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!

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Piloting Change:
The Flin Flon Pharmasave Health Centre Experience

A strong and effective team can make the difference between perpetuating a blame-and-shame culture or cultivating a safety culture. For the Pharmasave Health Centre team, the introduction of Safety IQ has transformed the discussion of medication errors and near-misses to build a culture founded on improvement rather than blame.

"On the paperwork we used to submit to our head office, you had to identify the pharmacist that made the mistake and so there was always that shame," said pharmacy manager, Susan Thompson. "Now, with the Safety IQ, I love the fact that it doesn't matter who did it. I find that we're a lot more open in discussing it because no one is necessarily being pin-pointed or identified."

From left to right: Corey Thompson, Susan Thompson, Dawn Craig, Chelsea Kirschman, and Jennifer Kritzer

For pharmacy technician, Leslie Fernandes, moving away from a blame-and-shame approach to medication errors has meant that incident investigations focus on what happened, rather than who is responsible.

"Medication errors for us were hush-hush quiet," she said. "It's completely different now. It's almost shocking how different. It doesn't matter who made the error, it just matters what happened—that's been our biggest change. The first questions out of someone's mouth isn't who, it's what and how."

As blame-and-shame decreases, open discussion of medication errors is on the rise within the pharmacy, said Thompson. When similar patient names led to a medication error in the pharmacy, the consequent discussion resulted in an innovative solution.

"An error that happened when somebody came in to pick up their sister's medications and got the wrong name because [the patients share a first name and have very similar last names]," said Thompson. "Of course, because the sister picked it up, she wasn't really sure what she was getting and so she took it and left. Now, we do TALLman lettering for patients with similar names."

Pharmacy technicians have a key role to play in team-building and championing safety in their pharmacies, said Fernandes. While a pharmacy technician oversees the technical aspects of prescription filling—including safety checks—the pharmacist is able to fulfill their clinical role with drug therapy and patient counselling.

"I can administer the program when the pharmacists should be checking and counselling," said Fernandes. "This is exactly the kind of high-level things a technician should be doing. It's been great for me and that it's the right role. It's given me a lot of learning opportunity."

Thompson and Fernandes work closely together to ensure the Safety IQ tools are being used to their full potential, including the Stats section of the Community Pharmacy Incident Reporting (CPhIR) platform. The Stats section can be used to compare the number of incidents reported by a pharmacy to the aggregate data generated from all other Canadian pharmacies that report to CPhIR.

"We didn't necessarily report near-misses since we started the pilot back in September," said Fernandes. "Once we started looking at the stats and data we knew that we were missing something. We realized that the majority of the errors in our pharmacy were caught by patients and for most other pharmacies the errors were caught by a pharmacist."

Based on their analysis of these statistics, Thompson and Fernandes now ensure that near misses are reported as often as possible to embrace more opportunities to make their system safer.

"We went back and had a good look at near misses and now we share that information more openly," said Fernandes. "Now we know that we can fix these things before they reach the pharmacist. The near misses have been quite eye-opening."

The team also noticed that medication incidents and near misses were happening on a specific time and day—the solution: more staff overlap at that time.

For more information about using the Stats section of CPhIR, you can login using your unique user name and password to watch the short instructional video:

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:

659 INCIDENTS REPORTED

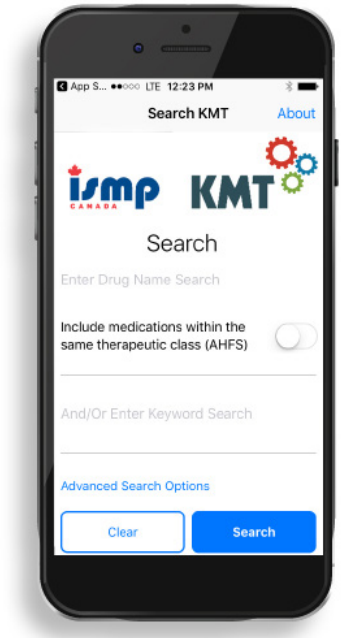
- **456** NEAR MISS/MEDICATION DISCREPANCY (MEDICATION NOT DISPENSED)
- **189** NO HARM (MEDICATION DISPENSED - NO SYMPTOMS AND NO TREATMENT NEEDED)
- **12** MILD HARM (MEDICATION DISPENSED - NO TREATMENT OR MINOR TREATMENT NEEDED)
- **2** MODERATE HARM (MEDICATION DISPENSED - ADDITIONAL TREATMENT OR OPERATION NEEDED; CAUSED PERMANENT HARM OR LOSS OF FUNCTION)

MOST FREQUENT INCIDENTS BY TYPE

INCORRECT DOSE / FREQUENCY	156
INCORRECT DRUG	149
INCORRECT STRENGTH / CONCENTRATION	70
OMITTED MEDICATION / DOSE	67
INCORRECT QUANTITY	67

> "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*

Q & A: Are there any resources that can help my team address specific medication issues?



