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 Mountain Park Pharmacy Experience

Safety IQ Update

Q & A: How do I know what near misses to report?

Safety Measures

Measuring Safety Culture Through Analysis of Incident Reporting

Messages from ISMP Canada: Psychological Safety: An Essential Constituent of Safety IQ

The SMART Medical Safety Agenda

Contacts

Piloting Change: The Mountain Park Pharmacy Experience

Mountain Park Pharmacy manager, Dustin Hunt, prides himself on the strides his team has made since beginning the Safety IQ pilot project in September 2017. The pharmacy's two assistants, Jennifer Ritchie and Kari-Ida Dobson complete the pharmacy staff of three working out of Erickson in rural Manitoba.

From left to right: Jennifer Ritchie, Dustin Hunt, Kara-Ida Dobson

"It's been a positive experience overall for sure," says Hunt. "I'm surprised the year is over already."

At the beginning of the pilot project, Hunt integrated the Safety IQ Tools into his workplace. This included the CPhIR incident reporting tool and the MSSA (Medical Safety Self-Assessment). It took a bit of time to complete the MSSA but the end result was very worthwhile for his pharmacy team.

"It ended up being not that difficult to implement, using the CPhIR tool for reporting doesn't take a large amount of time to fill it out. If you're really busy, you make a note so you don't forget to do it. It takes 3-to-5 minutes to fill out the form and send it in," says Hunt. "While it (MSSA) took a couple of days to complete, I found the MSSA quite interesting. There were things that we wouldn't have thought about that could, in the future, be implemented."

Hunt noted the quarterly meetings as a key way to communicate and review medication errors with his staff and develop plans to improve safety.

"With doing the quarterly meetings, that has been helpful and we've been able to look over the total numbers and look for a certain type of error that's continually going on or if it's just random things that are happening. It just opens up that discussion."

This openness to sharing near-misses and incidents is key to moving from a blame-and-shame culture to a safety culture. At Mountain Park Pharmacy, Hunt admitted the Safety IQ pilot project has changed the way these issues were discussed and dealt with.

"Now with Safety IQ, we will look back quarterly and say "ok, this happened, what are the things we can do to reduce the risk of this happening again?"

As a result of the staff discussions, Hunt and his pharmacy staff have made changes in their pharmacy practice throughout the course of the pilot.

"We just always have reminders at our meetings about always checking DINs. We will make little sticky notes on our shelves to check in case packaging is very similar. If we do think there is a chance for a medication to be mistaken for another, we will separate them enough just so that it's not mistakenly grabbed."

Safety IQ has "reemphasized for us that we're an important last safety net and when the team is working together well, it does work to prevent incidents from happening.

Safety IQ Update

The College appreciates the valuable feedback that Safety IQ pharmacy staff provided through the Safety IQ evaluation survey. The St. Francis Xavier research team received 52 responses from 110 surveys – a 47% response rate! With the final evaluation the Safety IQ Pilot complete, the College wants to keep you updated on the possible future of Safety IQ.

The College has been provided with a final report from the St. Francis Xavier research team. The report includes an analysis of the survey results and an overall recommendation for the future of Safety IQ including detailed recommendations for improvement and implementation going forward. A summary report will be sent to those respondents who requested a copy.

The Safety IQ Pilot outcomes will be reviewed by the College's Quality Assurance (QA) Committee and the QA Committee will provide Council a recommendation regarding the future of Safety IQ.

On October 15, 2018, Council will consider the QA Committee's recommendation for Safety IQ.

Your participation and feedback in this important patient safety initiative is very much appreciated.

CPhIR Subscription Update

With the pilot ending on September 18, 2018, Safety IQ pharmacies have expressed concerns regarding the future of the program and their ability to continue to access the CPhIR tools and report medication incidents and near misses. ISMP Canada has confirmed that the CPhIR subscription for each Safety IQ pharmacy will be extended beyond September 18th until a decision has been made by Council. A red header may appear indicating the account has expired.

The red header cannot be closed, but the pharmacy can still proceed with their incident reporting. The College encourages all Safety IQ pharmacies to continue the important work of reporting medication incidents and valuable near misses into the CPhIR program.

Q & A: Are there any resources that can help my team address near misses?

QUICK GUIDE: ENTERING A CPhIR REPORT

WHEN DO I ENTER A MEDICATION INCIDENT OR NEAR MISS TO CPhIR?

Ideally, medication incidents and near misses should be entered as they happen. Alternatively, staff can fill out paper reports and enter the information into CPhIR when the pharmacy is less busy.

The following instances are examples of what should be reported to CPhIR:

- All medication incidents that reach the patient regardless of harm
- Any near miss that had the potential to cause harm had it not been caught
- Any near miss that is occurring repeatedly
- Any near miss that a pharmacy member feels is important to report

WHO SHOULD I TALK TO IF I HAVE QUESTIONS ABOUT A MEDICATION INCIDENT OR NEAR MISS ?

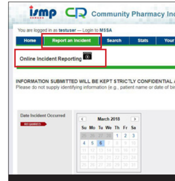
You can talk with ______________________ about any medication incident, near miss, or patient safety concern.

