General Housekeeping

2

- Session will be approximately 60 minutes:
  - 45 minutes from all of our speakers, 15 minutes for audience Q&A
- Accredited for 1.00 CEUs under CCCEP file #: 8002-2019-2913-B-T; a Statement of Completion will be emailed after the webinar
- All material will be publicly posted on the CPhA website after the webinar, links will be emailed to you
- Use questions box for technical support at anytime and for Q&A at end

Presenter Disclosures

3

Presenter: Shelita Dattani
- I have no current or past personal relationships with commercial entities relevant to this presentation
- I have not received an honorarium for this learning activity
- CPhA has a commercial relationship with Pharmapod

Presenter: Lisa Woodill
- I have no current or past personal relationships with commercial entities relevant to this presentation
- Director of Pharmacy Practice for the Pharmacy Association of Nova Scotia (PANS)
- I have not received an honorarium for this learning activity

Presenter: Anastasia Shiamptanis
- I have no current or past personal relationships with commercial entities relevant to this presentation
- Policy Advisory for the Ontario College of Pharmacists (OCP)
- I have not received an honorarium for this learning activity

Learning Objectives

4

By the end of this presentation the learner will be able to

- Describe the importance of medication incident reporting and continuous quality improvement to the creation of a culture of safety in community pharmacy
- Develop strategies to begin conversations with the pharmacy team using medication safety language and strategies
- Identify opportunities for shared learning and ongoing system improvements to minimize medication incidents and maximize health outcomes for Canadians

The Voice of a Mother

5

"I realized that these errors are not random. They are common everyday occurrences and they are harming Canadians of all ages. These errors are avoidable and preventable and we must work harder to have regulations and policies in place to reduce their number, frequency and severity."

Melissa Sheldrick, CPhA Medication Error Reporting Panel, 2018

The Melissa Sheldrick Effect ?
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6410425

Why a Medication Safety Program?

6

7000 Americans die from medication errors each year.[1]

An estimated 51.5 million errors occur during the filling of 3 billion prescriptions in North America each year.[2]

Medication error was significantly related to overtime and shift length for nurses in Canada.[3]

Adapted with permission from the Ontario College of Pharmacists

[1]Nat Acad Press 2000
[2]J Am Pharm A 2003; 43(2)
[3]Statistics Canada 2015

7

The Patient Safety Movement In Canada

- Over the past few years, the patient safety movement has gained momentum in Canada
- Institute of Medicine's Report – To err Is Human drew worldwide attention to problem of errors in health care
- Canadian Adverse Event Study – 2004
- Canadian Patient Safety Institute/Safer Healthcare Now! – early 2000s
- Institute for Safe Medication Practices (ISMP) Canada – early 2000s
- CIHI and other provincial quality agencies
- Initially in acute care
  - Accreditation Canada – medication management standards – now in long term care facilities and community based organizations
  - Community pharmacies can work with these organizations as well

8

Current State of Safety Culture In Canada

- Much of the activity has been limited to acute care settings and is now moving across touchpoints in care
- Accreditation Canada – requirements for patient and medication management system safety – standards
- Community pharmacies dispense more than 600 million prescriptions each year
- Little known about medication incidents with this process

CMAJ open 2018; 6(4) e651-656

9

CQI Approach – Systems Approach vs. Blame Culture

The Nova Scotia Experience

Nova Scotia

- Pilot project started with 13 pharmacies in 2008
- Input from these pharmacies was used to create the Community Pharmacy Incident Reporting Database (CPhIR)
- NSCP developed standards of practice for community pharmacies
- Mandatory Reporting in 2010

CMAJ open 2018; 6(4) e651-656

CQI Themes From SafetyNet Rx

Perceived outcomes of implementing CQI:

- reduction in the number of medication errors that were occurring in the pharmacy
- increased awareness/confidence of individual actions related to dispensing
- increased understanding of the dispensing and related processes/workflow
- increased openness to talking about medication errors among pharmacy staff
- quality and safety becoming more entrenched in the workflow

