Safety.
Improvement.
Quality.

eQuipped

Safety IQ eNewsletter

eQuipped is the official e-newsletter for the College of Pharmacist 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 Update

On October 15, 2018, the College of Pharmacists of Manitoba (College) Council approved the implementation of Safety IQ within all community pharmacies in Manitoba. With that decision, College Council also directed that an advisory committee for Safety IQ be created to develop a plan for implementation, including considerations for different options for reporting technology provider, program requirements, training and education and timelines for provincial roll-out. Once fully implemented, the committee will periodically review the Safety IQ program to evaluate the progress of the program.

Who is on the Safety IQ Advisory Committee?

The Committee includes representatives from various stakeholders:

- Five representatives from Safety IQ pilot pharmacies
- One pharmacy assistant
- Two representatives from the Quality Assurance Committee
- Two representatives from the University of Manitoba, College of Pharmacy
- One representative from a pharmacy technician college
- One public representative
- One chair from Council

The advisory committee is currently seeking a pharmacy technician representative. Interested pharmacy technicians are welcome to contact the College (safetyiq@cphm.ca) for more information.

The advisory committee meets bi-monthly in advance of College Council meetings. When more information becomes available regarding potential timelines for implementation, the College will inform members through the various College publications.

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:

795 INCIDENTS REPORTED

- 548 NEAR MISS/MEDICATION DISCREPANCY (MEDICATION NOT DISPENSED)
- 227 NO HARM (MEDICATION DISPENSED - NO SYMPTOMS AND NO TREATMENT NEEDED)
- 17 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

INCORRECT DRUG	201
INCORRECT DOSE / FREQUENCY	185
INCORRECT STRENGTH / DOSE	89
OMITTED MEDICATION / DOSE	72
INCORRECT QUANITY	71

Safety IQ Q&A: How do I Find Out More About Safety IQ?

The College has developed resources, namely - the Safety IQ Fact Sheet and the Safety IQ Q&A documents to help pharmacy staff become more familiar with Safety IQ in preparation for provincial implementation.

Safety IQ Q&A

Safety IQ Fact Sheet

These resources will be updated as more information regarding the implementation of Safety IQ is determined. Be sure to contact the College (safetyiq@cphm.ca)with any questions.

eQuipped is now sent to all members of the College to make sure important updates get distributed to community pharmacists and pharmacy technicians across Manitoba. Be sure to read previous issues of eQuipped for more information on the pilot pharmacies and the different resources they utilized in 2018.

eQuipped Vol. 1

eQuipped Vol. 2

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eQuipped Vol. 4

The Safety IQ webpage on the College website also provides information on the Safety IQ program as well as featured resources for CQI and patient safety.

MedSCIM - Medication Safety Culture Indicator Matrix

(Article adapted from the Saskatchewan College of Pharmacy Professionals)

The MedSCIM tool was developed by ISMP Canada to qualitatively assess a pharmacy's safety culture towards incident reporting. The MedSCIM analysis involves 2 or more individuals looking at the narratives of medication incidents reported and assessing the report for completeness and maturity of culture.

There are three levels for assessing the reports' completeness:

Level 1 – Report fully complete – The medication incident provides sufficient information to describe the medication incident and contributing factors.

Level 2 – Report semi-complete – The medication incident provides sufficient information to describe the medication incident. No information is provided about contributing factors.

Level 3 – Report is not complete – The medication incident provides insufficient information to allow meaningful qualitative analysis.

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MedSCIM - Cont'd

There are four levels for assessing the maturity of culture:

Grade A – Generative – the medication incident uses a systems-based approach to describe the root causes and develop possible solutions to prevent future recurrence.

Grade B – Calculative – The medication incident uses a systems-based approach to describe the root causes. No solutions are offered to prevent future recurrence.

Grade C – Reactive – The medication incident is treated as an isolated incident. No solutions are offered to prevent future recurrence.

Grade D – Pathological – The incident focuses on human behaviours instead of a systems-based approach.

The desired level of assessment would be 1A, where the report is fully complete, and the narrative indicates a generative culture. As is illustrated below 1B, 1A and 2A fall into the green area, whereas 1C, 2C and 2B fall into the yellow and 1D, 2D, 3D, 3C, 3B and 3A fall into the red.

Over time, it is expected that with increased experience with reporting that the culture of safety will be strong and therefore the majority of incidents report will fall into the green area.