HOW DO I ENTER A MEDICATION INCIDENT OR NEAR MISS INTO CPhIR?

Log in to CPhIR at www.cphir.ca using your pharmacy's unique username and password:

Username: ______________________

Password: ______________________



Fill out the seven mandatory fields:

- Date incident occurred
- Type of incident
- Incident discovered by
- Medication system stage involved
- Medications involved
- Degree of harm to patient due to incident
- Incident description/how it was discovered (only free text field)

The optional fields are also valuable for analysis. If you don't have time to enter the details, leave the incident report open until all information about the incident is included then close the incident.

KEY POINTS TO REMEMBER:

- Reporting is anonymous
- Short training videos are included in the CPhIR platform (see image above)
- DO NOT enter identifying patient information
- Open incidents **cannot** be searched--to find an open incident, click on the "Home" tab and you can sort incidents by date or number
- Open incidents will automatically close after 90 days
- Close open incidents as soon as the details are complete
- Closed incidents cannot be edited

The CPhIR statistics on incident reporting from ISMP Canada confirm that the majority of errors reported are near misses which are caught by the pharmacy. However, pharmacy staff can find the reporting of near misses to be time consuming and overwhelming. Is it necessary to report all near misses and if not, which ones should be reported?

The College has developed a Quick Guide: Entering a CPhIR Report which outlines some examples of near misses that would be beneficial to report:
• Any near miss that had the potential to cause harm had it not been caught
• Any near miss that is occurring repeatedly
• Any near miss that a pharmacy member feels is important to report

The pharmacy manager and staff can discuss and outline on the Quick Guide the types of near misses they feel are beneficial to report within their pharmacy into the CPhIR reporting tool. The Quick Guide is also a useful tool for new and current staff as it provides an area to list the pharmacy's CPhIR login information, mandatory fields to be entered, and key points to remember.

Near misses provide an excellent opportunity for pharmacies to learn and develop processes to prevent reoccurrence of the same error. Reporting near misses including information on the pharmacy's action plan, allows the pharmacy to share their learning experience with others.

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:

712 INCIDENTS REPORTED

- **494** NEAR MISS/MEDICATION DISCREPANCY (MEDICATION NOT DISPENSED)
- **199** NO HARM (MEDICATION DISPENSED - NO SYMPTOMS AND NO TREATMENT NEEDED)
- **16** MILD HARM (MEDICATION DISPENSED - NO TREATMENT OR MINOR TREATMENT NEEDED)
- **3** MODERATE HARM (MEDICATION DISPENSED - ADDITIONAL TREATMENT OR OPERATION NEEDED; CAUSED PERMANENT HARM OR LOSS OF FUNCTION)

MOST FREQUENT INCIDENTS BY TYPE

INCIDENT TYPE	COUNT
INCORRECT DRUG	176
INCORRECT DOSE / FREQUENCY	166
INCORRECT STRENGTH / DOSE	73
OMITTED MEDICATION / DOSE	69
INCORRECT QUANITY	67

Measuring Safety Culture Through Analaysis of Incident Reporting

Medication incidents reports are used to conduct a multi-incident analysis where a group of incidents are analyzed to determine common contributing factors and develop potential recommendations for improvement plans. The goal of a multi-incident analysis is to share key learnings among healthcare professionals to reduce patient harm.

Analysis of medication incidents can also be helpful to measure patient safety culture within a healthcare setting by using an ISMP tool – Medication Safety Culture Indicator Matrix (MedSCIM). Each incident report to ISMP Canada includes the description of the incident - the only free form text field. In this field, staff members have the opportunity to provide specific details about the error – what happened, how it happened and possible changes in procedures undertaken to prevent repetition of the error. The more details provided allows for better analysis by the ISMP team.

Please view the following resources from ISMP Canada to help understand the MedSCIM tool:

Medication Safety Culture Indicator Matrix (MedSCIM): Going Beyond the Numbers and Using Incident Reports to Assess Medication Safety Culture [Poster]

Not a numbers game: Medication Safety Culture Indicator Matrix (MedSCIM) [Hospital News Article]

The MedSCIM tool involves two or more individuals reviewing multiple incident descriptions to assess 1) the core event and 2) the maturity of the culture.

Core Event: First, the incident description is rated for completeness of the documentation and is given a rating from Level 1 (fully complete) to Level 3(Not complete). From reading the description, can you understand what happened?

Maturity of Culture: The incident description is ranked to determine what approach the reporter uses to describe the root cause. Do they look at system based or more human based causes? Also, are solutions developed to prevent re-occurrence? The rating for the maturity of ranges from Generative (Grade A) to Blame and Shame (Grade D).

Using the ranking for the Core Event and Maturity of Culture and the MedSCIM Matrix tool, one can assess the level of medication safety culture – Level 1 and Grade A being the most positive safety culture and Level 3 and Grade D being the least positive.