CQI Themes From SafetyNet Rx

13

- Input from these pharmacies was used to create a national Community Pharmacy Incident Reporting system (CPhIR)
- NSCP adopted new standards of practice for quality improvement processes
  - Number of mandatory patient safety practice for community pharmacy
- Numerous studies demonstrated value of these practices in changing structure and process of patient care and improved perceptions of safety by pharmacy professionals

Quality-Related Events Reported By Community Pharmacists in Nova Scotia Over a 7 year period – a descriptive analysis

14

- Evaluated first seven years of mandatory anonymous reporting by 301 NS pharmacies
- Documented 131,031 quality related events reported by these pharmacies
  - 98,097 were medication related
- Mean number of QREs for each pharmacy during study period = 326
  - NS pharmacies are committed to CQI are recognize the value in reporting and learning from all errors to improve safety
  - 82% of reported errors were near misses
    - Identified, corrected and never reached the patient

CMAJ Open 2018; 6(4) e651-656

Canada › Toronto

GO PUBLIC | Parents find son's lifeless body after pharmacy switches sleep medication for toxic dose of another drug

Boy's mother wants legislation that would force pharmacies to make prescription errors public

By Rosa Marchitelli, CBC News Posted: Oct 20, 2016 5:00 AM ET | Last Updated: Oct 21, 2016 9:20 AM ET

News / Canada

Mother of boy who died from wrong medication calls for better reporting of pharmacy errors

NEWS ONTARIO

MANDEL

Pharmacy's error killed boy, lawsuit claims

Ontario doesn't track mistakes

17

My Campaign for Change in Ontario

The petition created awareness and galvanized the medication safety movement in many ways.

The Ontario College of Pharmacists formally announced that the CQI program would be phased into all Ontario pharmacies by December 2018.

Source: https://www.facebook.com/AndrewsAllies/

18

AIMS Assurance and Improvement in Medication Safety

A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

There is a Patient Behind Every Prescription

-Melissa Sheldrick
Mother, Patient Advocate, Educator

18

19

Our Medication Safety Journey

- ✓ Commitment to consider improving medication safety
- ✓ Task Force recommendations = standardized program including mandatory anonymous incident recording embedded within a safety QI culture

Recording, understanding and learning from medication incidents involving pharmacy to reduce the risk of recurrence and create a safer pharmacy system

- ✓ Program approval and development
- ✓ Ambassador phase, followed by formal launch and implementation

Ontario College of Pharmacists

19

20

AIMS Program

- Supports CQI and puts in place a mandatory consistent standard for medication safety for pharmacy professionals
- Goal: To reduce risk of patient harm caused by medication incidents
- Emphasizes learning and accountability through a safety culture and a just culture
- Four components: Report – Document – Analyze – Share Learning
- supplemental Standard of Practice (sSOP) builds upon NAPRA Standards of Practice and provides more clarity on specific expectations.