Maturity of Medication Safety Culture

Core Event Description	Grade D: Blame and Shame	Grade C: Reactive	Grade B: Calculative	Grade A: Generative
Level 1: Report fully complete	0	0	0	0
Level 2: Report semi-complete	0	0	0	0
Level 3: Report not complete	0	0	0	0

The information presented in the chart below is from a MedSCIM assessment of Safety IQ pharmacies conducted by ISMP Canada on incident reports (near misses not included) between September 2017 and June 2018. A total of 200 incidents were included in the analysis.

Maturity of Medication Safety Culture

Core Event Description	Grade D: Blame and Shame	Grade C: Reactive	Grade B: Calculative	Grade A: Generative
Level 1: Report fully complete	29	58	35	9
Level 2: Report semi-complete	11	48	1	0
Level 3: Report not complete	2	6	1	0

The chart shows that medication incidents were reported with a high degree of completeness. The majority of reports included a good description of what the error was but some were considered semi-complete (usually missing the "why" or "how" the incident occurred).

MedSCIM - Cont'd

The maturity of culture varied widely with over half of the reported incidents characterized as "reactive" suggesting that many pharmacies were either treating the incident as a single or isolated event with no further review into the "why" the error occurred (root cause) or system issue or they didn't determine a strategy to prevent it from occurring again.

It is important for pharmacy staff to understand that by first identifying and documenting the "why" or "how" an incident occurred, it will help them to them determine what needs to be implemented to prevent the error from occurring again. Regular discussion of contributing factors and learning pertaining to medication incidents will be valuable in identifying system vulnerabilities and ultimately improving medication safety.

For more details on the MedSCIM analysis conducted by ISMP Canada, please view the full report.

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 Blister Pack Preparation. Previous Agendas on Drug Shortages, Warfarin and Fentanyl can be viewed on the Safety IQ homepage under Resources.

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Community Pharmacy Incident Reporting (CPhIR)

November 2018

SMART Medication Safety Agenda

Multi-Medication Compliance Aid (Blister Pack) Preparation

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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Medication Safety Exchange Webinars

ISMP Canada offers complimentary bimonthly 50-minute webinars that provide a platform for frontline healthcare practitioners to share and learn about medication incident analyses and medication safety initiatives with colleagues across Canada.

The agenda for the webinar includes a healthcare professional outlining a medication incident that occurred in their practice site, the results of the incident analysis including contributing factors as well as recommendations arising from the investigation. Healthcare professionals or health organizations then present on medication safety initiatives implemented locally or nationally. Organizations such as ISMP Canada, Health Canada and the Canadian Patient Safety Institute also provide a Medication Safety Update. Participants are also given the opportunity to discuss and ask questions about the learnings shared in the webinar presentations.

These webinars are complimentary but you are asked to register beforehand by visiting ISMP Canada's website. The next Med Safety Exchange webinar is scheduled for March 27, 2019. Be sure to view past webinars that date back to Fall 2017 on the same linked page.

The Med Safety Exchange webinars provide an opportunity for pharmacy staff to learn about medication incidents occurring elsewhere that can help prevent similar errors in their pharmacy practice.

Messages from ISMP: Communication

Communication: An Indispensable Component of Safety IQ

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Communication gaps between patients and different health care providers (HCPs) are negatively impacting patient safety.1 A total of 134 medication incidents associated with moderate to severe harm between 2009 to 2017 were extracted from the Institute for Safe Medication Practices Canada (ISMP Canada) Community Pharmacy Incident Reporting (CPhIR) program (http://www.cphir.ca), of which 58% involved communication gaps. Communication gaps occurred between patients and HCPs (for example, physicians, pharmacists, nurses, etc.) or among HCPs. These gaps included incomplete verbal or written communication, or lack of communication. In some of these incidents, communication gaps had led to severe harm, such as hospitalization or even death.

