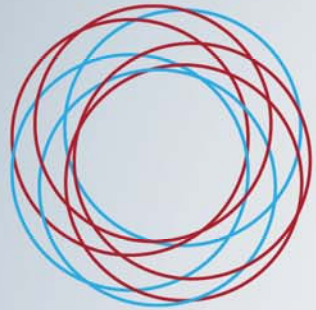


Canadian Pharmacists Conference 2015

Innovation and Collaboration

SafetyNET RX

Continuous Quality Assurance in Nova Scotia Community Pharmacies

Jointly presented by

Canadian Pharmacists Association / Association des pharmaciens du Canada

Ontario Pharmacists Association / Association des pharmaciens de l'Ontario

Objectives

- Discuss continuous quality improvement in the context of community pharmacy practice
- Explain the SafetyNET Rx process created and implemented by community pharmacies in Nova Scotia
- Discuss the importance of mandatory, anonymous error reporting as a component of continuous quality improvement.
- Describe the benefits realized from adoption of a mandatory, standardized continuous quality improvement process.

Quality

- Technical Care
- Interpersonal Relationship
- Amenities of Care

Donabedian, A., Institutional and Professional Responsibilities in Quality Assurance. Qualtiy Assurance in Health Care. Vol 1, No. 1.: 3-11;1989.

THE NEED FOR CONTINUOUS QUALITY IMPROVEMENT IN COMMUNITY PHARMACY

- Working Conditions
- Practitioner Factors
- Healthcare System

Boyle, T. A., Mahaffey, T., MacKinnon, N. J., Deal, H., Hallstrom, L. K., & Morgan, H. (2011). Determinants of medication incident reporting, recovery, and learning in community pharmacies: A conceptual model. Research in Social and Administrative Pharmacy, 7(1), 93-107. doi:10.1016/j.sapharm.2009.12.001

Munger, M. A., Gordon, E., Hartman, J., Vincent, K., & Feehan, M. (2013). Community pharmacists' occupational satisfaction and stress: A profession in jeopardy? Journal of the American Pharmacists Association : JAPhA, 53(3), 282. doi:10.1331/JAPhA.2013.12158

Errors

- Latent Errors: errors waiting to happen; system failures
- Active Errors: error that result from the action of the front line practitioner at the "pointy end":
  - slips – failures of typical, "reflexive" actions, often because of lapses in concentration, fatigue, stress, etc.
  - mistakes – incorrect choices; a reflection of lack of experience, insufficient training, outright negligence, etc