Ontario College of Pharmacists

20

21

The four pillars of AIMS

REPORT
Anonymous, specified, independent third party

DOCUMENT
Including plans and outcomes

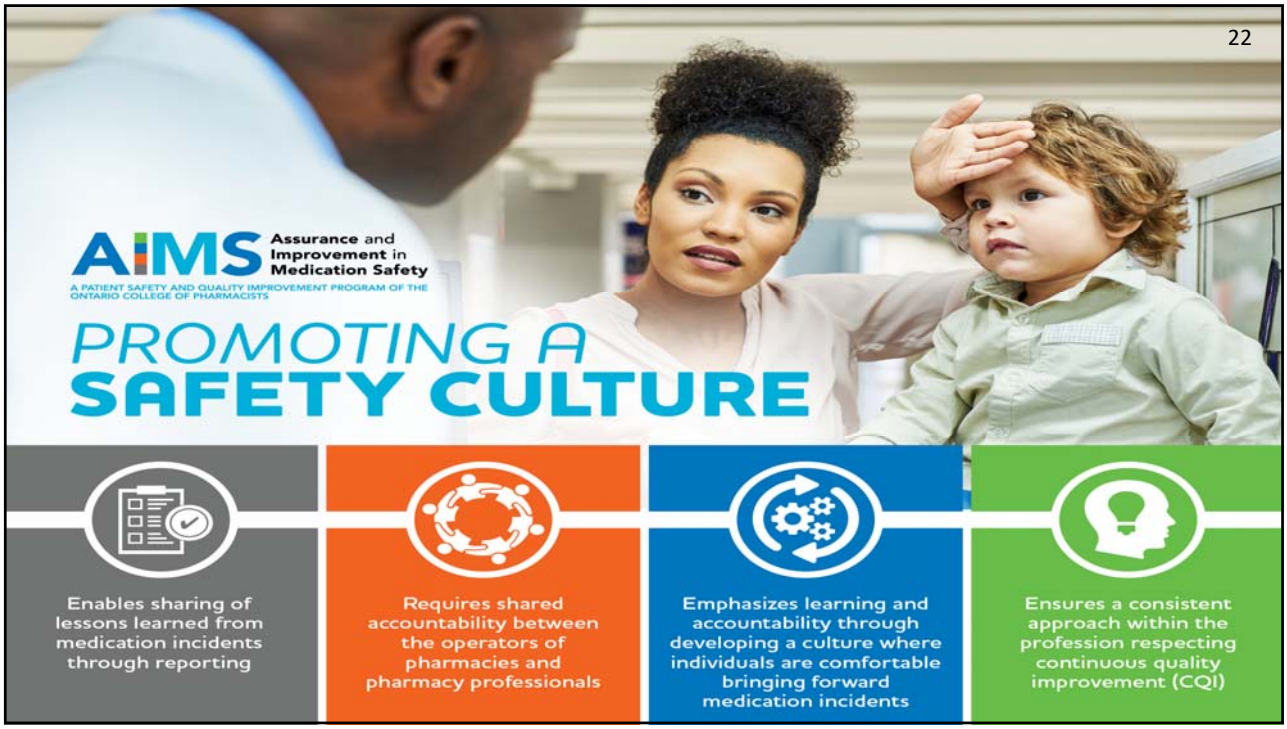
ANALYZE
For causal factors in order to take appropriate steps to minimize recurrence

SHARE LEARNING
Open dialogue

Ontario College of Pharmacists

21

22



23

The Safety/Just Culture Approach

- Recognition that healthcare is high risk and all employees must be actively engaged in the creation of safety
- Organizations are accountable for systems and how they respond to staff behaviours
- Staff are accountable for quality of choices and for reporting both errors and system vulnerabilities
- Learning and accountability are emphasized over blame and punishment
- There is zero tolerance for reckless behaviour

Ontario College of Pharmacists

24

Continuous Quality Improvement (CQI)

- An essential constituent of Patient/Medication Safety
- Regular systematic review, monitoring and improving workflow processes in medication management system
- Eliminate sources of inefficiencies, suboptimal quality of care and services and enhance overall system performance
- Lessons learned from incidents and near misses

Ontario College of Pharmacists

25

Shared Accountability

OWNERS, DMs, STAFF

- ✓ Record incidents & near misses
- ✓ Take prompt measures, document, analyze & implement improvements
- ✓ Use the tools and resources to help meet expectations
- ✓ **Nurturing a Safety Culture:** Operational Standards/ supplemental Standard of Practice

COLLEGE & PARTNERS

- ✓ Support education and continued competency
- ✓ onboarding and utilization
- ✓ Analyze de-identified, aggregate data
- ✓ Develop recommendations and guidance aimed at reducing risk
- ✓ Share broadly within the system and publicly to share learnings and promote accountability, transparency

Ontario College of Pharmacists

26

How Will The Information Be Used?