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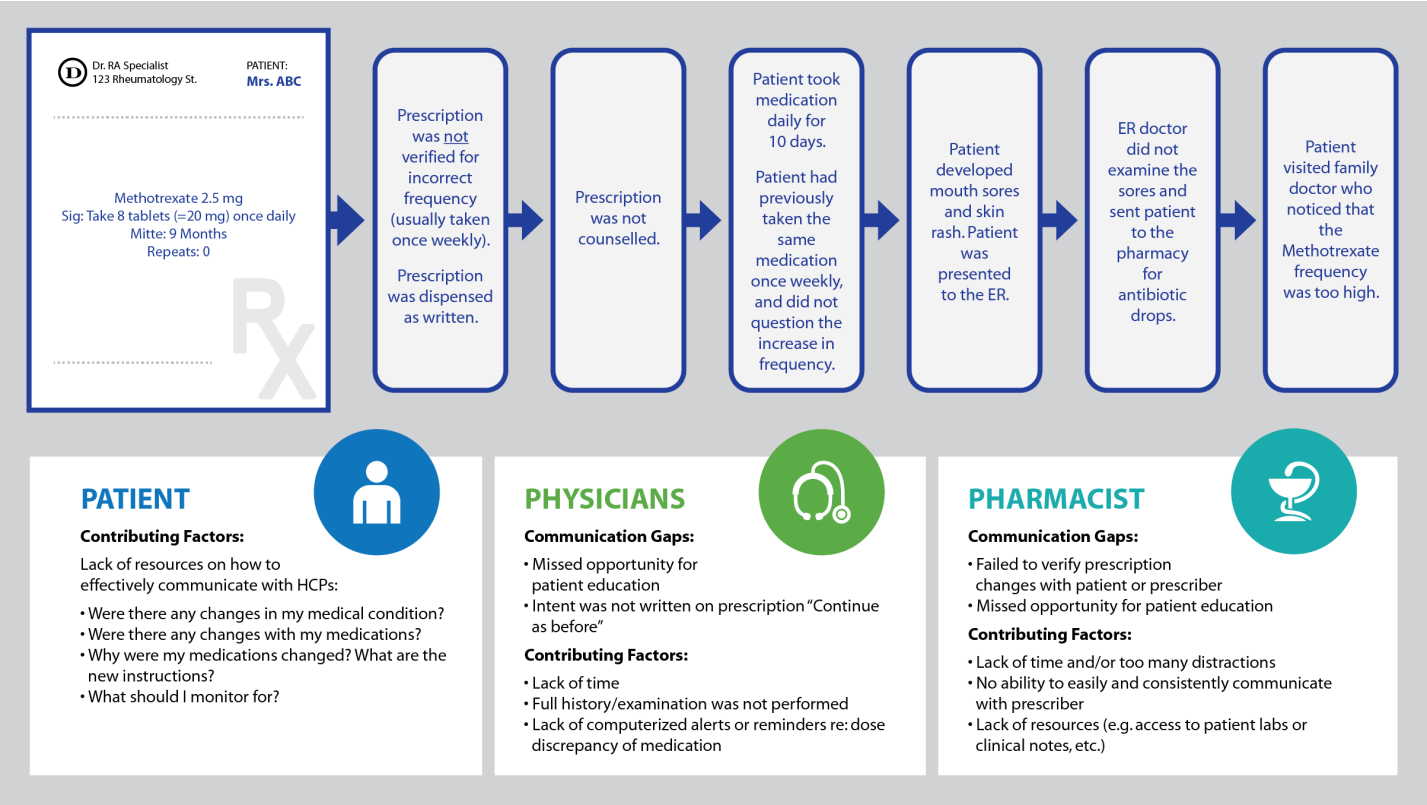
Messages from ISMP: Communication Cont'd

Figure 1 is an example of a medication incident that involves various degrees of communication gaps.

Figure 1 – A medication incident that involved communication gaps



Current Challenges

Ineffective communication skills
Advancement in technology has facilitated instantaneous communication globally (for example, text messages or instant messages via social media, etc.). However, as people communicate more frequently, the form of content becomes increasingly superficial and ineffective.2, 3 This is apparent in the digital world but is also influencing in-person communication skills.2, 3 Ineffective communication skills, amongst patients and HCPs, can compromise quality of care and patient safety.

Time is the largest barrier
Communication is a critical competency for HCPs.4, 5 An open dialogue with patients will facilitate a stronger patient-HCP relationship and may also allow for better gathering of patient information.4 However, HCPs are often challenged with limited face-time or contact time with patients. Decreasing time with patients may negatively affect the ability for patients and HCPs to build a relationship and also patient safety. How can patients and HCPs optimize the limited time that they spend together?

