Community Pharmacy Safety Culture Toolkit

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EXECUTIVE SUMMARY

Following the success of the Safety IQ Pilot for continuous quality improvement in community pharmacies, the College of Pharmacists of Manitoba (College) recognized a need for a resource to support safety culture in community pharmacy teams.

The Community Pharmacy Safety Culture (CPSC) Toolkit outlines key concepts and resources on safety culture including measurement and monitoring of safety culture, leadership, teamwork and communication, psychological safety, transparency, accountability, disclosing medication incidents to patients, and supporting pharmacy professionals following a medication incident.

The purpose of the CPSC Toolkit is to support community pharmacy teams to work toward a just-and-safe approach to preventing and dealing with medication incidents and to promote local, team-based solutions for improving patient safety.
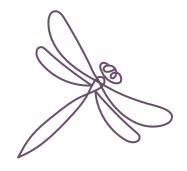
ACKNOWLEDGMENTS

MESSAGE FROM MELISSA SHELDRICK
PATIENT SAFETY ADVOCATE

On March 13, 2016, our 8-year-old son, Andrew, passed away suddenly and we later discovered that it was due to medication errors made during the dispensing process. Andrew's compounded Tryptophan liquid was substituted with Baclofen, unbeknown to us and the pharmacy. Since discovering that the only reporting program in existence at the time was in Nova Scotia, I made it my work to bring anonymous reporting and more stringent quality improvement programs to community pharmacies in Ontario and across the country. I was not ready to accept the fact that this devastation could happen to another family.

Andrew Sheldrick, age 8.

The champion pharmacists in Manitoba who volunteered to pilot Safety IQ were the first group with whom I shared my story and my vow to make sustainable change to patient safety in this country. This province is committed to increasing patient safety and protecting the public and the pharmacy professionals who work hard to keep their patients from experiencing harm via medication incidents. But human error is a continuous problem and we must work together to create a just and safe environment to help prevent future incidents.

Use this toolkit, frequently, as a resource in your pharmacy. Collaborate and communicate with your team to ensure that patient safety is the priority. Access the resources provided to you in this toolkit to minimize human error and to help prevent a tragedy similar to ours. Andrew's legacy is to see human error in community pharmacy minimized. Thank you for your commitment to do the same.

The dragonfly in the logo and used throughout this toolkit is very meaningful to our family. There is a story that tells the life of a water beetle that transforms into a dragonfly and cannot return to its home below the water, yet it is happy in its new life. It did not disappear, it was transformed. We see dragonflies everywhere and they remind us that Andrew is never far away.

Sincerely,

Melissa Sheldrick

Melissa Sheldrick

INTRODUCTION

The College launched a year-long pilot program called Safety IQ in September 2017 to develop a standardized continuous quality improvement (CQI) program for community pharmacies in Manitoba. Safety IQ enhanced existing medication incident and near-miss reporting and encouraged the development of safety cultures and blame-free approaches to medication incidents and near misses.

Overall, the Safety IQ Pilot was deemed a success by an independent evaluation implemented by SafetyNET-Rx Policy Advisor and Professor of Operations Management, Dr. Todd A. Boyle. Following Dr. Boyle's evaluation of Safety IQ, College Council approved the program as the mandatory CQI program for Manitoba community pharmacies in October 2018. College staff, pharmacists, and patient safety experts are working on a step-wise plan for province-wide implementation.

While Dr. Boyle's evaluation report was largely positive, showing that Safety IQ reduced blame culture and promoted safety culture, it also identified areas for improvement including increasing training/resources on safety, enhancing contact and engagement of pharmacy assistants and pharmacy technicians, and improving communication/discussion of incidents. Furthermore, the College has also identified risks to promoting a 'blame-free' culture in community pharmacy when, in fact, pharmacists in particular can be held accountable by the Complaints and Discipline Committee for medication incidents and/or patient harm. Therefore, a balance should be struck between a 'blame-free' and a 'just culture' in which people, organizations, and systems are accountable.

The CPSC Toolkit is designed to support pharmacy professionals in building, enhancing, and maintaining safety and just culture[1]. The CPSC Toolkit includes key concepts and resources on safety culture including:

- Measurement and monitoring of safety culture.

- Leadership.

- Teamwork and Communication.

- Psychological Safety.

- Transparency.

- Accountability.

- Disclosing medication incidents to patients.

- Supporting pharmacy professionals following a medication incident.

While the CPSC Toolkit is not an exhaustive resource, it provides a selection of tools you can use to define and support safety culture in your pharmacy. It is important to remember that safety culture is the outcome of many small changes and refinements over time. Find what works for your team by starting small and choosing the areas for improvement that your team believes are most pressing. Safety culture is an on-going endeavour that requires the dedication and engagement of pharmacy teams, managers, owners, and corporations.

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1 The remainder of this document will use the term 'safety culture' to encompass principles of safety and just culture.

DEFINING SAFETY CULTURE

Culture is a constant influence on how we live, play, and work. It is defined by a set of shared values, beliefs, and actions that combine to form 'the way we do things around here[1].' Culture influences everything we do—including what goes right and what goes wrong. In community pharmacy, our beliefs and actions are high-stakes.

Overall, the goal in healthcare is to protect and improve patient health, but in some circumstances patients are harmed.

Psychologist and scholar, James Reason, demonstrates that healthcare can learn from 'high-reliability organizations' (HROs) such as those in the nuclear or aviation industry. HROs are large and complex and failure could result in harm or death for hundreds or even thousands of people. HROs prevent and manage incidents with **safety culture**. According to Reason, members of a safety culture

- are preoccupied with safety and have current knowledge about the factors that determine the safety of the system;

- report incidents and near misses anonymously and without fear of blame;

- learn from incidents and near misses to make improvements;

- trust that their organization will deal with them fairly when something goes wrong; and

- adapt to changing pressures and demands.

In contrast, healthcare has traditionally engaged in a 'blame-and-shame' culture when it comes to adverse events and patient harm.