Purposed for QI	• To inform **Quality Improvement** in pharmacies and across the sector to improve patient care and reduce the risk of preventable harm
Broad learning	• An independent team of pharmacy professionals and experts will analyze de-identified, anonymous data to identify opportunity for system improvements
De-identified, aggrgreate level	• Pharmacy/pharmacist-specific data will **not** be available to the College

OCP will not have the ability to view data at the level of a specific pharmacy, pharmacy professional, or medication incident.

Ontario College of Pharmacists

Poll

27

What is the purpose of a medication incident reporting system?

A. To identify pharmacies that are more prone to medication incidents.

B. To better understand, evaluate and learn from the factors that contribute to medication incidents

C. To reduce the risk of patient harms caused by medication incidents.

D. B and C

Response Team bulletin – analysis of provincial data

28

- An independent team of medication safety experts
- First analysis shared Sept 2019 – available on College website

Ontario College of Pharmacists

Starting A National Conversation Around Medication Safety

30

- June 2018 – Pan Canadian conversation about medication safety
- Pharmacy practice research experts, regulators and patient advocates

Starting A National Conversation – Messages From Researchers

31

- Errors are the third leading cause of death
- Use feedback of the early adopters and air out those facilitators and barriers early
- Resolving problems should not be in isolation
- The handoffs are important to create the culture of collaboration
- "Take a team moment"

Starting A National Conversation – Messages From Regulators

32

- There is a culture but what does it look like – how do we develop structure and standards around it
- Think about meaningful engagement
- Make intentional impact
- Eliminate barriers to implementation
- Paradigm shift away from "reporting" – normalize this
- Solution to a long standing wicked problem
- Shared accountability – system recognition

National Conversation – Messages From The Front Line

33

- Think about what our priorities are and then work that into the workflow
- Create the conditions to make the system work
- One task for one person
  - Everyone needs to buy in
- Terminology is so important – error vs. QRE
  - Not just medications but services
- Anonymity is important

National Conversation – Messages From The Front Line

34

- It begins with you – be open yourself and show others that its OK
- Create a system of support and kindness
- All pharmacy team members are an important part of the team and can provide a different lens on solutions
- Duplication in reporting
- Separate from performance management
- Technology can be an enabler if used in right context

Poll

Why are pharmacy professionals reluctant to report medication incidents?

A. Fear of discipline by regulatory college

B. Fear of being reprimanded by employer for performance issues

C. Fear of patient complaints

D. All of the above

Learning A New Language and A New Culture

Safety Terminology – New Language?

37

Independent Double Check	Medication Incident
Second practitioner conducts a verification. Can be in presence or absence of the first practitioner. Maximize the independence of the double check by ensuring that the first practitioner does not communicate what he or she expects the second practitioner to see,	Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer.

Adapted from: Definition of Terms; *ISMP Canada*

Safety Terminology – New Language?

38

Near Miss	Root Cause Analysis
An event where an incident may have occurred, but was caught before the prescription reached the patient or caregiver . These near misses provide valuable insight into areas of risk, and may indicate where systems can be improved to prevent harm.	An analytic tool that can be used to perform a comprehensive, system-based review of critical incidents. It includes the identification of the root and contributory factors, determination of risk reduction strategies, and development of action plans along with measurement strategies to evaluate the effectiveness of the plans.

Adapted from: Definition of Terms; *ISMP Canada*

Safety Terminology – New Language?

39

Contributing Factors	Continuous Quality Improvement
A circumstance, action or influence which is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.	Continuous quality improvement (CQI) involves an ongoing and systematic examination of an organization's work processes and employment of scientific methods to identify and address the root causes of quality issues and implement changes

Adapted from: Definition of Terms; *ISMP Canada*

Some other key terms

40

- Adverse Drug Reaction
- High Alert Medications
- Just Culture
- Dangerous Abbreviations, symbols, dosages

Adapted from:
Definition of Terms; *ISMP Canada,*
Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions. Ottawa, ON: Canadian Medical Protective Association; 2009

41

Poll

Root cause analysis is:

