Safety.
Improvement.
Quality.

eQuipped

Safety IQ eNewsletter

eQuipped is the official e-newsletter for the College of Pharmacists 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:

IQ Insights: A discussion with Safety IQ Pilot Champions

Since September 2017, 20 community pharmacies in Manitoba have participated in the Safety IQ program. These pharmacies were part of the Safety IQ pilot, and many of them are now champions as Safety IQ will be rolling out to all community pharmacies in Manitoba in the near future.

The College had an opportunity to reflect on the experience with a few of the champions and discuss the breakthroughs and challenges they experienced as a pharmacy when it comes to the Safety IQ program.

The theme of this newsletter is CQI meetings and the change of culture in pilot pharmacies. The College had an opportunity to speak to the following pharmacy staff:

Jaimin Patel – Pharmacy Manager, Ashern Pharmacy

Melony Just – Pharmacy Technician, Ashern Pharmacy

Alison Desjardins – Pharmacy Manager, Birtle Pharmacy

Kristin Lane – Pharmacist, Birtle Pharmacy

Dustin Hunt – Pharmacy Manager, Mountain Park Pharmacy

Glen Rawluk – Pharmacy Manager, Meyers Drugs

How have the formal CQI meetings and the informal huddles evolved during your time with Safety IQ?

Our interviewees all had similar experiences when it came to these CQI discussions with their staff. Pharmacies are busy. Finding a time where you can sit down with all of your staff can be difficult. While the formal CQI meetings can offer the best chance for review of medication incidents in the pharmacy, informal discussions are often convenient and effective.

"Usually they were just smaller 5-10 minute huddles at the end of the day because we can't really block off a chunk of time during the day to do them. We would print off the statistics and see how many reports we did for the quarter and compare it to the previous quarter to see if we reported more/less and see what type of incidents there were."

One pharmacy manager noted the importance of discussing and analyzing errors caused by the process or the system before human mistakes like typos or incorrect directions.

"You just want everyone to learn. You want to bring up mistakes as they happen".

One pharmacy noted as a result of discussions, there is more awareness to check DIN's and the pharmacy uses warning labels on the drug shelf for look-a-like packaging. They also now pre-count medications for blister packages.

For one of the rural pharmacies, having a small staff leads to more informal meetings instead of formal staff meetings.

"There are no morning shifts or evening shifts, we are able to have these discussions as they happen."

They also discuss the near-misses that happen and have developed their threshold to determine whether to report them or not.

"When it comes to near-misses, we think "would it benefit someone else?" We think about other pharmacy professionals and whether they would find our experience useful.

How has the shift in culture benefited your pharmacy?

One pharmacy noted how the program has really improved their work environment. If an error happens, the pharmacy professional and the manager review the error and move forward to minimize the risk of the error. It requires a mindset change for all staff to view errors as opportunities to learn and improve and not be offended or ashamed when an incident is discussed.

The pharmacy professionals also noted that a poor work environment can influence errors. In instances where staff members feel especially busy or overworked, it is important that communication remains strong among the pharmacy team to provide support and help prevent medication incidents from occurring.

One pharmacy professional admitted they were skeptical of the program at the beginning but really saw the benefit after a few months.

"I think it can definitely improve attitudes towards incident reporting and not being as worried about it and then just improving and learning from them. That's the important thing. "

Safety Measures

Data matters! Here are the final medication incident and near miss statistics reported by the Safety IQ Pilot pharmacies to the Community Pharmacy Incident Reporting (CPhIR) program. The pilot program ran/operated from September 2017 to December 2019. Once the Safety IQ program is implemented in all community pharmacies in Manitoba, then medication incident and near miss statistics will again be included in the eQuipped newsletter.

931 INCIDENTS REPORTED

- 641 NEAR MISS/MEDICATION DISCREPANCY (MEDICATION NOT DISPENSED)
- 264 NO HARM (MEDICATION DISPENSED - NO SYMPTOMS AND NO TREATMENT NEEDED)
- 21 MILD HARM (MEDICATION DISPENSED - NO TREATMENT OR MINOR TREATMENT NEEDED)
- 5 MODERATE HARM (MEDICATION DISPENSED - ADDITIONAL TREATMENT OR OPERATION NEEDED; CAUSED PERMANENT HARM OR LOSS OF FUNCTION)

MOST FREQUENT INCIDENTS BY TYPE

INCORRECT DRUG	227
INCORRECT DOSE / FREQUENCY	219
INCORRECT STRENGTH / DOSE	115
INCORRECT PATIENT	81
INCORRECT QUANITY	79

Safety IQ Data Analysis - Narrated PowerPoint Presentations

During the pilot, ISMP conducted two different analyses on incident data from the Safety IQ pilot.

- Multi-incident Analysis of Medication Incidents that reached the Patient Manitoba Safety IQ Pilot Study
- MedSCIM Assessment on Incidents Involving Patients in Manitoba: Safety IQ Pilot

ISMP has posted two narrated PowerPoint presentations of these studies. These resources are usually available to only CPhIR subscribers, but ISMP has graciously offered our members to access these resources.

To view these valuable presentations, please log into the CPhIR training site:

http://www.cphir.ca/training

Username: testuser

Password: testuser

Once logged in, go to **CE & Resources > Module #46 and Module #47**, and you will be able to access them.

Module #46 - Multi-incident Analysis of Medication Incidents that reached the Patient Manitoba Safety IQ Pilot Study

Module #47 - MedSCIM Assessment on Incidents Involving Patients in Manitoba: Safety IQ Pilot

Preparing for Safety IQ

As the Safety IQ Advisory Committee and College staff continue to work on updates to the implementation plans for the full provincial roll-out of Safety IQ, pharmacy managers and staff can review the following resources for their own preparation. In the first quarter of 2020, information on the provincial implementation will be published.

Community Pharmacy Safety Toolkit

Throughout 2019, the College developed the Community Pharmacy Safety Toolkit. It launched in collaboration with the Safety IQ Professional Development (PD) event and Fall College newsletter release. The toolkit outlines key concepts of safety culture and provides resources to support pharmacy professionals in making necessary ongoing changes to improve communication of medication incidents and safety in their community pharmacy.

A Safer Future: Preparing your Pharmacy for Safety IQ

This Professional Development (PD) program provides information to help plan for the implementation of Safety IQ at community pharmacies in Manitoba. The PD program can be accessed on the Previously Recorded Program page on the College website. It is accredited for 2 CEU and information on how to claim CEU credits is also found on this page.

SMART Medication Safety Agenda

The SMART Medication Safety Agendas features anonymously reported medication incidents from across Canada through the Community Pharmacy Incident Reporting (CPhiR) program. Potential contributing factors and recommendations are provided in each issue for pharmacy teams to discuss and to encourage collaboration toward continuous quality improvement.

By putting together an action plan and monitoring its progress, the SMART Medication Safety Agenda can help raise awareness regarding similar incidents at the pharmacy. The most current Agendas are about Potentially Inappropriate Medication Use in Older Adults and Prescribing . Your pharmacy team can use the SMART Medication Safety Agenda as an outline to guide CQI discussions and initiatives on any incident or near miss that happened in your pharmacy.

Community Pharmacy Incident Reporting (CPhiR)
November 2019

SMART Medication Safety Agenda

Prescribing

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

Contacts

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