Some characteristics and beliefs of blame-and-shame culture include:

- Healthcare workers should never make mistakes

- Individuals are to blame when mistakes happen

- Punishment is an effective way to motivate carefulness

- With the hard work of individuals, things will improve

- Errors happen because of a few 'bad apples'

This approach is problematic because it assumes that the healthcare system is optimal and it separates individuals from their working environment. Reason calls this the *person approach* which is characteristic of poor safety culture:

"[A] serious weakness of the person approach is that by focusing on the individual origins of error it isolates unsafe acts from their system context. As a result, two important features of human error tend to be overlooked. Firstly, it is often the best people who make the worst mistakes—error is not the monopoly of an unfortunate few. Secondly, far from being random, mishaps tend to fall into recurrent patterns. The same set of circumstances can provoke similar errors, regardless of the people involved. The pursuit of greater safety is seriously impeded by an approach that does not seek out and remove the error provoking properties within the system at large[2]."

With the upcoming implementation of Safety IQ, Manitoba community pharmacists will have access to a de-identified reporting system for medication incidents and near misses in the province. Safety IQ will give

the pharmacy profession and its respective provincial regulators a window into the *system* of community pharmacy care with a focus on continuous quality improvement (CQI). With this foundation, community pharmacy professionals can further improve and build safety culture in their workplaces and enhance patient safety and care. The CPSC Toolkit is a collection of information and resources that can support and maintain your team's safety culture.

MEASURING SAFETY CULTURE

Measuring and monitoring transforms culture from an abstract or intangible concept into a concrete and defined reality. Gathering, sharing, and discussing evidence of positive and/or negative safety culture can

- define the successes and weaknesses of your pharmacy's safety culture;

- raise awareness about safety culture; spark ideas for safety culture improvement;

- generate a common language and understanding of safety culture within your pharmacy team;

- act as a starting point for your strategic plan to build or improve safety culture;

- highlight successes and movement in the right direction (this is often not apparent to staff but in looking back you can see how far you've come); and

- build teamwork, a key factor promoting patient safety and safety culture.

There are multiple ways to measure safety culture in your pharmacy and it's important to choose a method that works for your team. Ask some important questions before you decide what tool to use and begin an assessment of safety culture, including but not limited to:

- What time and resources do you have for measuring and monitoring safety culture?

- Do you have the technical ability to support the method you choose? Do you need outside help or expertise?

- Will your team members participate in your chosen method?

- Do you have any current measures or data on patient safety culture?

- Do you want to generate a few informal ideas of where to start or do you need formal data to track over time?

Importantly, assessing culture needs to be participatory. Culture can be damaged when we ask for feedback without sharing or acting on the results[3].

It's also important to remember that culture change is an on-going process and many methods or solutions are tried and refined over time to build a safety culture. If you picked a tool or method you think is inadequate, choose another tool or method, or mix several together until you find the best approach for your team.

For a list of measurement tools for safety culture, please see **Appendix A**.

LEADERSHIP

Effective leadership is the cornerstone of any positive safety culture. In a safety culture, leaders have the responsibility to

- support the work, education, and well-being of front line employees;

- manage and mitigate workplace conflict;

- create an environment of psychological safety;

- build a workplace founded on trust, respect, and inclusion;

- establish expectations of organizational behaviour;

- understand and implement safety science principles and CQI tactics;

- communicate in a timely and transparent way;

- ensure organizational values align with workplace conditions; and

- reward a just culture[4].

Through the above elements, leaders show their dedication to patient safety and lead by example. Importantly, leaders are not always identified by position or rank and can include pharmacy owners or managers, staff pharmacists, pharmacy technicians or assistants, and patients and their families[5]. Senior leaders may have more influence on developing strategies, mid-level managers mostly manage, and clinical and technician leaders may focus on the clinical and technical aspects of community pharmacy practice. Many elements of leadership cross all professional or workplace boundaries regardless of rank or position.

Every pharmacy team member can play a role in leading and modelling patient safety culture.

Training, education, and resources on leadership, teamwork, communication, and improvement science/tactics can help leaders and pharmacy team members build and maintain safety culture.

For a list of resources on developing leadership for a safety culture, please see **Appendix B**.

TEAMWORK AND COMMUNICATION

Like most healthcare service providers, community pharmacies are complex and demanding environments with multiple points of human interaction. Strong teamwork and effective communication are key to maintaining patient safety and safety culture. In fact, weak teamwork and communication are frequently cited as contributors to patient harm[6].

5 ELEMENTS OF EFFECTIVE TEAMS

1. Shared vision and values on patient safety.

2. Trust and confidence.

3. Shared understanding of professional roles and responsibilities.

4. Clear behavioural expectations.

5. Well-established systems of communication and conflict management.

In a safety culture, managers and leaders must have strong and transparent systems of communication with staff and patients. Team members need commonly understood modes of communicating with one another and with patients, and pharmacy staff must also have the skills to communicate with doctors and other healthcare providers.

Appendix C lists a number of methods and resources your team can use to communicate effectively. Again, it is important to choose methods that work for your team and then use them consistently.

Shared Vision and Values

A vision statement is an aspirational goal for the entire team to work toward. Values are our most important behavioural standards[3] and combined vision and values are the guiding principles of your organization.

Establishing or revisiting your vision and values can be a powerful exercise in teamwork and cohesion that places safety at the heart of everything you do.

Ideally, your vision and values should

• demonstrate your commitment to patient and workplace safety

• engage the entire workforce;

• include long-term perspective; and

• be clear and concise for easy remembering, repetition, and communication.

The **Neighbourhood Pharmacy Association of Canada's Pharmacy Patient Safety Program Resource Book** provides an excellent list of Guiding Principles in Patient Safety to help your team to think about and establish vision and values.

Ultimately, your vision and values are the touchstone of your workplace culture.

