Safety IQ

Continuous Quality Improvement & Medication Incident Reporting

COLLEGE OF PHARMACISTS OF MANITOBA

SEPTEMBER 26, 2019

Conflict of Interest

- No conflicts to disclose

Learning Objectives

- Describe the concept of continuous quality improvement within the health care field and pharmacy profession
- Outline the elements and value of the Safety IQ program
- Define safety culture and its importance in continuous quality improvement within pharmacy
- Employ some initial strategies for your pharmacy to prepare for Safety IQ

What is Continuous Quality Improvement (CQI)?

- "What are we doing now and how can we do better".
- Ongoing approach to problem-solving and harm prevention
- Continuously reassessing to see if improvements are effective

Safety IQ = Standardized Continuous Quality Improvement Program

- Beyond simply fulfilling the College's or pharmacy's liability requirements
- Establish a culture of safety to encourage reporting
- Analyze incidents using a system-based approach vs person based approach
- Proactively looking for areas to improve safety in pharmacy practice

Standardized – each pharmacy may use a different system but each will have similar elements or criteria and documentation

Safety IQ is a standardized CQI program

What is the Value of CQI?

Denise Melanson, 43, died last summer at Edmonton's Cross Cancer Institute.

CQI Movement in Canada

Provinces with established CQI programs or requirements	Provinces/Territories researching for future CQI program
Nova Scotia (2010) Saskatchewan (2017) Ontario (2019) New Brunswick (2019) Manitoba (2020?)	British Columbia (2022/23) Alberta Quebec Prince Edward Island Newfoundland Nunavut Northwest Territories Yukon

Safety IQ Pilot

Si Safety. Improvement. Quality.

- 20 volunteer community pharmacies - September 2017 – September 2018
- Enhance CQI program in community pharmacy by developing a standardized process and identifying barriers and enablers that may influence reporting

Safety IQ Pilot

- June 2018 – evaluation of pilot by SafetyNET-Rx research team to provide assessment and recommendations to Council
- October 2018 – Council approved provincial implementation of Safety IQ and created an Advisory Committee to work on the plan for implementation

Timeline for provincial implementation – 2020

Safety IQ Advisory Committee

- Consider the current requirements of pilot and make any updates for provincial program
- All incident report data must be exported to the national incident data repository – ISMP Canada
- Review and update Incident and Discrepancy Practice Direction
- Pharmacies to choose a reporting platform provider
- Develop criteria for platform providers to meet

Differences in Safety IQ Then and Now

Requirements	Pilot	Provincial Program
Reporting Platform	ISMP – CPhIR	Pharmacy choose a College approved platform
Safety Self-Assessment	Annually	Within first year then every 3 years or sooner
CQI meetings	Quarterly	Annual formal meeting Informal meetings as needed
Documentation	Meetings and Improvement plans	Meetings and Improvement plans

Safety IQ Cycle - Report

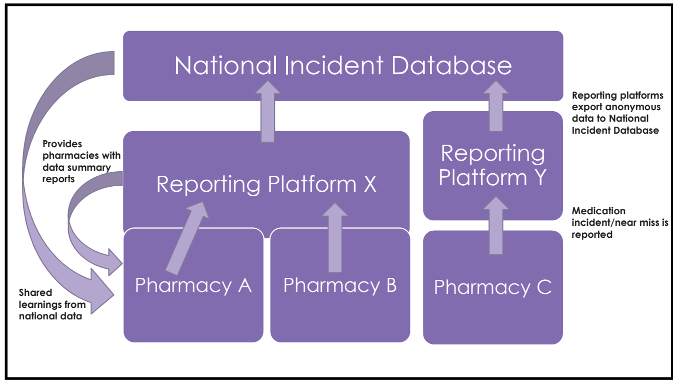
"At a minimum, reporting can help identify hazards and risks, and provide information as to where the system is breaking down."

Reference: WHO Draft Guidelines For Adverse Event Reporting And Learning Systems
http://apps.who.int/iris/bitstream/10665/69797/1/WHO-EIP-SPO-QPS-05.3-eng.pdf

Incident and Near Miss Reporting

- All medication incidents
- Near misses that could possible cause harm or are repeated
- No patient identifiers or names of pharmacy staff are reported to the national database

College does not have direct access to incident reports



Safety IQ Reporting Statistics

Accumulative Reporting Statistics

- 909 medication incidents reported (as of Sept 1, 2019)
  - 626 incidents were near misses
  - 283 incidents reached the patient
    - 258 incidents caused no harm
    - 20 incidents caused mild harm
    - 5 incident caused moderate harm

Top categories of incidents

- Incorrect drug
- Incorrect dose/frequency
- Incorrect strength/concentration

Safety.
Improvement.
Quality.