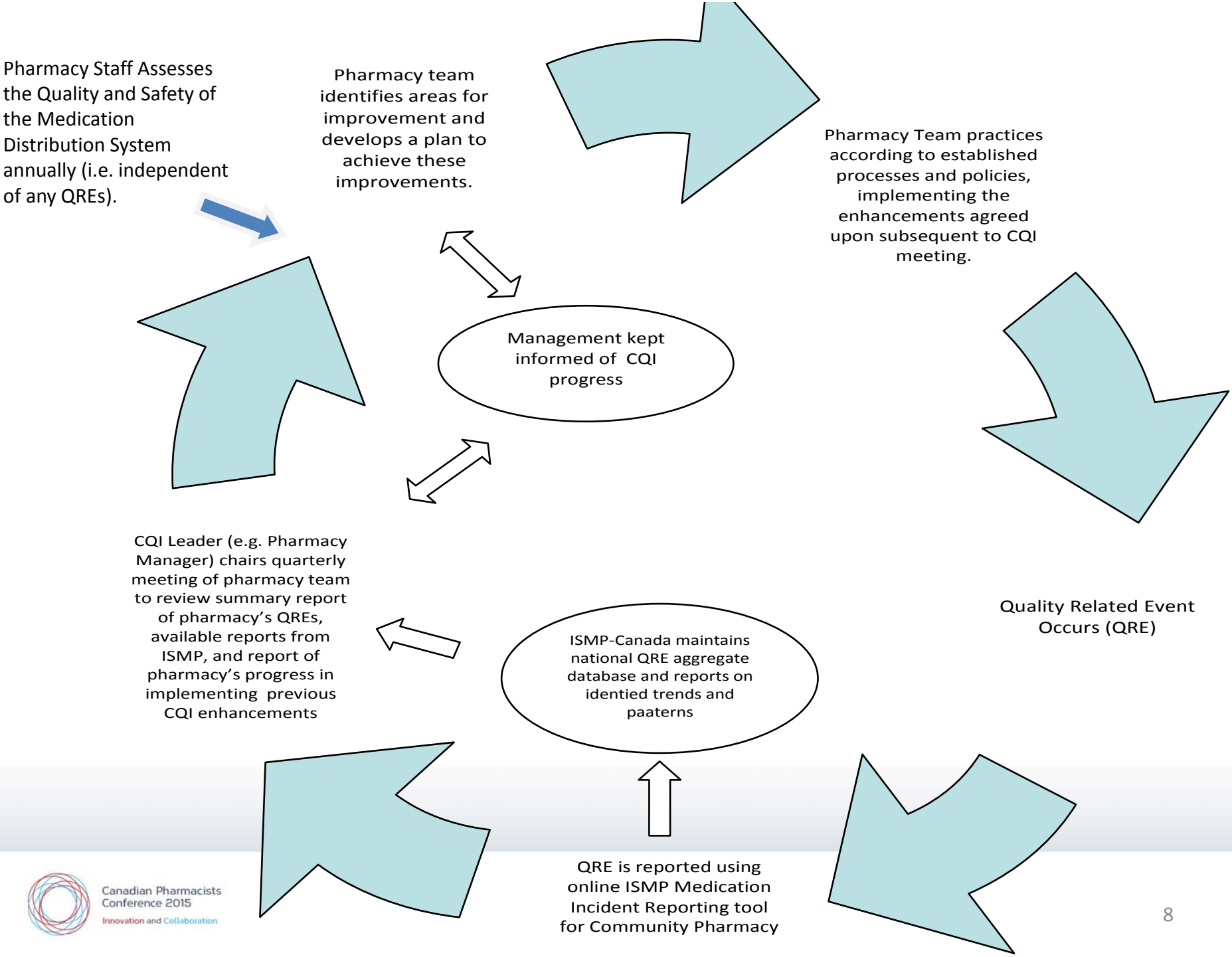
Agency for Healthcare Research and Quality. (March 2015). Patient safety primers: System approach. Retrieved, May 2015, from http://psnet.ahrq.gov/default.aspx

SafetyNET RX: History

- NS Pharmacies required to have a continuous quality assurance program (Pharmacy Act 2001)
- Contemplated a systems approach to medication error reporting and learning, to address the “Swiss Cheese Model” of Medical Errors
- SafetyNET Rx research initiated in 2008; subsequent projects ongoing

SafetyNET RX

- Standardized, continuous quality improvement created by community pharmacies for community pharmacy practice.
- *Standards of Practice: Continuous Quality Assurance Programs in Community Pharmacies* approved by NSCP Council in 2013.


Pharmacy Staff Assesses the Quality and Safety of the Medication Distribution System annually (i.e. independent of any QREs).
Pharmacy team identifies areas for improvement and develops a plan to achieve these improvements.
Pharmacy Team practices according to established processes and policies, implementing the enhancements agreed upon subsequent to CQI meeting.
Management kept informed of CQI progress
Quality Related Event Occurs (QRE)
CQI Leader (e.g. Pharmacy Manager) chairs quarterly meeting of pharmacy team to review summary report of pharmacy's QREs, available reports from ISMP, and report of pharmacy's progress in implementing previous CQI enhancements
ISMP-Canada maintains national QRE aggregate database and reports on identied trends and paaterns
QRE is reported using online ISMP Medication Incident Reporting tool for Community Pharmacy

SafetyNET RX

- Nova Scotia College of Pharmacists *Standards of Practice for Continuous Quality Assurance Programs in Community Pharmacies*

- SafetyNET Rx website *http://www.safetynetrx.ca/*

Nova Scotia College of Pharmacists, Standards of Practice for Continuous Quality Assurance Programs in Community Pharmacies (January 2010), www.nspharmacists.ca

Managing Medication Errors

QUOTES
ERRORS AND MISTAKES

'Failure is the opportunity to begin again more intelligently.'