Conflict Prevention and Management

A community pharmacy can be a stressful environment with abundant potential for conflict. Conflict can arise from personality differences, stress, disagreements over a patient's care plan, or competition for resources. Conflict has both positive and negative outcomes depending on how it is managed. Healthy conflict can lead to improvements and solutions, while unhealthy conflict can negatively impact productivity, morale, communication, trust, and patient care[3].

It is equally important to consider conflict management between pharmacy professionals and other healthcare providers, and between pharmacy professionals and patients. The Canadian Interprofessional Health Collaborative recommends the following methods to address and manage conflict[7]:

- Value the positive potential of conflict

- Identify situations where conflict is likely to occur including role ambiguity, power differences, and discrepancies in goals

- Know and understand strategies to resolve conflict

- Establish guidelines for dealing with conflict

- Address and resolve conflict in a timely manner

- Create a safe environment for people to express diverse opinions

See **Appendix D** for more resources on managing and resolving conflict within teams and between professions.

4 WAYS TO REDUCE WORKPLACE CONFLICT

1. Clearly define staff roles and responsibilities.

2. Learn conflict management skills to minimize negative conflict.

3. Overtly recognize and value the contributions of all pharmacy team members.

4. Observe and prevent tight, confined, or overcrowded areas in the pharmacy. Physical constraints can add to stress and conflict.

Roles, Responsibilities, and Workflows

Unclear roles and responsibilities can contribute to workplace conflict and undermine a positive safety culture[3]. With the introduction of pharmacy technician regulation, clear roles and responsibilities have become increasingly important to a positive safety culture in community pharmacy.

It is important for the entire team to understand the scope of practice for each professional role as established by the Regulation to the Pharmaceutical Act.

You can ask each team member to share their own description of their roles and responsibilities. Working on this in a team setting can clarify day-to-day workflows and improve efficiency by eliminating redundancies.

Create job descriptions based on regulatory requirements and everyday workflows. Make these descriptions part of staff training and make them readily accessible.

Establishing a practice of ongoing discussion of workflow and work management can also help clarify who is responsible for what. Do not assume that your team shares an intuitive or automatic understanding of one another's roles and responsibilities[8].

The Code of Ethics states that pharmacists must maintain a professional relationship with each patient and their primary consideration must be the health and safety of each patient.

COMMUNICATION WITH PATIENTS

Pharmacists must identify the patient's health needs and expectations, collect the information required to provide pharmacist services to the patient and make decisions in the best interest of the patient. The patient's autonomy to make their own informed health care decisions must be respected.

The **Ensuring Patient Safety Practice Direction** outlines pharmacists' obligations to clinical communication with patients. Health literacy, patient empowerment, and conflict management are also key to community pharmacy safety culture.

Health Literacy
The Manitoba Institute for Patient Safety (MIPS) describes health literacy as "the ability to access, understand, evaluate, and communicate information needed to make healthcare decisions[9]". In Manitoba, about 60 per cent of adults have low levels of health literacy. Low levels of health literacy have been associated with poor patient outcomes.

Pharmacy professionals should understand health literacy and the techniques they can use to ensure every patient understands their medication(s) and how to take them.

The College of Pharmacists of Manitoba has a health literacy program available here: **https://www.cphm.ca/site/pd_previous?nav=qa**

Patients should be encouraged to be active partners in their healthcare through improving health literacy. Your team can promote health literacy by displaying or providing ISMP Canada's **5 Questions to Ask About Your Medication** for patients.

You can learn more about encouraging patients and families to engage with their healthcare by visiting the **It's Safe to Ask** website.

4 METHODS FOR CONFLICT MANAGEMENT

1. **Remain calm and commit to keeping your cool**

Resist being drawn into anger; detach from the situation and try to observe as a third-party person or by-stander.

DO NOT take the patient's remarks personally.

2. **Sympathize and acknowledge the anger**

Sympathize with what the patient has told you and make a genuine attempt to understand their point of view.

Address the patient by their first name; use a soft, firm, and slow voice when speaking to the patient.

DO NOT respond to the patient's anger with your anger including shouting and faulting the patient or being overly defensive.

3. **Apologize**

Offer a sincere and straightforward apology for the problem they are having (or perceive they are having).

4. **Look for a solution**

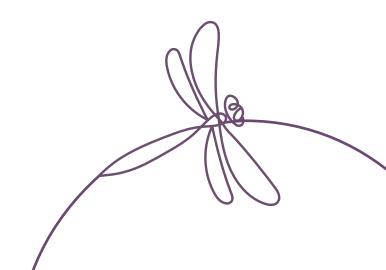Ask the patient what they believe should be done, or offer your own feasible resolution to the problem.

Managing Conflict Between Pharmacy Professionals and Patients
Adapted from *Pharmacist-Patient Communication and Disclosure*[10]

As the most accessible healthcare providers, community pharmacy professionals encounter many different scenarios during a typical shift and this often involves the challenge of navigating unexpected situations. Among these unexpected situations is having to resolve a conflict with an angry or frustrated patient.

Handling a difficult situation that involves an angry or upset patient is a reality that most, if not all, pharmacists will face or have faced at least once in their career. How individuals respond and resolve the issue is just as important as the issue itself, if not more so; the approach taken by the pharmacy professional, and the way in which the situation is dealt with can make the difference between a satisfactory and resolved outcome, or the abrupt end of the patient-provider relationship. An unsatisfied or wronged patient may also decide to launch a formal complaint with the respective regulatory authority.

Some issues may be directly related to a medication incident or clinical practice, while others may be related to a customer service complaint or other form of dissatisfaction. While not all patient-provider relationships will be salvaged at the time of the conflict, there are concrete steps every pharmacy professional can take to try to deescalate the situation and resolve the issue.

Discussing an Issue or Incident with a Patient

If a patient is noticeably upset and is causing a disruption in the pharmacy and the provision of services to other patients, try asking the patient to see if they would accompany you to a more private setting such as the counselling room or an office. Doing so may help to further calm the patient down, as this shows a sincere interest in speaking with the patient and that he or she will receive your full attention.