What is a near miss? Why report them?

"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: Building a Safer Health System

What near misses have to be reported?

- A near miss that:
  - May have caused patient harm if it had reached patient
  - Occur repeatedly and may indicate a gap in systems or procedures
  - Provide an opportunity to learn

Pharmacy managers and staff can discuss and determine which near misses would provide an opportunity to improve

Use professional judgment

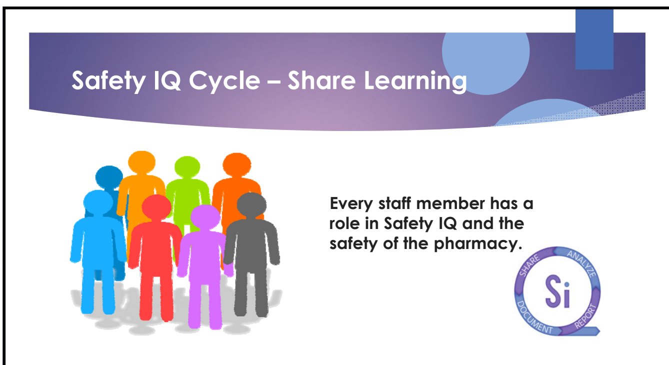
Safety IQ Cycle - Analyze

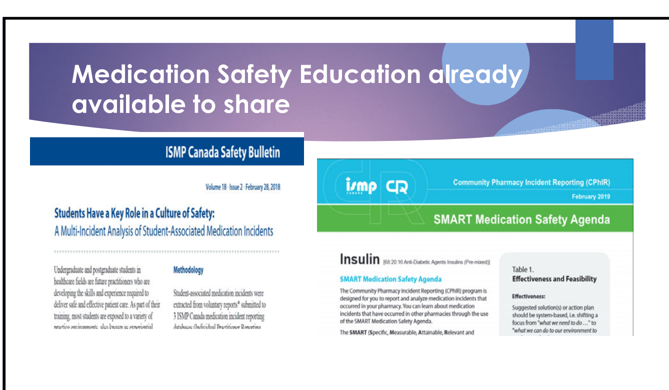
Reactive

- Analysis of your own pharmacy's incident and near miss reports using tools in the reporting platform
- Considering contributing factors
- Developing changes in systems or processes to prevent recurrence
- Goal = improvement not identifying who is at fault

Proactive

- Safety self-assessments (SSAs)
  - "What are we doing now?"
  - "How can we do better?"
- SSAs empower pharmacy teams to determine areas of strength and areas for improvement
- Subsequent safety self-assessments reveal the extent to which action plans caused improvement
- Reviewing data reports for your pharmacy to consider trends



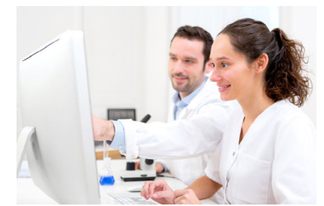


Safety IQ Cycle - Document

Document staff meetings and discussions in response to:

- Medication incidents
- SSA improvement initiatives
- Staff education

Keep track of the effectiveness of improvement plans – what is working and what doesn't



Safety IQ - Benefits and Challenges

Benefits

- Increased discussions of medication incidents
- More openness and less blame in incident discussions
- Ongoing assessment of risks and striving for improvement
- Increased awareness of individual actions and factors that may lead to incidents or near misses

Challenges

- Dual reporting
- Time to report
- Designating staff to report
- Number of near misses to report
- Training and engaging all staff to report

Safety Culture

US Institute of Medicine –

"the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm."

Community Pharmacy Safety Culture Toolkit

Goals

- Support community pharmacy teams to shift from a *blame-and-shame* to a *just-and-safe* culture
- Provide resources on safety culture to promote open discussion and communication of medication errors and near misses in order to make system-based changes
- Improve patient safety

Community Pharmacy Safety Culture Toolkit

- Defining and measuring safety culture
- Leadership
- Teamwork and communication
- Transparency
- Psychological safety
- Accountability
- Communication and Disclosure with Patients

How to Use the CPSC Toolkit

- Changing a culture involves many small changes over time
- Find what works for your pharmacy and start small
- Choose areas of improvement that are most pressing
- It is not a one time change but rather an ongoing process
- Encourage all employees to engage with safety initiatives

What can my pharmacy and I do now to get ready for Safety IQ?