Pharmacy professionals can face a vast body of knowledge and recommendations when it comes to researching medication safety solutions. A general internet search can cause frustration and apprehension as it is sometimes difficult to assess the quality and accuracy of medication safety recommendations from multiple sources.

The Knowledge Mobilization Tool (KMT) developed by the Institute for Safe Medication Practices Canada (ISMP Canada) offers a novel solution to endless research and fact-checking. The KMT is an educational tool that gathers and sorts relevant, context-specific information to help healthcare practitioners address medication safety issues. The KMT is a database powered by almost a decade's worth of medication incident and near miss reporting by healthcare professionals and patients to ISMP Canada. With the KMT, you can quickly and easily search incident analysis and recommendations made by ISMP Canada over the last decade. By searching the KMT you can find reports on previously published incidents, contributing factors, and published recommendations.

Best of all, the KMT is now available as a mobile application for iPhone and IOS!

Please visit the KMT platform to begin your search for medication safety solutions:

Desktop: https://secure.ismp-canada.org/KMT/

Mobile Application for iPhone and iOS: https://itunes.apple.com/ca/app/knowledge-mobilization-tool/id1399246988?platform=iphone&preserveScrollPosition=true#platform/iphone

Review the following article for more details on the KMT platform:

https://www.ismp-canada.org/download/hnews/201712-HospitalNews-KMT.pdf

Messages from ISMP Canada

Pharmacist-Patient Communication and Disclosure

As the most accessible healthcare providers, community pharmacists encounter many different scenarios during a typical shift and this often involves the challenge of navigating unexpected situations. Among these unexpected situations is having to resolve a conflict with an angry or frustrated patient.

Handling a difficult situation that involves an angry or upset patient is a reality that most, if not all, pharmacists will face or have faced at least once in their career. How individuals respond and resolve the issue is just as important as the issue itself, if not more so; the approach taken by the pharmacist, and the way in which the situation is dealt with can make the difference between a satisfactory and resolved outcome, or the abrupt end of the patient-provider relationship. An unsatisfied or wronged patient may also decide to launch a formal complaint with the respective regulatory authority.

Some issues may be directly related to a medication incident or clinical practice, while others may be related to a customer service complaint or other form of dissatisfaction. While not all patient-provider relationships will be salvaged at the time of the conflict, there are concrete steps every pharmacist can take to try to deescalate the situation and resolve the issue.

General Communication Tips:

Considerations	DO	DO NOT
Stop, focus, and use your best listening skills	Stop whatever you are in the middle of doing	Multi-task (e.g. listen and do something else at the same time)
	Give the patient your full attention, and listen to him/her	Assume that you know all of the facts about the situation without letting the patient finish his/her explanation, clarifying facts, and/or inquiring about certain points
	Summarize or paraphrase what you've heard/understood and ask questions to clarify	Interrupt the patient while he/she is speaking
	Express through your facial expression (e.g. keeping eye contact) and body posture (e.g. stand or sit up straight) that you are paying attention, receptive, and in control	Use any hostile or dismissive facial expressions or body language (e.g. clenching the jaw, frowning, smirking, rolling of the eyes)

Considerations	DO	DO NOT
Remain calm and commit to keeping your cool	Resist being drawn into anger; detach from the situation and try to observe as a third-party person or by-stander	Take the patient's remark seriously
Sympathize and acknowledge the anger	Resist the temptation to rationalize with the patient at the very beginning. This should be attempted after the issue is resolved and the patient has calmed down	Respond to the patient's anger with your anger
	Sympathize with what the patient has told you, and how he/she feels	Fault the patient for the situation or be overly defensive
	Address the patient by his/her first name; use a soft, firm, and slow voice when speaking to the patient	Shout over the patient
Apologize	Offer a sincere and straightforward apology for the problem they are having (or perceive to be having) and/ or the emotions that they are experiencing; Manitoba has an Apology Act and this means healthcare providers can apologize for an incident and that apology cannot be counted as an admission of guilt in court	Infer that you accept blame for something for which you are not responsible or have no control over
	Show empathy for the patient – acknowledge their emotions	
Look for a solution	Ask the patient what he/she believes should be done, or offer your own feasible resolution to the problem	Try to win or argue with an angry patient

Where Should You Discuss an Issue or Incident with a Patient?