At the same time, however, be vigilant and judge the situation appropriately; never attempt to defuse an angry patient who could be dangerous (e.g. verbally or physically abusive) by yourself or place yourself in a situation where you would be alone with him/her. Instead, ask a colleague to join the discussion and never place the patient between yourself and the exit.

If you find that the patient is becoming progressively hostile or threatening as the discussion goes on, do not hesitate to contact security or the police when necessary. In anticipation of such potential cases that may arise, it may be helpful for you and your staff to come up with a secret code or phrase that signals to other members of the team to call for help.

THE APOLOGY ACT

Manitoba's Apology Act allows health care providers, including pharmacists, to apologize to patients who have experienced a medication or patient incident that may or not have resulted in harm. The Apology Act empowers pharmacists to express empathy and compassion to their patients without the worry that an apology could be used against them in court.

Pharmacists can provide a sincere apology to a patient without the fear that it will create legal liability or impact their malpractice insurance coverage. A genuine apology to a patient who has experienced a medication or patient incident is an act of human connection that can contribute to healing both patient and practitioner.

Pharmacists should know the following facts about Manitoba's Apology Act:

- Apologizing does not create legal liability.

- Apologizing does not impact malpractice or liability insurance.

- Apologies are not admissible in courts, tribunals, arbitrations, disciplinary hearings, civil litigation, or "any other person who is acting in judicial or quasi-judicial capacity."

Disclosing a Medication Incident

While medication incidents in community pharmacies tend to be rare, they do happen. One of a pharmacy professionals greatest fears is that they could miss catching a medication error that results in patient harm sometime during the course of their career. Disclosing a medication incident to a patient, or their care-giver or loved one, is a difficult, but necessary, act that requires compassion and empathy for everyone involved.

In Manitoba, pharmacists must follow the **Medication Incident and Discrepancies or Near-Miss Events Practice Direction** when a medication incident occurs in their pharmacy. This Practice Direction requires that the pharmacy has written policies and procedures for addressing, reporting, investigating, documenting, disclosing and learning from medication incidents.

Above all, pharmacy professionals must ensure the immediate safety of the patient, including informing the prescriber, but the follow-up can be equally important to both pharmacy staff and the patient or their loved ones.

The proper disclosure of a medication incident can contribute many benefits to patients, loved ones, and the pharmacy professionals involved, including:

- Building a culture of safety through open, honest, and effective communication

- Healing for the patient and/or family and pharmacy professionals involved in the incident

- Learning from mistakes to prevent recurrence through patient and pharmacy professionals' input

Implementing or revisiting your pharmacy's policy and procedure to address medication incidents and near misses to include the principles listed above could mean the difference between healing and learning from a tragic or harmful event, and irrevocably rupturing the relationship between the healthcare provider(s) and their patient and/or their patient's loved ones.

For additional information on disclosing medication incidents to patients, please see **Appendix E.**

3 THINGS PATIENTS NEED AFTER A MEDICATION INCIDENT

1. **Immediate safety**

The Medication Incident and Discrepancy Practice Direction states that upon discovery of a medication incident, the pharmacist must find out if the patient has experienced, or is at risk of experiencing, harm and must ensure the patient has the necessary medical care. Pharmacists must provide any additional follow-up outlined in this Practice Direction, including informing the prescriber.

2. **A sincere apology**

Patients need to know that healthcare provider or organization is sorry for what happened.

3. **The facts about what has and/or will happen**

Patients need to know what steps were or will be taken to minimize harm. Patients need and deserve to know the details of the incident and how they will be cared for.

Patients also need to know what steps will be taken to prevent a similar incident in the future. Patients can be a valuable asset in planning preventative measures and implementing their suggestions can go a long way to prevent future incidents and promote healing from the incident.

CARING FOR HEALTHCARE PROVIDERS AFTER A MEDICATION INCIDENT

Adapted from *The Second Victim: Supporting Healthcare Providers Involved in Medication Incidents*[11]

A medication incident can place a patient at the centre of a health emergency that ripples outward to encompass friends and family, care-givers and healthcare providers. Patients and their loved-ones are the focus of any medication or patient incident, but the effects can also be devastating to the healthcare providers involved in the error. When we discover and address medication or patient incidents we should remember there are two parties impacted by a medication or patient incident— the primary individuals to consider are the patient and their loved ones, and the 'secondary individuals' to consider are the healthcare professionals involved in the error.

The profound effects and impact of errors to the primary victim and their family are of utmost importance, consideration, and priority. Take care of them first, but don't lose sight of the healthcare providers involved.

In the aftermath of an error, the healthcare provider(s) experiences emotional distress about the harm caused to their patient. They feel as though they have failed the patient, and start to second guess their clinical skills, knowledge, and career choice.

It is estimated that almost 50 per cent of all healthcare providers are involved in a medical or medication error at least once in their professional career. Frequently, these individuals feel isolated and personally responsible for the patient outcome, and experience emotions such as anxiety, grief, depression, withdrawal or agitation, and self-doubt. The emotional burden to the healthcare provider can last for a long time, ranging from several days to several weeks; a few go on to suffer long-term consequences similar to post-traumatic stress disorder.

In To err is human: Building a safer health system, Don Berwick argues that **"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**[12]**."**

In keeping with this philosophy, healthcare providers should have the opportunity to participate in post-incident discussion, and be provided with emotional first-aid, counselling, and education to help them recover in the aftermath of the error.

Pharmacy professionals who have been involved in a medication incident, particularly one that has contributed to patient harm, should be encouraged to seek help. They should consider contacting their union or benefits program to seek support.

Klinic Community Health also offers a 24-hour Crisis Line: 204-788-8222 or 1-833-788-8222.

To learn more about what you can do to support healthcare professionals who have been involved in a medical or medication error, please see Appendix F.

PSYCHOLOGICAL SAFETY

Psychological safety is a fundamental part of safety culture. In community pharmacy, psychological safety makes room for people to discuss and learn from medication errors and near misses without fear of punishment or damage to self-image, status, or career[13].