- *Henry Ford*

Any man can make mistakes, but only an idiot persists in his error.'

- *Marcus Tullius Cicero*

QUOTES
ERRORS AND MISTAKES

Failure is not a crime. Failure to learn from failure is.'

- *Walter Wriston*

The only real mistake is the one from which we learn nothing.

- *John Powell*

The Greatest Mistake?
Not Learning from Our Mistakes

"Insanity: **doing the same thing** over and over again **and expecting different results**."

Albert Einstein

Proper management requires RESPONDING and not REACTING

All Pharmacists will make mistakes.

Good Pharmacists will MANAGE THEM PROPERLY and use them as an opportunity to learn how to enhance their practice.

"Maybe we could agree that the whole board was at the theatre – a kind of 'corporate alibi'."

SafetyNET RX

2. **Anonymous** reporting of quality related events (QREs) to an **independent, objective third party** organization for **population of a national aggregate database** from which learnings arising from trends and patterns can be communicated across the profession.

SafetyNET RX

Canadian Pharmacy Incident Reporting Tool -CPhIR
(Institute for Safe Medication Practice [ISMP])
www.cphir.ca

SafetyNET RX

3. Quarterly CQI meetings of staff for:

- Open dialogue on QREs between pharmacy staff and management through quarterly review of the pharmacy's aggregate QRE data (e.g. total number of incidents, type of incidents, etc.).

SafetyNET RX

3. Quarterly CQI meetings of staff for:

- Documenting quality improvements made as a result of the
- Completing a medication safety self-assessment annually, and monitoring the progress of the resulting enhancement plan