Rating of the incidents can be subjective; therefore, it is beneficial to have 2 or more individuals involved in the rating discussion. The use of the MedSCIM Matrix Tool can give pharmacies an opportunity to assess their safety culture and present areas for improvement in their safety culture.

In the next eQuipped, a MedSCIM assessment of Safety IQ pharmacies conducted by ISMP Canada will be shared. Review of the above material will be helpful to better understand ISMP's analysis.

Messages from ISMP Canada

Psychological Safety: An Essential Constituent of Safety IQ

Given the complexity of the dispensing of medications, medication incidents are an inevitable part of community pharmacy practice. In fact, it is estimated that as many as 7 million medication incidents occur in Canadian community pharmacies each year.[1] Quality improvement programs such as Safety IQ encourage the reporting and analysis of these incidents in an effort to improve learning and prevent recurrence.

Unfortunately, reporting and discussing errors among pharmacy staff is often avoided due to the fear of retribution from both fellow colleagues and management.[1] Overcoming these barriers is necessary to create an environment of psychological safety. Psychological safety refers to the phenomenon where members of a team are comfortable taking interpersonal risks, such as reporting and discussing medication errors, without fear of negative consequences to self-image, status, or career.[2] In healthcare, where errors form the basis upon which improvements in processes are established, psychological safety sets the foundation in allowing organizations and individual practitioners to learn from errors. The effects of psychological safety can be expressed across three different levels: individual, group, and organizational (Table 1).

Table 1. Effects of Psychological Safety at the Individual, Group, and Organization Levels:

Level	Description
Individual	A working environment where an individual feels psychologically safe elicits confidence, and therefore drives creativity, proactivity, and eagerness to share information with others. Employees are more likely to proactively engage in sharing information with their peers and create opportunity for generative discussion of improvement.[2]
Group	Psychological safety at a group level is encompassed by team learning and continuing innovation developed through task conflict and group collaboration. The resulting supportive networks allow members to learn from shortcomings and incidents, and encourage innovative changes in existing processes to optimize outcomes in the future.[2]
Organizational	Psychological safety at the organizational level involves building relationships between employer and employee, and the development of support networks within the organization.[2] Management practices that promote a sense of psychological safety within the organization facilitate knowledge exchange between peers and create an environment where individuals feel safe taking interpersonal risks.[2]

Creating an environment of Psychological Safety

Development of psychological safety within the workplace promotes sharing of errors via upwards communication. This encourages staff to express concerns and share incidents not only among their peers, but also with executive staff members, resulting in potential for implementation of organization-wide changes and improvements.[2]

To develop a work culture that embraces psychological safety, factors that influence employees' perception of the work environment must first be addressed. This includes improvement in key areas of interpersonal relationships, management behaviours, and organizational practices. Cumulatively, these factors enhance psychological safety and ensure that employees consistently feel comfortable with sharing any incidents that they encounter.

Interpersonal Relationships

Interpersonal relationships, and the social support and resources inherent within, promote psychological safety and contribute to team learning, performance, and innovation.[2] Characteristics such as shared team rewards, formal team structures, and engagement in cross disciplinary work improve the strength of social networks and enhance psychological safety.[2]

Management Behaviours

Supportive and clarifying management processes are the most effective management styles in promoting psychological safety in the workplace.[2] Management characteristics such as inclusiveness, support, trustworthiness, openness, and behavioural integrity strongly influence employee perceptions of psychological safety, which in turn, fosters beneficial outcomes such as team learning behavior, team performance, engagement in quality improvement work, and a reduction in errors.[2]

Organizational Practices

Supportive organizational practices are positively related to employee work outcomes such as organizational commitment and job performance as they heighten perceptions of psychological safety.2 Providing a supportive environment through access to mentoring and implementation of diversity practices promotes open discussion and willingness of staff to express concerns.[2]

Psychological Safety and Continuous Quality Improvement (CQI)

Creating a psychologically safe environment in community pharmacies will be necessary for the success of Safety IQ. Safety IQ requires participating community pharmacies to report all medication incidents and near misses to the Institute for Medication Practices Canada (ISMP Canada) through the Community Pharmacy Incident Reporting (CPhIR) program.[3] The incident reports generated not only help individual pharmacies develop quality improvement initiatives, but also allow aggregate analysis for shared learning across Canada.[3] Without psychological safety, pharmacy staff will be less likely to report incidents, suggest new ideas, or seek assistance. Creating a positive team dynamic and ensuring management and regulatory support are essential to establishing a safe environment at the individual, group, and organizational levels. By working towards psychological safety in community pharmacies, organizations and individual practitioners can better learn from incidents and improve medication safety

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Newman A, Donohue R, Eva N. Psychological safety: A systematic review of the literature. Human Resource Management Review 2017; 27(3): 521-535.

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The SMART Medication Safety Agenda

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 most current Agenda is about Fentanyl. Your team can use the SMART Medication Safety Agenda to improve safety on Fentanyl even if you have not reported a Fentanyl-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.

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Community Pharmacy Incident Reporting (CPhIR)
August 2018
SMART Medication Safety Agenda

Fentanyl [28:08:08 Analgesics Opiate Agonists]

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

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