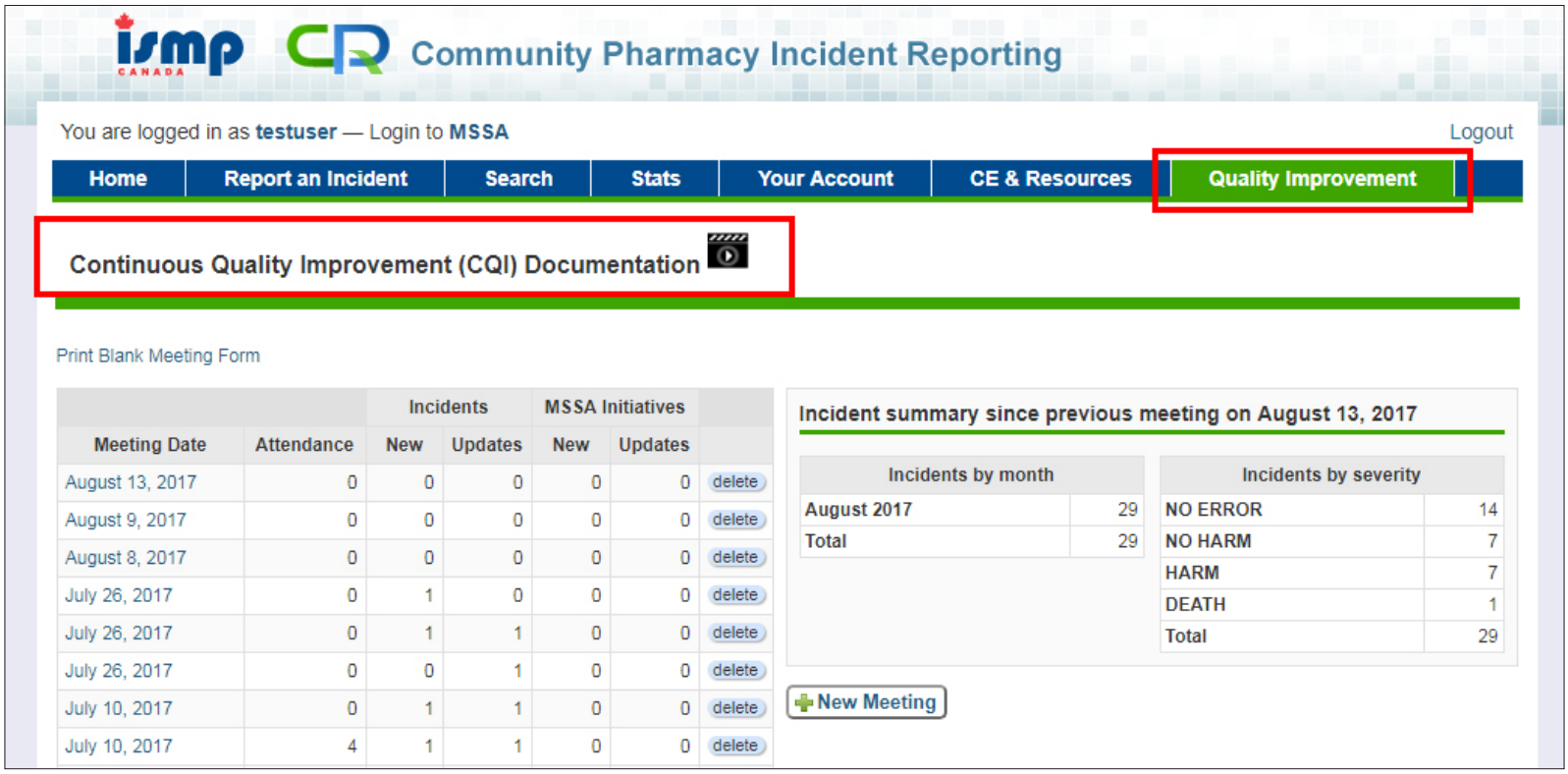
Continuous Quality Improvement Meetings

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 shown 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 of the MSSA, 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

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Community Pharmacy Incident Reporting (CPhIR):

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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.