Leaders play a key role in building psychological safety. Asking for, and acting upon, feedback from the team shows that their knowledge and experience matter. Safety Briefs and Huddles are a good place to begin asking what specific people think about what is being discussed. Recognize their contribution and expertise as front line workers and act on suggestions.

4 KEY ELEMENTS OF PSYCHOLOGICAL SAFETY

1. Anyone can ask questions without looking or feeling incompetent.

2. Anyone can ask for feedback or help without looking or feeling incompetent.

3. Anyone can be respectfully critical without appearing negative.

4. Anyone can suggest innovative ideas without being perceived as disruptive.

TRANSPARENCY

A transparent healthcare organization shares information between leaders, staff, clinicians, patients, and other professions and healthcare organizations. Transparency is characterized by openness, communication, and accountability in a variety of contexts:

- **Transparency among pharmacy professionals** means there is no fear in making suggestions or providing feedback and knowledge, information, or data is shared openly.

- **Transparency with patients**, particularly after a medication incident, means apologizing for the incident and explaining what happened and how a similar error will be prevented in the future.

- **Transparency within the pharmacy profession** means sharing learning in regards to medication incidents and near misses[5].

- **Transparency in the work environment** means the information people need to do their work is highly visible and readily available.

Sharing information and talking openly in your pharmacy about medication incidents and near misses generates solutions and demonstrates commitment to patient safety and safety culture.

Consistently reporting medication incidents and near misses contributes to professional transparency as learning is shared across pharmacies.

ACCOUNTABILITY

A safety culture is not blame-free. While a safety culture does not punish people for mistakes that are the result of a flawed system, pharmacy professionals are still held accountable for following protocols, procedures, and practice directions. It's important for your pharmacy to ensure that behavioural and work expectations are clear and that staff have the resources and education to work safely and efficiently.

It is important to have an accountability framework in place that ensures that leadership responds to medication errors in a way that is expected, practiced, and applied uniformly across the entire workforce[4].

Leaders and pharmacy team members should also be familiar with their obligations under provincial and federal legislation (listed on **cphm.ca**), including, but not limited to

- *The Pharmaceutical Act*

- Pharmaceutical Regulation

- The Protecting Children (Information Sharing) Act

- The Protecting Children (Information Sharing) Regulation

- The Apology Act

A Guide to Pharmacy Practice, CPhM's guide to the legislation, standards of practice, practice directions, and code of ethics, provides a framework for daily pharmacy practice and supports a firm understanding of legislative accountability in pharmacy practice.

JUST CULTURE PRINCIPLES

Establishing principles of accountability while maintaining safety culture supports an environment of trust and transparency. In **Leading a Culture of Safety: A Blueprint for Success**, Just Culture Principles outline the types of behaviours that can lead to adverse events and the appropriate responses:

1. **Human Error:**
An unintended slip or lapse.

Human error is inevitable and systems must be designed to help people do the right thing and avoid doing the wrong thing.

Response: Provide support to the person who made the error (see section on 'Second Victims'). Investigate the incident and figure out how the system can be changed to help prevent the error from recurring. Share information from the investigation with the pharmacy team and follow through with needed changes.

2. **At-Risk Behaviour:**
Consciously choosing an action without knowing the risk of an unintended outcome.

Response: Provide education on why the behaviour is risky. Investigate the incident, determine why the person chose this behaviour, and enact system changes if needed.

3. **Reckless Behaviour or Negligence:**
Consciously choosing an action with knowledge of and disregard for risk or harm.

Response: Disciplinary action.

Accountability Algorithm

There are several accountability algorithms in the literature. A Framework for Safe, Reliable, and Effective Care adapted two of the best known algorithms from David Marx and James Reason:

WERE THE ACTIONS OF THE STAFF MEMBER MALICIOUS? DID THEY INTEND TO CAUSE HARM?

YES ⌄

NO ⌄

This points to potential criminal activity and the organization should respond accordingly.

WERE THEIR MENTAL AND PHYSICAL FACULTIES INTACT? WERE THEY THINKING CLEARLY?

Clear thinking can be impacted by health issues, severe social stressors such as divorce or family illness, drugs (legal or illegal), or alcohol abuse.

YES ⌄

NO ⌄

Were their actions reasonable and appropriate?

Would at least three other staff members have done the same thing?

Were they following company policies and procedures?

The organization should engage the employee assistance program or other supports. See also the section on Second Victims on page ---.

YES ⌄

NO ⌄

In some cases, the official procedure can be to blame for unsafe practices. On the other hand, when an entire team deviates from sound procedures, the entire group should be asked to reflect on their behaviour and meet to talk about the incident and develop ways to prevent the incident from recurring.

Were their actions risky, reckless, or unintentional?

Unintentional Actions: Likely the result of a system issue and should be investigated to determine the cause.

Risky Actions: May be a possible issue with judgment, decision-making, or misunderstanding. Education or group discussion could help.

Reckless Actions: When the person willingly and knowingly took unnecessary risks, then they should be held fully accountable for their actions.

Does the individual have a history of unsafe behaviour?

When an individual has a history of unsafe behaviour despite proper training and support, it's possible they are not fit to hold their position. In these situations, managers should reasonably evaluate the individual's performance and reassign or terminate their position.

CONCLUSION

Safety culture is key to understanding and preventing medication incidents. The tools to report and learn from medication incidents and near misses have been provided to Manitoba community pharmacy professionals through CPhM's Safety IQ program. Pharmacy professionals can use Safety IQ as the jumping-off point for building, enhancing, and maintaining safety culture to learn from and help prevent medication incidents. The Community Pharmacy Safety Culture Toolkit provides your pharmacy team with a collection of resources to further support your safety culture journey.

Remember that safety culture is achieved through hundreds or even thousands of small changes over the long-term. Your culture may not shift overnight, but each team discussion, training, educational endeavour, or process change can make a contribution to patient safety. It is most important that you find a system that works for your team through openness, flexibility, curiosity, commitment, and perseverance.