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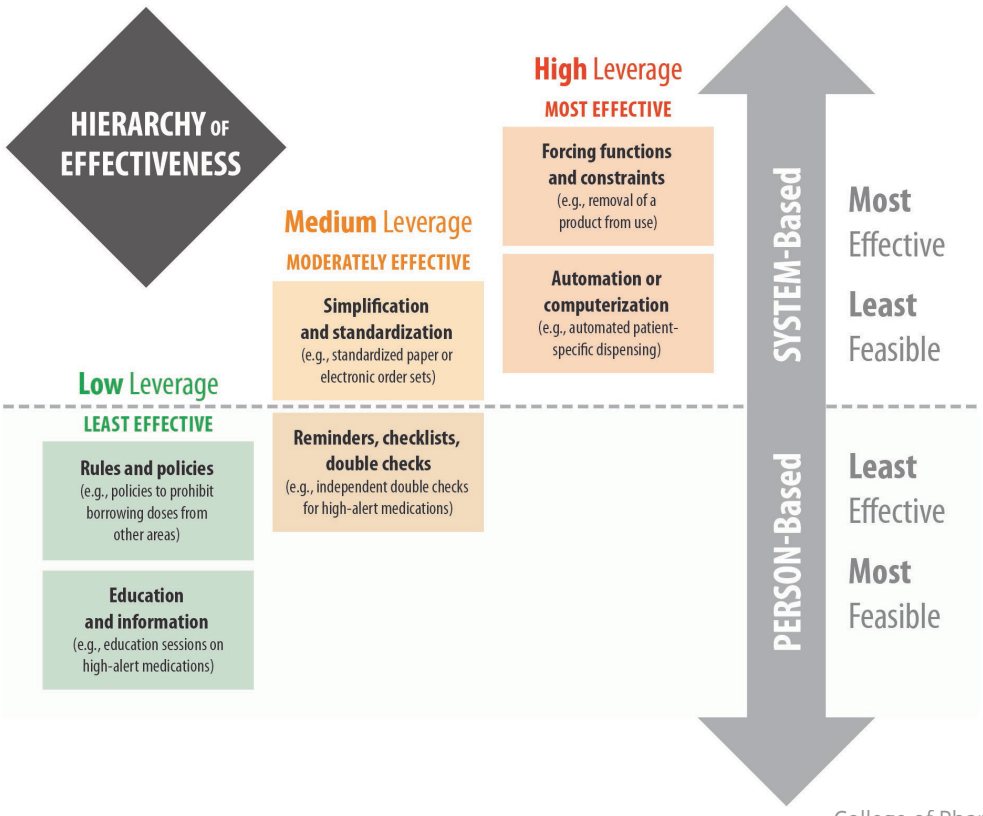
Preparing for the appointment
Patients are the common denominator among interactions of all members of the circle of care. Patients need to be educated on inquiring for the necessary information from their HCPs, such as, whether there are any changes in their medication(s), the nature of the changes in their therapy, and what actions are required on their part as patients.6-8 HealthLinkBC has printable patient reference sheets that will guide patients with communication and asking important questions during different appointments (for example, new ailment, follow-up appointment, etc.).7 HCPs should ensure that their patients fully understand what happen during the encounter. Techniques such as "show and tell" counselling and "teach back" patient education can help HCPs gauge the patient's understanding.1 In addition, ISMP Canada, the Canadian Patient Safety Institute, Patients for Patient Safety Canada, the Canadian Pharmacists Association, and the Canadian Society for Hospital Pharmacists collaborated and developed a set of five questions (to help patients start a conversation about their medications to improve communications with their HCPs. When both parties come prepared for the interaction, it facilitates more effective and efficient communication.

Technology
A patient's healthcare team should communicate with each other and with the patient. The hierarchy of effectiveness (Figure 2) demonstrates that merely expecting individuals to communicate, provide/receive education and information is, superficially, the most feasible, yet the least effective and sustainable solution.1 So why not use a high-leverage solution, like technology, to approach the problem and facilitate lasting change?

The gold standard would be a fully functional e-health system. HCPs will then have ready access to the patient's health and medication records. This would give clinicians the "full picture" of a patient's history and would be especially useful if a patient is not aware of the health condition(s) and/or medication(s).

In the meantime, HCPs should demand their point-of-care or clinical decision support software vendors to arm them with better communication and clinical tools (for example, an app that will allow and support for urgent communication; or safety features, such as reminders for patient medication list updates and alerts for dose discrepancy, dose too high, or dose too low, etc.).

Figure 2 – Hierarchy of effectiveness



Messages from ISMP: Communication Cont'd

Conclusion

The inherent nature of society's current way of communication largely hinges upon technology and networking. It is therefore prudent to leverage technology and evolve our current tools in order to be able to even begin delivering the highest possible standard of the future for patient care and safety.

The solutions are not by any means novel. In the end, all parties involved in the circle of care are responsible for ensuring that communication is clear and complete, as gaps in communication can have a detrimental effect on a patient's health and safety.

