GUS GOTTFRED - COLLEGE OF PHARMACISTS OF MANITOBA

HOW PHARMACISTS CAN LEARN FROM ELITE ATHLETES AND THEIR USE OF ANALYTICS

CONFLICT OF INTEREST/DISCLOSURE

There are none

LEARNING OBJECTIVE

- Reflect on the value of incident data and the use of analytical tools to improve patient safety in your pharmacy practice

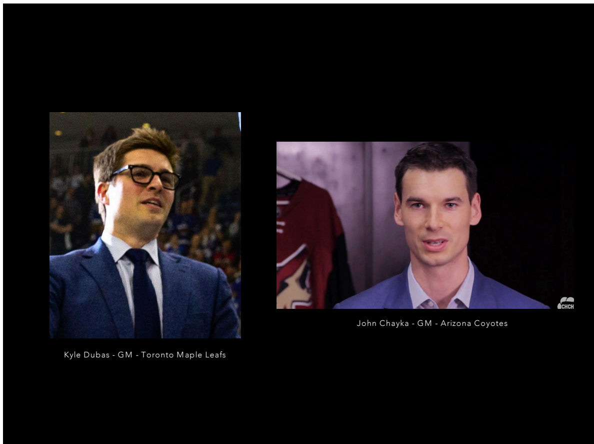
A BIT ABOUT MYSELF

- I have worked at the College for nearly two years
- No background in Pharmacy when I started
- I have tracked stats/analytics since 2004 for the Moose/Jets

WHAT ARE ANALYTICS AND HOW ARE THEY USED IN SPORTS?

- Teams figure out potential weaknesses as a group
- Then analyze individual players for weaknesses
- Come up with solutions
- Meet again as a group

SPORTS CULTURE

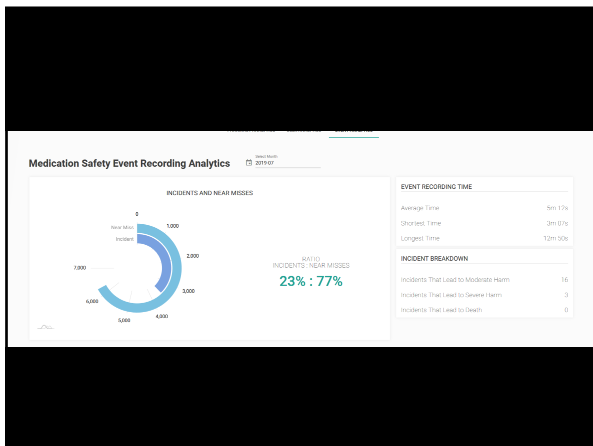


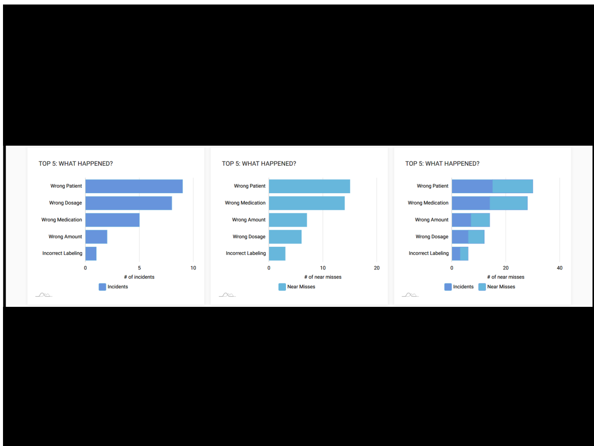
IT DOESN'T MATTER WHAT PROFESSION YOU ARE IN, USING ALL AVAILABLE DATA TO IMPROVE YOUR CRAFT IS CRUCIAL TO DEVELOPING AS A PROFESSIONAL

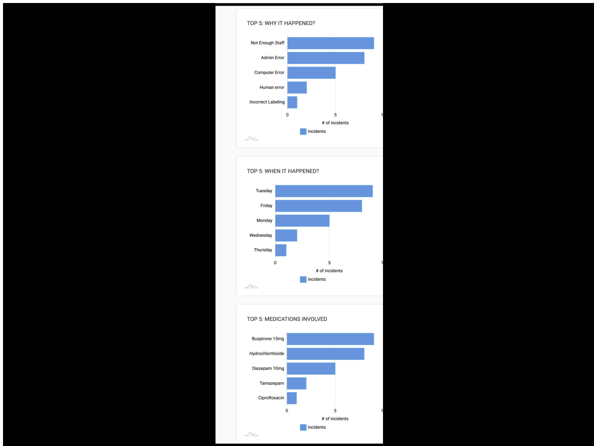
PHARMACISTS

HOW DO YOU START?

- Report to your database
- Watch for trends
- Discuss as a group
- Make changes in processes







AS MUCH AS I LOVE DATA, IT CANNOT BE SOLELY RELIED ON WHEN ANALYZING MEDICATION INCIDENTS

QUALITATIVE AND QUANTITATIVE

	Quantitative Analysis	Qualitative Analysis
Benefits	• Offer a quick summary of incident rates • Allow monitoring of trends	• Allow identification of case-specific contributing factors
Limitations	• Does not address case-specific contributing factors	• Does not identify incident rates • Can be time-consuming

Source: Hospital News - August 2019 edition

QUALITATIVE

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Community Pharmacy Incident Reporting (CPhIR)

August 2019

SMART Medication Safety Agenda

Potentially Inappropriate Medication Use in Older Adults

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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WHAT CAN WE ACHIEVE AND HOW CAN WE ACHIEVE IT?

IN CONCLUSION

- We need analysis and recommendations to be strong enough so similar events can be **prevented**
  - To achieve this, it requires a commitment of time, resources, and expertise.
- In the end, a deeper look at the narratives surrounding the incidents is **necessary**

ANY QUESTIONS?