If a patient is noticeably irate and is causing a disruption to the pharmacy and the provision of services to other patients, try asking the patient to see if they would accompany you to a more private setting such as the counselling room or an office. Doing so may help to further calm the patient down, as this shows a sincere interest in speaking with the patient and that he or she will receive your full attention.

At the same time, however, be vigilant and judge the situation appropriately; never attempt to defuse an angry patient who could be dangerous (e.g. verbally or physically abusive) by yourself or place yourself in a situation where you would be alone with him/her. Instead, ask a colleague to join the discussion. If you find that the patient is becoming progressively hostile or threatening as the discussion goes on, do not hesitate to contact security or the police when necessary. In anticipation of such potential cases that may arise, it may be helpful for you and your staff to come up with a secret code or phrase that signals to other members of the team to call for help.

Disclosing a Medication Incident

While medication incidents in community pharmacies tend to be rare, they do, occasionally, happen. One of a pharmacy professionals greatest fears is that they could miss catching a rare medication error that results in patient harm sometime during the course of their career. Disclosing a medication incident to a patient, or their care-giver or loved one, is a difficult, but necessary, act that requires compassion and empathy for everyone involved.

In Manitoba, pharmacists must follow the Medication Incident and Discrepancies or Near-Miss Events Practice Direction when a medication incident occurs in their pharmacy. This Practice Direction requires that the pharmacy has written policies and procedures for addressing, reporting, investigating, documenting, disclosing and learning from medication incidents. Above all, pharmacy professionals must ensure the immediate safety of the patient, but the follow-up can be equally important to both pharmacy staff and the patient or their loved ones.

The proper disclosure of a medication incident can contribute many benefits to patients, loved ones, and the pharmacy professionals involved, including:

- Building a culture of safety through open, honest, and effective communication
- Healing for both pharmacy professionals and the patient and/or family involved
- Learning from mistakes to prevent recurrence through patient and pharmacy professionals' input

According the Canadian Patient Safety Institute Canadian Disclosure Guidelines, patients want to know

- the facts about what happened;
- the steps that were and will be taken to minimize the harm;
- that the healthcare provider organization and/or provider is/are sorry for what happened; and
- what will be done to prevent similar events in the future.

Implementing or revisiting your pharmacy's policy and procedure to address medication incidents and near-misses to include the principles listed above could mean the difference between healing and learning from a tragic or harmful event, and irrevocably rupturing the relationship between the healthcare provider(s) and their patient and/or their patient's loved ones. The following resources and information can help you to ensure the best possible outcomes following a medication incident:

- Canadian Disclosure Guidelines
- Manitoba Apology Act
- Safety IQ Brochure for Patients and Providers (for Safety IQ Pilot Pharmacies)
- How to handle a medication error (Tech Talk CE, May 2013)
- The Second Victim: Supporting healthcare providers involved in medication errors

References

Disclosure working group. Canadian disclosure guidelines: Being open and honest with patients and families. Edmonton, AB: Canadian Patient Safety Institute; 2011.

Hills L. Defusing the angry patient: 25 tips. J Med Pract Manage 2010; 26(3): 158-62

Forbes Entrepreneurs. (2013, Aug 2). 7 Steps For Dealing With Angry Customers. Retrieved March 15, 2018 from: https://www.forbes.com/sites/thesba/2013/08/02/7-steps-for-dealing-with-angry-customers/#56ae303c6d27

Reminders

Important Deadlines

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.