Safety Culture Maturity Models

The 'maturity model' approach to measuring safety culture identifies five stages of cultural maturity[14,15]:

1. **Pathological:** Why do we need to waste our time on risk management and safety issues? No systems are in place to promote a positive safety culture

2. **Reactive:** We take risk seriously and do something when we have an incident. Safety is addressed only when something goes wrong or when changes are enforced by regulators or accrediting bodies.

3. **Calculative:** We have systems in place to manage all likely risks but implementation is inconsistent and largely focuses on specific safety events.

4. **Proactive:** We are always on the alert, thinking about risks that might emerge. We promote a positive safety culture and we use evidence-based interventions across our organization.

5. **Generative:** Risk management is an integral part of everything we do. We evaluate our interventions, engage in continuous learning, and take significant actions to improve.

Safety culture measurement tools based on this maturity model are relatively novel and are not fully validated. Safety culture measurements based on the maturity model can, however, raise awareness about patient safety, encourage discussion about the strengths and weaknesses of patient safety culture in the pharmacy, highlight areas of success or improvement, and help track changes over time. The following measurement tools can be used by your team as a benchmark of patient safety culture to guide changes over time.

Manchester Patient Safety Assessment Framework:

The Manchester Patient Safety Assessment Framework (MaPSAF) was originally developed to measure safety culture maturity in primary care settings in the UK. In 2005, the MaPSAF was adapted by Darren Ashcroft et al for use in community pharmacies[15]. This model is based on eight dimensions of patient safety in community pharmacy:

- Commitment to patient safety

- Perceptions of the causes of incidents and their reporting

- Investigating incidents

- Learning following an incident

- Communication within the pharmacy

- Staff management

- Staff education and training about risk management

- Teamwork

These dimensions are evaluated by individual employees and the overall results are discussed in a team setting.

Patient Safety Culture Improvement Tool:

The Patient Safety Culture Improvement Tool (PSCIT) was developed in 2008 by Mark Fleming and Natasha Wentzell. The PSCIT was developed to help healthcare organizations identify tangible actions and areas for patient safety culture improvement. This model is based five patient safety culture dimensions:

- Leadership

- Risk analysis

- Workload management

- Sharing and learning

- Resource management

Like the MaPSAF, the PSCIT is completed by individual employees and then discussed in a team setting.

Medication Safety Cultural Indicator Matrix

The Medication Safety Culture Indicator Matrix (MedSCIM) was developed by ISMP Canada to assess the quality of narrative data gathered about medication incidents as an indicator of safety culture maturity. Rather than a survey or facilitated discussion, MedSCIM is a method of analyzing medication incident reports to determine the maturity level of patient safety culture in an organization.

Throughout the year, ISMP Canada hosts, *Going beyond the numbers: Using incident reports to assess medication safety culture*, to teach participants how to use MedSCIM.

For more information, please visit: **https://www.ismp-canada.org/education/**

For a local example of MedSCIM, please see the ISMP Canada analysis of the Safety IQ Pilot data:

https://cphm.ca/uploaded/web/Safety%20IQ/MedSCIM%20Assessment%20for%20Safety%20IQ%2020Aug2018%20-%20Final.pdf

Community Pharmacy Survey Patient Safety Culture

The Community Pharmacy Survey on Patient Safety Culture was developed by the Agency for Healthcare Research and Quality in the US. This survey covers 11 dimensions of safety culture in community pharmacy:

- Communication about prescriptions across shifts

- Communication about mistakes

- Openness of communication

- Organizational learning/continuous improvement

- Patient counselling

- Physical space and environment

- Response to mistakes

- Staff training and skills

- Staffing, work pressure, and pace

- Teamwork

The survey can be paper-based, web-based, or a mix of both methods.

The survey and supporting documents are available here: **https://www.ahrq.gov/sops/surveys/pharmacy/index.html**

Safety Attitudes Questionnaire

The Safety Attitudes Questionnaire (SAQ) originate in the aviation industry to measure cockpit culture and has since been widely used to measure safety culture in a number of professions, including healthcare.
The SAQ is

- rigorously validated;

- associated with positive patient and staff outcomes;

- relatively short and quick to complete; and

- suitable to measure changes over time.

In Sweden, the SAQ was changed for use in community pharmacies and shown to be an effective tool to measure safety culture[16]. It includes a 40 item questionnaire that addresses six domains of safety culture:

1. Teamwork

2. Safety Culture

3. Job Satisfaction

4. Stress Recognition

5. Perceptions of Management

6. Working Conditions

In 2018, the SAQ was also used to measure safety culture in Manitoba community pharmacies. You can review the Manitoba SAQ outcomes, including the full questionnaire and methods used, on the College website:

http://www.cphm.ca/uploaded/web/ Professional%20Development/2018/ Culture-Shift-101/Safety-Culture-MB-Web. pdf

Observation

Observation can be an effective way to assess safety culture if used with care. It is important that the observer is chosen wisely and that the pharmacy team understands the purpose of the observation exercise. Team leaders or observers should be clear that the purpose of observing is to learn about team culture rather than being an assessment of individual performance .

Observers should have a framework for assessing what they see such as the Communication and Teamwork Skills (CATS) Assessment or the Clinical Teamwork Scale (CTS) .

Be mindful that people may change their behaviour when they are observed due to the Hawthorne effect and that observation is an assessment tool that works best when a culture of trust is already established[3].

APPENDIX B - LEADERSHIP

The following list is not exhaustive, but provides a starting point for leadership and team education.

Culture Shift 101: Safety and Just Culture in Community Pharmacy

This College of Pharmacists of Manitoba professional development presentation demonstrates some of the fundamentals of safety culture including:

- The characteristics of just-and-safe vs. blame-and-shame culture.

- An outline of the current culture in Manitoba community pharmacies.

- Strategies to improve community pharmacy safety culture.

- Resources to support a just-and-safe approach to medication errors.