A. An analytical tool that can be used to find the root cause of a critical incident.

B. An analytical tool that can be used to help identify root causes and contributing factors

C. An analytical tool used to identify the person responsible for a medication incident

D. A and B

42

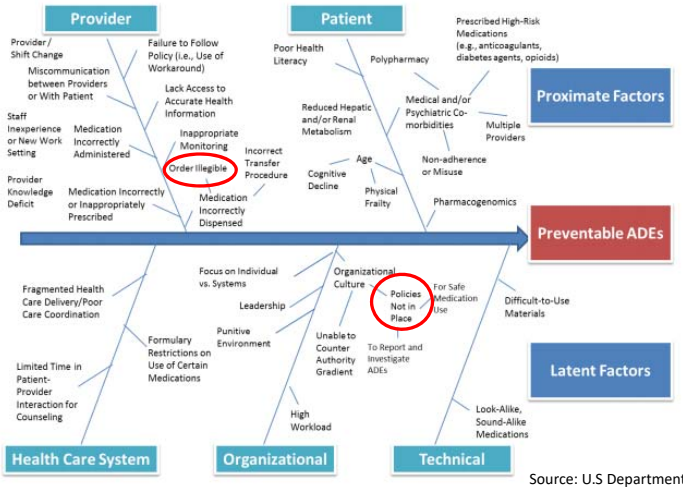
The Process is Complex - Stages Of The Medication Management Process In Community Pharmacy

FIGURE 2: MEDICATION WORKFLOW PROCESS

Pharm Connect 2016; 23(2): 34-38

Contributing Factors to Incidents

43



Source: U.S Department of Health and Human Services 2014: 45
https://health.gov/hcq/pdfs/ade-action-plan-508c.pdf

Fostering A Safety Culture In Your Environment

44

- Talk to patients openly
- Acknowledge the emotional impact
- Talk about errors and near misses to others in the circle of care to foster the culture

Foster Safety When Engaging Patients

45

Source: ISMP Canada
https://www.ismp-canada.org/download/MedRec/MedSafety_5_questions_to_ask_poster.pdf

Principles of Fostering A Safety Culture

46

- Enables sharing of lessons learned from medication incidents through reporting
- Requires shared accountability between the operators of pharmacies and pharmacy professionals
- Emphasizes learning and accountability through developing a culture where individuals are comfortable bringing forward medication incidents
- Ensures a consistent approach within the profession respecting CQI

Poll

47

How can you foster a safety culture in your practice environment?

