

**SAFETY CULTURE IN  
COMMUNITY PHARMACY**

SHANNON TRAPP, BSC, BA, BSC PHARM,  
PHARMACY MANAGER

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**CONFLICTS OF INTEREST**

- I have no conflicts to disclose

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**OBJECTIVES**

- Engage strategies to address challenges to improve the safety culture of community pharmacy

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### THE FRAMEWORK

**ORGANIZATIONAL CULTURE**

- A complex framework of national, organizational and professional attitudes and values within which groups and individuals function
- What does this mean and why does it matter?

**SAFETY CULTURE**

- A subject of organizational culture relating specifically to the beliefs and values concerning health and safety within an organization
- What does this mean and why does it matter?

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### HOW SHIFTING BLAME ACTUALLY IMPROVES PHARMACY PRACTICE

TREATING ERRORS AS PERSONAL FAILURES RESULTS IN LESS REPORTING

AN OPEN AND SAFE ENVIRONMENT FOR REPORTING ERRORS INCREASES IMPROVEMENT TO THE SYSTEM THAT FAILED

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### HOW PRACTICE CHANGES WITH A CHANGE IN ATTITUDE TO SAFETY CULTURE

- When we move away from treating errors as personal failures we open our practice to opportunities for improvement
- When we create an environment of stability and trust within the pharmacy we protect our patients from harm outside the pharmacy

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**CHALLENGES:**  
EXAMINING WHERE THINGS GO WRONG

- Fear of blame or “I don’t want to get in trouble”
- We are too busy or “I don’t have time to go to the washroom let alone record errors
- I don’t want to get anyone else in trouble
- We talked about it so I didn’t feel the need to report it

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**BLAME AND SHAME:**  
THERE IS NO PLACE FOR YOU HERE

- The act of blaming and the act of reporting cannot coexist
- Getting rid of the blame:
  - There should be more than one person/one way to report an error
  - Errors should be reported to a group and discussed by a group
  - Ask what happened instead of who is responsible for the error
  - Make everyone responsible for the solution

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**CHALLENGES:**  
TROUBLE SHOOTING IMPLEMENTATION

- What most often challenges successful execution
  - Information was not communicated to all pharmacy staff
  - Instructions or information regarding the error was unclear
  - Execution of reporting and follow up is inconsistent
  - Priorities are unclear
  - Staff do not know how to report an error
  - There is no recorded information on how to report an error or staff does not know where to find instructions

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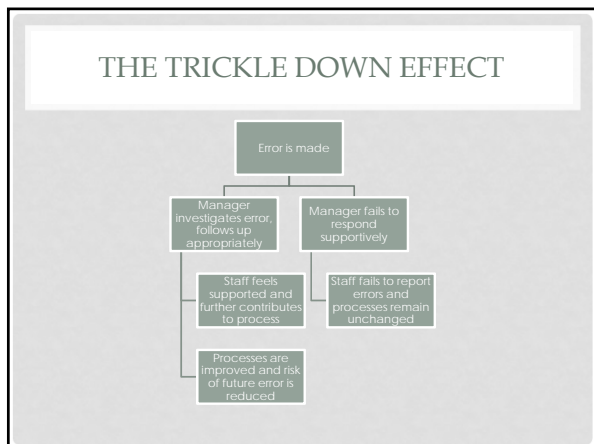
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### THE CHAIN OF POSITIVE LEADERSHIP

- The most damaging message a pharmacy team can receive is when the team witnesses management fail to follow up with respect to an error, fail to discuss the error with the entire pharmacy or worse rush to judgment or punitive action
- The result is that the members of the team will be less likely to report future errors and will become less involved in a process that improves pharmacy practice

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### PRACTICAL TIPS: WHAT WE DO WELL

PARTICIPATION

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EDUCATION

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OWNERSHIP

- We are all committed to reducing errors and improving patient safety by reporting and discussing errors as they happen...and they do happen
- Team huddles once a week to discuss
  - Processes that need improvement
  - Sources of weakness
  - Learning following an error
  - Should take no longer than a few minutes
- Rotation of facilitators is recommended
- Assigning communication roles gives a sense of responsibility

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**PRACTICAL TIPS:  
WHAT WE DO WELL**

**APPLICATION**

- Information is relayed to all staff at the beginning of a shift change
- Information is recorded in a communication binder that provides a brief synopsis of the error and circumstances relating to the error and a plan for future preventative action

**DISCUSSION**

- Re-evaluation facilitates a continuously improving practice
- If something isn't working or improving what else can we try?

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**PRACTICAL TIPS:  
WHAT WE ARE WORKING ON DOING BETTER**

- All errors matter and reporting all errors is the only way to shed light on possible patterns or trends with respect to errors
- We are working to make sure we address every single error in the pharmacy with the same level of diligence in order to help illuminate processes that require adjustment

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**TAKE HOME MESSAGE**

- Patient safety is all of our responsibility
- Creating a positive safety culture should be a priority
- Viewing all errors as opportunities to improve processes reduces the likelihood of repeat mistakes...which is good for everyone

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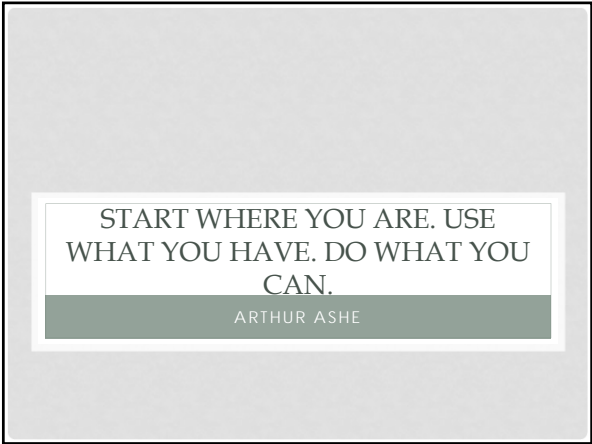
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