This presentation is available on the College website:

https://www.cphm.ca/site/pd_previous?nav=qa

TeamSTEPPS Canada™ (CPSI)
This course will help you to improve team collaboration, clinical outcomes and patient safety at your organization. TeamSTEPPS Canada™ is an evidence-based teamwork system that optimizes patient care by improving communication and teamwork skills among healthcare professionals, including front-line staff.

Details can be found on the Canadian Patient Safety Institute website:

https://www.patientsafetyinstitute.ca/en/education/teamstepps/pages/default.aspx

ISMP Canada's Medication Safety Learning Centre
ISMP Canada provides high quality, interactive educational programs for healthcare practitioners offered through eLearning and hands-on workshops. ISMP Canada's education courses are facilitated by content experts with educational backgrounds and experience in pharmacy, nursing, and physicians in all healthcare settings.

For more information, please visit
https://www.ismp-canada.org/education/

Canadian Failure Mode and Effects Analysis Framework - Proactively Assessing Risk in Healthcare©

ISMP Canada has developed the Canadian Failure Mode and Effects Analysis Framework (FMEA) — Proactively Assessing Risk in Healthcare©, with assistance from healthcare and human factors engineering consultants. It can be applied to all healthcare processes, such as, medication use, patient identification, specimen labelling, emergency room triage, identification of risk of patients

falls, to list a few examples. It can be used in acute care, long-term care, and community settings.

Details on FMEA, please visit
https://www.ismp-canada.org/fmea.htm

The Improvement Frameworks Getting Started Kit
The Improvement Frameworks Getting Started Kit is intended to serve as a common document appended to the Safer Healthcare Now! Getting Started Kits. The goal is to help provide a consistent way for teams and individuals to approach the challenge of making changes that result in improvements.

For more information, please visit
https://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Pages/default.aspx

A Just Culture Guide
This guide was created by England's National Health Service to encourage the fair treatment of staff and support managers in decision-making following a patient safety incident. The guide is available here:

https://improvement.nhs.uk/resources/just-culture-guide/

The Manitoba Institute for Patient Safety Resources for Healthcare Providers

Information and resources for healthcare providers and healthcare organizations that facilitate working with the public to promote patient safety and the best possible patient outcomes, including topics such as

- Medication Safety

- Communication

- Patient Engagement

- Critical Incidents and Disclosure

For details, please visit
https://www.mips.ca/healthcare-providers.html

The Canadian Patient Safety Institute SHIFT to Safety Program

SHIFT to Safety is a major shift to empower you with the tools and information you need to keep patients safe, whether you are a member of the public, a practitioner, or a leader.

The SHIFT to Safety program is available here:
https://www.patientsafetyinstitute.ca/en/About/Programs/shift-to-safety/Pages/default.aspx

How to Prevent Medication Incidents

TechTalk presents a professional development program for pharmacy technicians to understand the role of pharmacy technicians in identifying and preventing medication incidents;

This program is available here:
https://tevapharmacysolutions.com/sites/default/files/TT%20CE%202018%20October_FINAL.pdf

APPENDIX C – TEAMWORK AND COMMUNICATION

The following communication techniques and opportunities for learning can help you build effective team communication to promote patient safety and safety culture. This is not an exhaustive resource list and there are many communication training programs available if you want or need more support. The most important thing is to find a training program or method of communicating that works for your team.

Safety Briefs and Huddles

Safety Briefs and Huddles are a simple and easy-to-use tool that your pharmacy team can use to share information about safety issues or concerns on a day-to-day basis, for example, at the beginning of the workday, at shift changes, or at the end of the workday.

Safety Briefings and Huddles are a good way to

- raise awareness of patient safety issues;

- encourage a workplace where staff can share information without fear of reprisal or embarrassment; and

- integrate discussion of medication incidents and near misses into everyday practice[18];

- discuss barriers and figure out how to overcome them (e.g. drug shortage); and

- address any new or changing situations as they arise.

It is critical that Safety Briefings or Huddles are non-punitive, brief, and easy-to-use by:

1. Ensuring that you develop a structure for the conversation[3]:

- Will you use a checklist or a set of key questions?

- Will you use recently reported medication incidents or near-misses as a focal point for discussion?

- Who will lead the conversation?

- How long will it be?

- How will you make it meaningful and relevant for everyone who attends?

- Will you follow-up on action items from previous Safety Briefings or Huddles as needed?

2. Creating an atmosphere where everyone can speak up. Safety Briefings or Huddles are a good time to ask for feedback from pharmacy team members and to show that their input is important by sharing updates or actions taken as a result of a previous Briefing or Huddles.

3. Acknowledging the contributions of your team to patient safety. Safety Briefings or Huddles are a good opportunity to recognize any of the ways your team has improved patient safety or culture in the pharmacy. Did a member of your team catch a medication error before it reached a patient? Was an error handled well by the pharmacy team? Acknowledge 'good catches' and responses to medication errors before discussing possible ways to improve the system.

SBAR (Situation-Background-Assessment-Recommendation)

SBAR (Situation-Background-Assessment-Recommendation) is a framework that supports concise communication of critical information. The SBAR technique is easy-to-use and can enable your team to communicate a complete message[19, 20].

S = Situation (a concise statement of the problem)

B = Background (brief statement of information about the situation)

A = Assessment (analysis of the viable option – what you found/think)

R = Recommendation (action recommended – what you want to see happen)

The Joint Commission provides the following example[19]:

Situation: 'Mr. Jones has multiple prescriptions of Coumadin in his home and he is unclear as to which ones he is supposed to take.'

Background: Provide clear, relevant background information that relates to the situation. In the example above, you should consider including the patient's diagnosis, the prescribing physicians, and the dates and dosages of the medications.

Assessment: A statement of your professional conclusion.

Recommendation: What do you need from this individual? For example, 'Please clarify which is the correct dose of Coumadin for Mr. Jones to take and which physician will be responsible for managing his anticoagulant therapy?'