SafetyNET RX

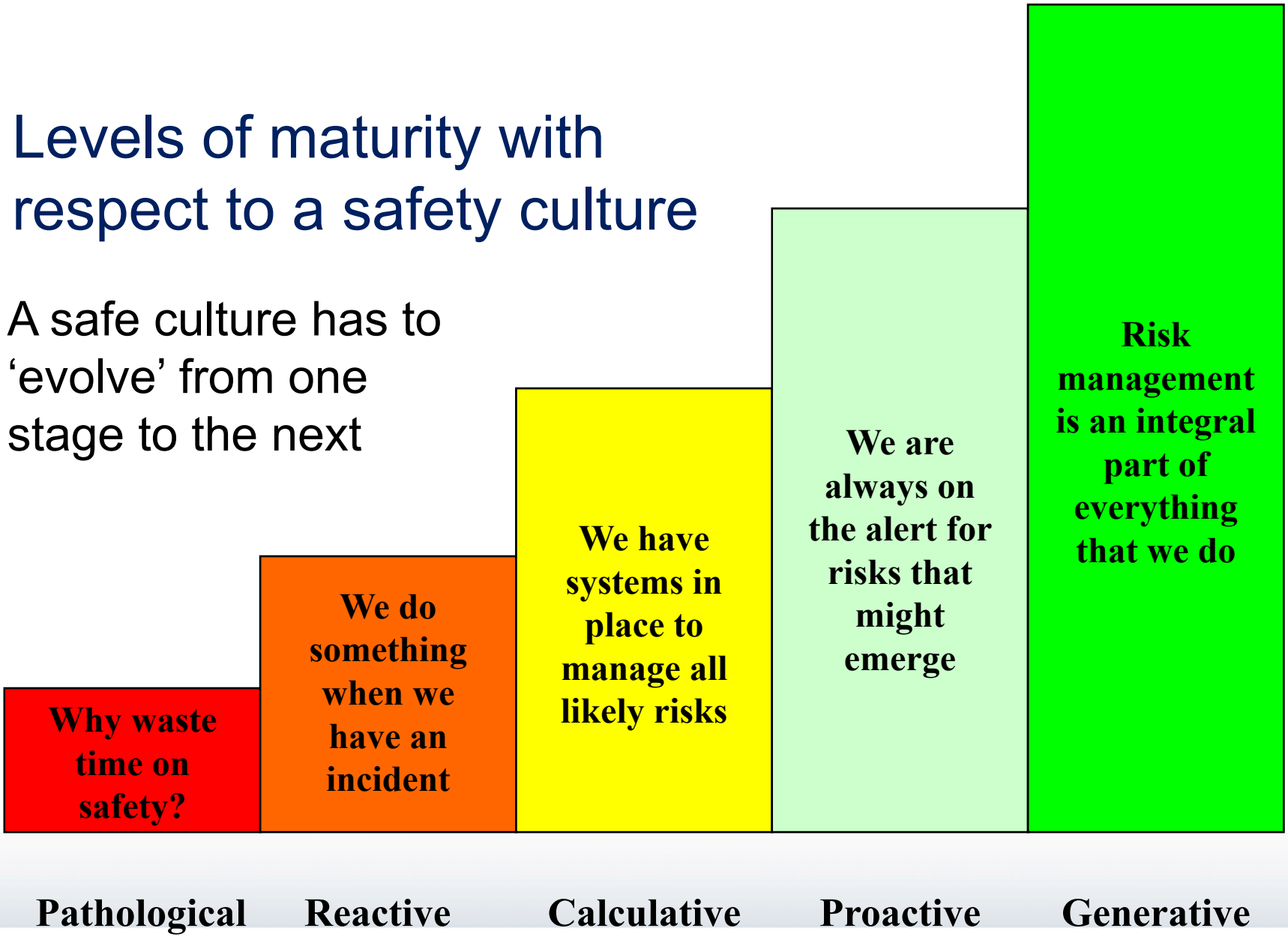
(4) Achieves the purposes of an effective CQI program ... through ongoing education of pharmacy staff on the current best practices in QRE management and ADOPTION of these practices

.....with the goal of DISCOURAGINE PUNITIVE IDENTIFICATION or other approaches that are detrimental to reporting and learning.

MATURING THE SAFETY " CULTURE" OF THE PHARMACY

Levels of maturity with respect to a safety culture

A safe culture has to 'evolve' from one stage to the next



Generative Safety Culture

- Errors are recognized as inevitable; can be devastating and efforts made to discover and address system weaknesses before harm occurs
- Reporting of errors is encouraged
- Frontline workers are not punished for committing slips
- Errors are seen as learning opportunities and analyzed to identify latent errors

Generative Safety Culture

- Effective and open communication within organization
- Openness about problems and errors
- Knowledge obtained from errors analysis is shared among pharmacies to improve quality overall across the healthcare system

Boyle et al., 2011) (Ashcroft, Morecroft, Parker, & Noyce, 2005) (Singer et al., 2003)

SafetyNET RX: Outcomes

- ✓ Decrease in the number of medication errors
- ✓ 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

Boyle, T. A., Bishop, A. C., Duggan, K., Reid, C., Mahaffey, T., MacKinnon, N. J., & Mahaffey, A. (2014). Keeping the " continuous" in continuous quality improvement: Exploring perceived outcomes of CQI program use in community pharmacy. *Research in Social and Administrative Pharmacy, 10*(1), 45-57. doi:10.1016/j.sapharm.2013.01.006

Final Thought

"People have a big problem understanding the relationship between quality and systems". ..."There's lip service to quality and, goodness knows, propaganda, but real commitment is in short supply". "Systems awareness and systems design are important for health professionals, but are not enough. They are enabling mechanisms only. It is the ethical dimension of individuals that is essential to a system's success. Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system." (Avedis Donabedian)

Best, M., & Neuhauser, D. (2004). Avedis donabedian: Father of quality assurance and poet. *Quality and Safety in Health Care, 13*(6), 472.

QUESTIONS?