Final Remarks

The information in this article is adapted from an article published in the Fall 2018 issue of the Ontario College of Pharmacists (OCP) Pharmacy Connection and the Safe Medication column in May 2018 issue of Hospital News.

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Reminders for Safety IQ Pilot Pharmacies

CPhIR Subscription

During this planning and implementation phase of the provincial roll-out of a Safety IQ program, the pilot pharmacies will continue to have a CPhIR subscription for 2019. You and your team are encouraged to continue reporting incidents and valuable near misses to ISMP Canada, and use the other CPhIR tools during this transition period.

Reporting

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.

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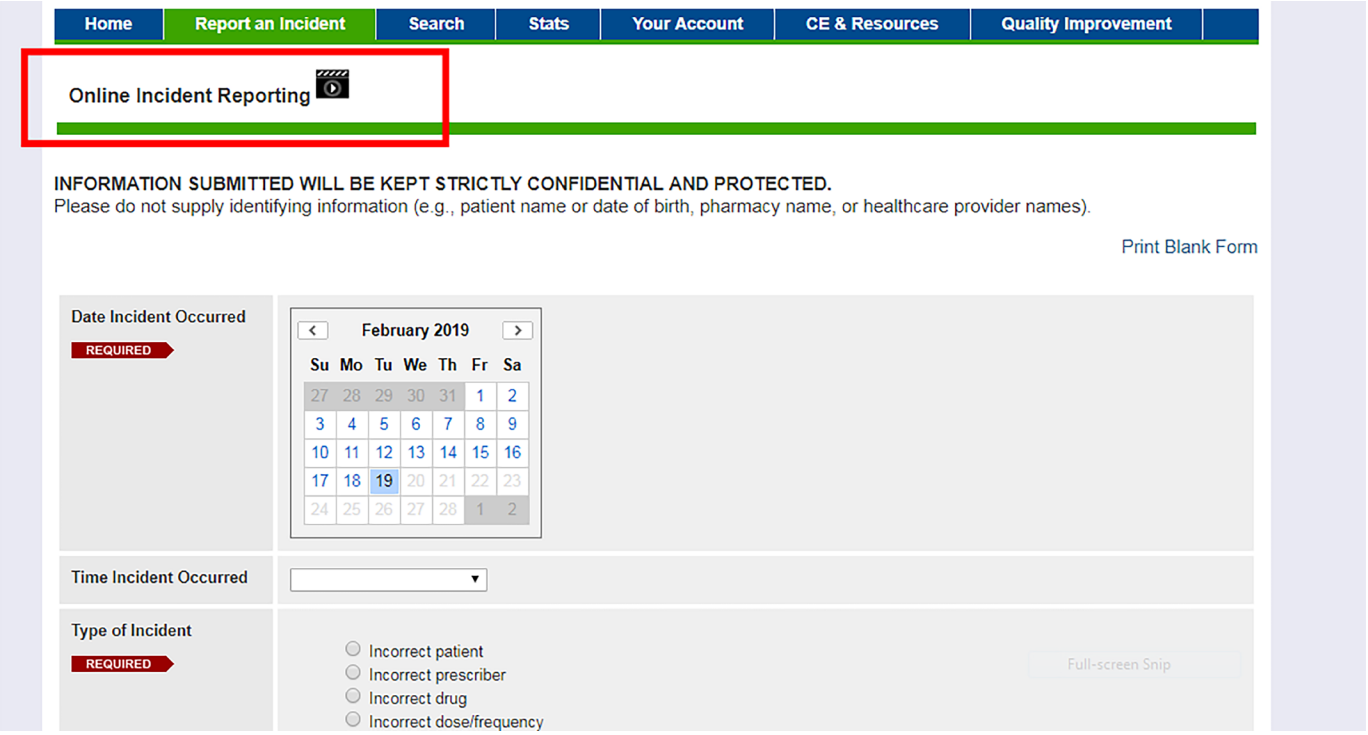
Discuss with your staff who may take the lead on inputting the reports into CPhIR as it can be someone other than the pharmacy manager. A pharmacist, technician or assistant can enter the information and then closed once the incident has been reviewed by the pharmacy manager and all pertinent information has been included.

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 for analysis.

The College has developed a Quick Guide: Entering a CPhIR Report which outlines some examples of near misses that would be beneficial to report. 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.

Safety IQ pilots - Training new and current staff

On the CPhIR website, a short video module is available on each tab – Report an Incident, Search, etc. which provides information on how to use that particular CPhIR tool. To help new and current staff orient themselves with reporting, they can access the video modules by clicking on the video reel icon on the Report an Incident page.



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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.