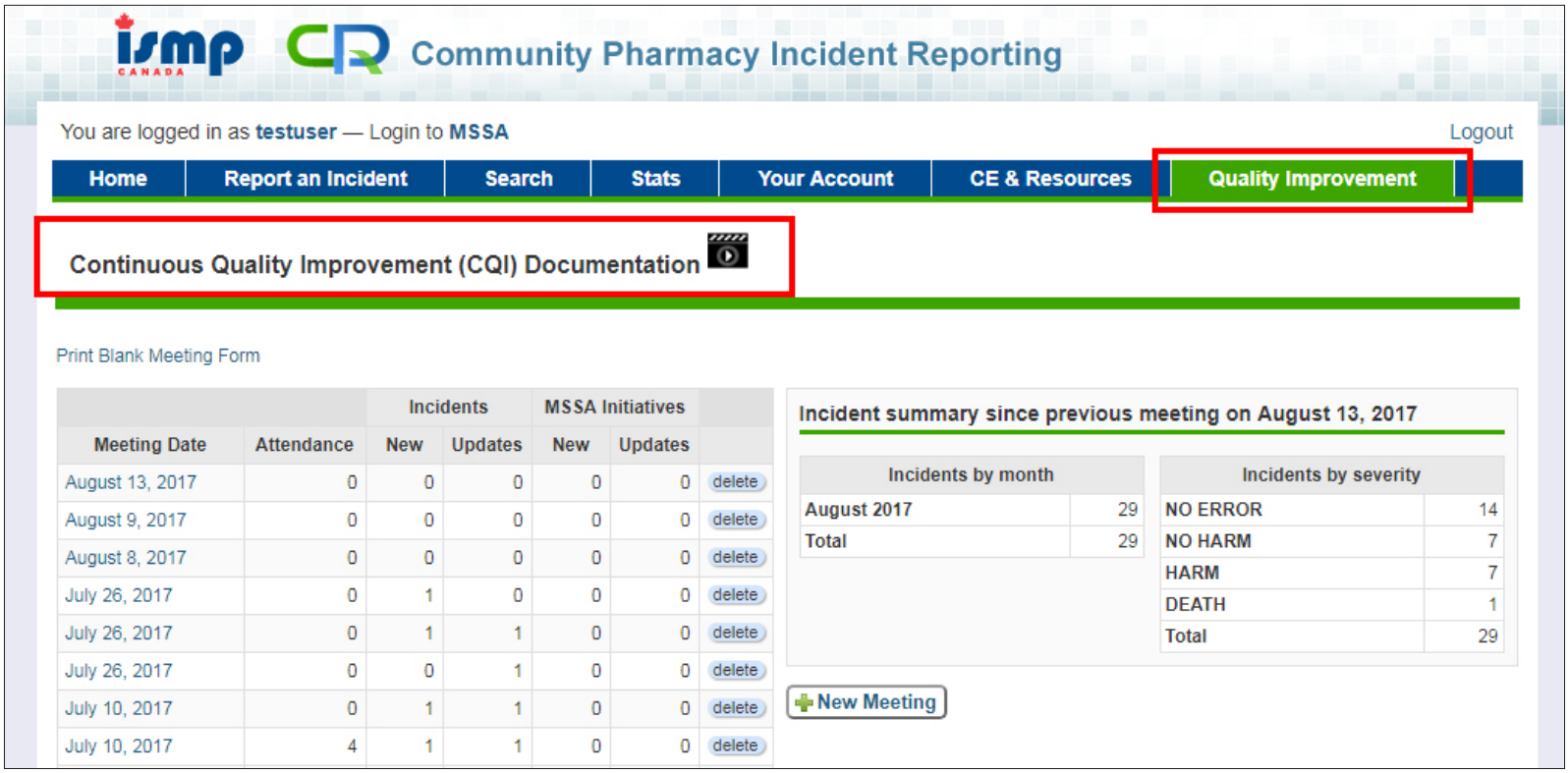
If your pharmacy staff are having difficulty reporting to CPhIR 'in-the-moment' you can try printing the off-line forms and using a paper system until you have time to enter the information online. Have a stack of report forms readily available to staff to fill out manually until business slows down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

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

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

All twenty Safety IQ pharmacies have completed their Medication Safety Self-Assessment (MSSA). Thank you to all the pharmacy staff and managers who took the effort to perform this comprehensive review of their medication practices to identify their pharmacy's strengths and areas for improvement. You have empowered your pharmacy to enhance patient safety! Please continue your improvement efforts and refer back to your MSSA to guide your ongoing and upcoming initiatives.

The 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.

Contacts

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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.