A. Report all incidents and near-misses as frequently as you can

B. Transparently post the top three monthly incidents in your pharmacy

C. Create a culture where all pharmacy team members are comfortable bringing forward medication incidents

D. Ensure that pharmacy professionals are accountable for reporting indicents

CQI Approach To Facilitate Shared Learning

48

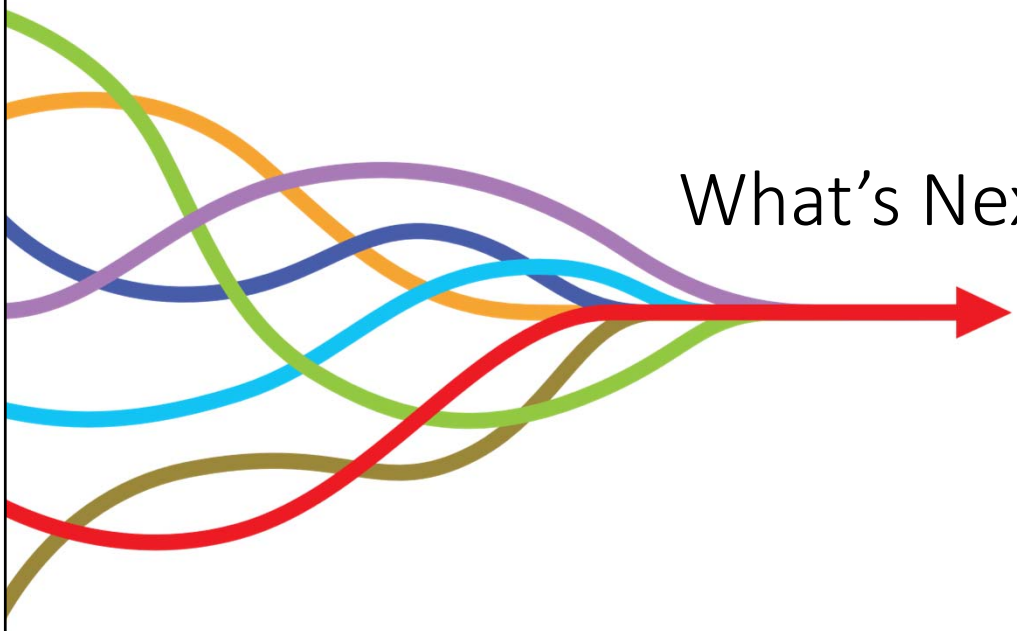
ISMP Canada – shared learnings

- E.g. Multi-incident analysis of student associated medication incidents - addressing culture of safety enablers and challenges
- https://www.ismp-canada.org/download/safetyBulletins/2018/ISMPCSB2018-02-MIA-Student-Incidents.pdf

AIMS Response Team – shared learnings

- 1/10 incidents involved wrong patient – recommendations for practice change included in bulletin
- https://www.ocpinfo.com/wp-content/uploads/2019/09/AIMS-response-team-bulletin.pdf

49



What's Next?

50

Momentum In Community Pharmacy

- 2017 – SK adopted similar requirements
- 2018 – MB pilot
- 2017 – Ontario – AIMS program
- Rapid expansion of Pan Canadian interest in provincial error reporting and safety culture
  - NB made announcement for implementation to begin in 2019
  - BC to have all pharmacies implemented by 2023
- International Growth

51

Patient Safety Legislation for Community Pharmacies in Canada

Provinces	Does the province have CQI legislation/ standards for practice?	Monitor staff performance, equipment, facilities, and adherence to standards of practice	Manage known, alleged, and suspected medication errors that reach the patient	Report errors/ incidents	Report near misses	Report anonymously	Report to an independent, objective third-party organization	Support a national database for sharing learnings arising from trends and patterns	Review pharmacy's aggregate data quarterly	Document quality improvements made resulting from the quarterly meetings of staff	Complete a medication safety self-assessment annually	Educate pharmacy staff on best practices in error/incident management	Encourage open dialogue about errors and other activities to support patient safety culture	Other
Alberta														Accessing and using Netcare, using Chat, Check, Chart model
British Columbia														
Manitoba														New pilot program contains all elements currently missing
New Brunswick														Publishing a practice directive for handling near misses/errors
Newfoundland & Labrador														
Northwest Territories														
Nova Scotia														Scheduled audits + randomly occurring audits
Nunavut														
Ontario														Supplemental standards of practice for each profession
Prince Edward Island														In 2019, mandatory incident reporting, safety self-assessments
Quebec														Encourage an active risk management culture
Saskatchewan														Safety culture assessments, plan to implement "medskim" tool
Yukon														

The province does have this requirement in their CQI standards The province does not have this requirement in their CQI standards (provinces with all yellow cells have a plan to implement CQI standards or are exploring it)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6410425/figure/fig1-1715163519827981/

52

Culture of Safety – Harmonizing Across The Country

- Considerable variation in reporting and CQI/A practices across jurisdictions
- Harmonization of legislation, including reporting practices could help ensure continuity and standardization for SAFE community pharmacy practice across Canada
- Need additional research in the evaluation of these practices (like in NS)
- One centralized database of incidents and near misses or commit to sharing a process nationally
  - Rich environment for learning