Closed-Loop Communication[3]

When we communicate with others, we often assume we have been heard and understood. In reality, we can't be sure unless they confirm what we have said. With closed loop communication, you ensure that your message was received as you intended.

During closed-loop communication, the person receiving the message repeats the details back to the messenger and 'closes the loop' on the exchange. The exchange is repeated if the messenger does not hear the necessary details back from the receiver.

Tips for using closed loop communication include:

- Establish when closed loop communication should be used.

- Test the technique in a small group with role play or simulation.

- Start small. Start using closed-loop communication when preparing or dispensing a particular medication and then expand its use as needed.

- Extend the closed-loop technique throughout the pharmacy.

- Have leaders or influential team members use the closed-loop technique to maintain the practice.

Active Listening
Active listening is the conscious effort to listen to another person completely while providing visual cues (eye contact, nodding) and verbal signals that express your interest and focus on what the other person is saying. Repeating back or summarizing what the other person has said is a way to confirm understanding[6].

Active listening is important because we can miss critical meaning or information in a conversation if we lack focus. Active listening also signals your respect and engagement with the other person. Active listening is a useful tool for team interactions, communication with physicians, and during patient counselling.

Key tips for active listening[17]:

- Give the person your undivided attention

- Listen for the feelings/emotions behind what the person is saying

- Be sincere in your interest

- Restate or summarize what the other person said

- Save your opinion or recommendation until the person is finished speaking and you have a firm understanding of what has been said

APPENDIX D - CONFLICT RESOLUTION

There are many conflict resolution resources and training available. Whatever you choose, it is most important that you and consistently apply conflict resolution techniques that work for your team. The following is a non-exhaustive list of local and national resources on conflict resolution/management.

Mediation Services Winnipeg
Mediation Services offers tangible tools and knowledge on how to deal with conflict and disrespect. Trainings include mediation, leadership, and conflict management.

A full details on training and resources are available here:
https://www.mediationserviceswpg.ca

ACHIEVE Centre for Leadership & Workplace Performance
ACHIEVE provides professional development training in the areas of leadership and workplace performance to over 15,000 people each year. ACHIEVE's training and resources include topics such as leadership, conflict and communication.

For more information, please visit
https://ca.achievecentre.com

Managing Conflict:
A Guide for the Pharmacy Manager
This article explores the management of people and groups as part of a high performance pharmacy department.

The article is available here:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4568116/

Canadian Interprofessional Health Collaborative National Interprofessional Competency Framework
This National Interprofessional Competency Framework provides an integrative approach to describing the competencies required for effective interprofessional collaboration. Six competency domains highlight the knowledge, skills, attitudes and values that shape the judgments essential for interprofessional collaborative practice.

The framework is available here:
https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

Improve Pharmacy Workflow in Six Simple Steps
This article demonstrates six simple things you can do to improve pharmacy workflow to optimize service and avoid conflict.

The article is available here:
https://www.pbahealth.com/improve-pharmacy-workflow/

Integrating Pharmacy Technicians into Pharmacy Workflow
The Ontario College of Pharmacists presents a short animation on how to integrate pharmacy technicians into an optimized and friction-reducing community pharmacy workflow.

The video is available here:
https://www.youtube.com/watch?v=gBl-a5MV8ZE

APPENDIX E –
DISCLOSURE OF MEDICATION INCIDENTS

The following resources and information can help you to ensure the best possible outcomes following a medication incident and compliance with the required Practice Direction.

Canadian Disclosure Guidelines
The purpose of these guidelines is to support and guide healthcare providers in these communications, and to encourage organizations to develop policies and processes to effectively support the communications between patients and providers in these difficult circumstances. The guidelines emphasize the importance of a clear and consistent approach to disclosure, regardless of the reason for the harm.

The guidelines are available here:
https://www.patientsafetyinstitute.ca/en/toolsResources/disclosure/Documents/CPSI%20Canadian%20Disclosure%20Guidelines.pdf

The Importance and Impact of an Apology Information Sheet
This information sheet from the Manitoba Institute for Patient Safety and the Manitoba Alliance of Health regulatory colleges outlines Manitoba's Apology Act and the significance of a heartfelt apology for healthcare practitioners and patients involved in patient incidents.

The information sheet is available here:
https://mips.ca/assets/info_sheet_on_mb_apology_act.pdf

How to Handle a Medication Error

This continuing education module from TechTalk provided learning on professional responsibilities of managing medication incidents under provincial regulations and within the expanded scope of practice.

For more information, please visit **https://tevapharmacysolutions.com/sites/default/files/May%202013%20Tech%20Talk%20CE%20ENG.pdf**

APPENDIX F – SUPPORTING HEALTHCARE PROVIDERS

Learn more about how your organization can support second victims following a medication error with the following resources.

The Second Victim: Supporting the Health Care Providers involved in Medication Errors

This ISMP Canada presentation includes information on identifying second victims, stages of recovery, barriers to support, and the structures that can promote healing.

The presentation is available here: **https://www.youtube.com/watch?v=bz1MKJ0Z0dQ&feature=youtu.be**

The Second Victim: Sharing the Journey Toward Healing

This ISMP Canada article presents firsthand account of a pharmacist who was involved in the death of his patient and how he coped in the aftermath of this fatal medication error. Consider making this resource available in your pharmacy or use it to facilitate discussion about second victims and how the entire pharmacy can and should support someone following a medication incident.

The article is available here: **https://www.ismp-canada.org/download/safetyBulletins/2017/ISMPCSB2017-10-SecondVictim.pdf**

The Healthcare Provider's Experience of Patient Safety Incidents

This Canadian Patient Safety Institute learning module explores the healthcare failures to address the spiritual, emotional, cognitive and behavioural difficulties health providers experience following an unintended patient harm incident. Learners will also explore the strategies organizations can use to support healthcare professionals during and after patient incidents.

The module is available here: **https://www.patientsafetyinstitute.ca/en/education/PatientSafetyEducationProgram/PatientSafetyEducationCurriculum/Pages/module-19-second-victim.aspx**

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