- Become familiar with the updated practice direction and guidance document
- Talk to your staff and colleagues about Safety IQ and the changes coming
- Review current procedures when an incident occurs – do we look at what happened and consider possible contributing factors and make changes in processes
- What is the culture of your pharmacy regarding medication incidents
  - Do staff feel isolated?
  - Is the incident discussed openly without blame or shame?
  - Do staff come forward with suggestions to improve safety?

What can my pharmacy and I do now to get ready for Safety IQ?

- Consider a process for reporting that would work in your pharmacy –
  - Who reports,
  - When do you report – when it happens or later in the day, and
- What near misses do you think should be reported.
  - Would the patient be harmed?
  - Are they repeated?
  - Could we learn and make changes from a near miss to prevent a future incident?
- Begin reviewing and sharing learning already available through ISMP and the eQuipped newsletter

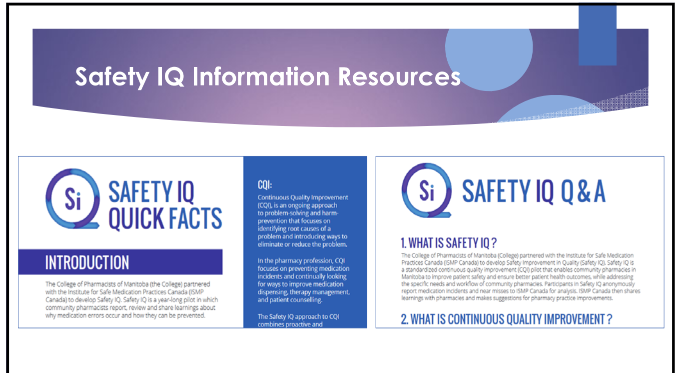
Safety IQ Information Resources

Safety. Improvement. Quality.

LEARN MORE | Q & A | QUICK FACTS

eQuipped

Safety IQ eNewsletter


Safety IQ Information Resources
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SAFETY IQ
QUICK FACTS
INTRODUCTION
The College of Pharmacists of Manitoba (the College) partnered with the Institute for Safe Medication Practices Canada (ISMP Canada) to develop Safety IQ. Safety IQ is a year-long pilot in which community pharmacists report, review and share learnings about why medication errors occur and how they can be prevented.
CQI:
Continuous Quality Improvement (CQI), is an ongoing approach to problem-solving and harm-prevention that focuses on identifying root causes of a problem and introducing ways to eliminate or reduce the problem.
In the pharmacy profession, CQI focuses on preventing medication incidents and continually looking for ways to improve medication dispensing, therapy management, and patient counselling.
The Safety IQ approach to CQI combines proactive and
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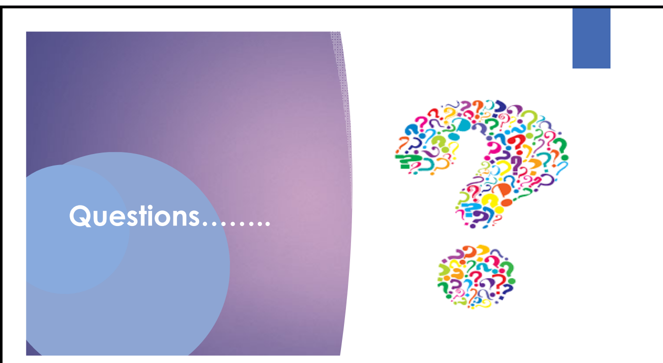
SAFETY IQ Q & A
1. WHAT IS SAFETY IQ ?
The College of Pharmacists of Manitoba (College) partnered with the Institute for Safe Medication Practices Canada (ISMP Canada) to develop Safety Improvement in Quality (Safety IQ). Safety IQ is a standardized continuous quality improvement (CQI) pilot that enables community pharmacies in Manitoba to improve patient safety and ensure better patient health outcomes, while addressing the specific needs and workflow of community pharmacies. Participants in Safety IQ anonymously report medication incidents and near misses to ISMP Canada for analysis. ISMP Canada then shares learnings with pharmacies and makes suggestions for pharmacy practice improvements.
2. WHAT IS CONTINUOUS QUALITY IMPROVEMENT ?


Questions……..