Pharmacy Professionals As Safety Stewards – The Time Is Now

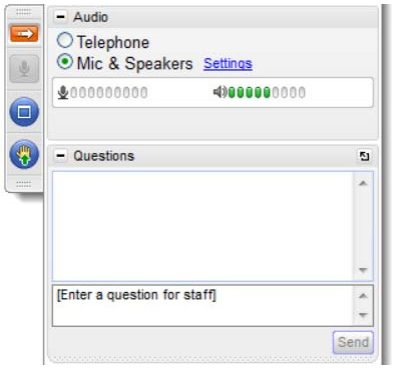
53

- Pharmacists are the hockey goalies of safe medication use
- A near miss can be a gift - pharmacies are choosing to report errors that they've intercepted because we can learn how to do things better
- We have an opportunity to set standards for ourselves
- Must be intentional
- A place to tell all those untold stories – for our patients
- Errors will happen but most important is to record, evaluate and learn
- Should similar requirement apply to HCPs outside the hospital setting

Questions?

54

Please type your questions in the "Questions" window in the control panel and click **Send**



Closing Notes…

- Today's session is accredited for 1.00 CEUs under file #: 8002-2019-2913-B-T.
- You will get a follow up email later today with our Statement of Completion, a link to view the recording, and a link to download the slide deck from our website if you were not able to download it during our broadcast.
- After the broadcast ends, please take a moment to complete our feedback survey
- Stay tuned for our upcoming webinars on therapeutic nutrition in diabetes, pharmacist wellness and caring for Indigenous patients.

References

Baker, G. Ross, Peter G. Norton, Virginia Flintoft, Régis Blais, Adalsteinn Brown, Jafna Cox, Ed Etchells, et al. 2004. "The Canadian Adverse Events Study: The incidence of adverse events among hospital patients in Canada." *CMAJ.* Vol. 170. no. 11. 5 25. 1678-1686.

Boucher, Adrian, Certina Ho, Neil MacKinnon, Todd A. Boyle, Andrea Bishop, Paola Gonzalez, Christopher Hartt, and James R. Barker. 2018. "Quality-related events reported by community pharmacies in Nova Scotia over a 7-year period: a descriptive analysis." *CMAJ Open* (Joule Inc.) 6 (4): E651-E656.

n.d. *Canadian Patient Safety Institute.* https://www.patientsafetyinstitute.ca/en/Pages/default.aspx.

Chung, Necole; Ho, Certina;. 2016. "Lessons Learned from a Provincial Pilot Study." *Pharmacy Connection* 23 (2): 34-38.

Flynn, Elizabeth Allan, Kenneth N. Barker, and Brian J. Carnahan. 2003. "National observational study of prescription dispensing accuracy and safety in 50 pharmacies." *Journal of the American Pharmacists Association* (American Pharmacists Association) 43 (2): 191-200.

Hudes, Sammy. 2016. "Ontario health minister vows increased transparency for pharmacy errors | The Star." *The Star*, 11 24.

ISMP Canada. 2019. *Definition of Terms.* https://www.ismp-canada.org/index.htm.

Kohn, Linda T, Janet M Corrigan, and Molla S Donaldson. 2000. "THE NATIONAL ACADEMIES PRESS To Err Is Human Building a Safer Health System." *NATIONAL ACADEMY PRESS • 2101 Constitution Avenue, N.W. • Washington, DC 20418.*

Marchitelli, Rosa. 2016. "Parents find son's lifeless body after pharmacy switches sleep medication for toxic dose of another drug | CBC News." *Go Public-CBC Newa*, 10 20.

Mehta, Diana. 2016. "Mother of boy who died from wrong medication calls for better reporting of pharmacy errors." *680 News*, 10 21.

Ontario College of Pharmacists. 2019. *AIMS (Assurance and Improvement in Medication Safety) – OCPInfo.com.* https://www.ocpinfo.com/regulations-standards/aims-assurance-and-improvement-in-medication-safety/.

n.d. *Pharmapod - Patient Safety Software for Healthcare Professionals.* https://www.pharmapodhq.com/.

Statistics Canada. 2015. *Health Reports: Correlates of medication error in hospitals, findings.* https://www150.statcan.gc.ca/n1/pub/82-003-x/2008002/article/10565/5202501-eng.htm.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. 2014. "National Action Plan for Adverse Drug Event Prevention." Washington DC.